Three-Question Matrix and References RFP No. GEN2116451P2 Group Dental Preferred Provider Organization (DPPO) Insurance

Ranking	1	2	3	4	5	6	7
Firm Name	UnitedHealthcare Insurance Company	Humana Insurance Company	Cigna Health and Life Insurance Company	Solstice Benefits, Inc.	Metropolitan Life Insurance Company	Delta Dental Insurance Company	Aetna Life Insurance Company
Questions							
Have the vendors taken any exceptions to the County's Standard Terms and Conditions?	NO EXCEPTIONS	NO EXCEPTIONS	YES	NO EXCEPTIONS	YES	NO EXCEPTIONS	NO EXCEPTIONS
2. Do the vendors have comparable government experience?	County 2) Miami-Dade Public	Office 2) Town of Davie 3) Broward County	Palm Beach County Sheriff's Office City of Miami Lee County Sheriff's Office	City of Pembroke Pines Palm Beach Board of County Commissioners United Teachers of Dade		City of Coral Springs Broward College Jackson Health Systems	Orlando Utilities Commission
3. Have the vendors' references been checked?	YES (Attached)	YES (Attached)	YES (Attached)	YES (Attached)	YES (Attached)	YES (Attached)	YES (Attached)

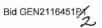
Broward County Board of County Commissioners





Vendor Reference Verification Form

Broward County Solicitation No. and Title:				•
GEN2116451P Group Dental Pref	erred Provid	ler Organiza	tion (PPO)	Insurance
Reference for: (Name of Proposer) Aetna Life Ins	surance Company			
Organization/Firm Name providing reference:				
Gables Residential Services, Inc.				-
CONTROL PROPERTY OF THE PROPER	e: Director of	PR & BaRefere		05/21/2018
Contact Email: vvaldes@gables.com		Conta	act Phone: 561	-999-4032
Name of Referenced Project:	200 m	1000		
Contract No. Date Services P	rovided:		Project Amou	unt:
01/01/2010	to present			
Vendor's role in Project: ✓ Prime Vendor S	ubconsultant/S	ubcontractor		
Would you use this vendor again? √Yes	□No If No	, please specify	in Additional C	omments (below).
Description of services provided by Vendor:				
DMO and PPO dental plan provided by Aetna. Fully participation rate on the dental plans.	insured plan 10	0% employee pai	id. We have ap	proximately 80%
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable
Vendor's Quality of Service			7	
a. Responsive b. Accuracy	H		<u>V</u>	H
c. Deliverables				
2. Vendor's Organization:	П		7	
a. Staff expertise b. Professionalism	H		<u>v</u>	H
c. Turnover			V	
3. Timeliness of:	_	_		
a. Project	H		✓	
b. Deliverables			V	
4. Project completed within budget			\checkmark	
Cooperation with: a. Your Firm			7	
b. Subcontractor(s)/Subconsultant(s)	H	H		7
c. Regulatory Agency(ies)			✓	
Additional Comments: (provide on additional sheet if needed)				
THIS SECTION FOR COUNTY USE ONLY				
Verified via: X EMAIL VERBAL Verified by: Tracey	A. Gordon	Division: Hu	man Resources	pate: 1/22/2019





Broward County Solicitation No. and Title: GEN2116451P1-2 Group Dental Pre	ferred Provid	der Organiza	ation (PPO) Insurance	
Reference for: Aetna Life Insurance Company					
Organization/Firm Name providing reference:				19	
Interbond Corporation of America dba Bran	dsMart USA				
Contact Name: Janet Witczak Tit	le: VP, HR	Refe	rence date:	05/23/2018	
Contact Email: Janet.Witczak@bm1.brandsmart.com Contact Phone: 954-797-4045					
Name of Referenced Project: Dental PPO		100	(#)		
Contract No. Date Services F	Provided:		Project Am	nount:	
835779 08/01/2015	to 08/31/2	2019			
Vendor's role in Project: ✓ Prime Vendor	Subconsultant/S	ubcontractor	, , , , , , , , , , , , , , , , , , , ,		
Would you use this vendor again? Yes	□No If No	, please specify	/ in Additional	Comments (below).	
Description of services provided by Vendor:					
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable	
Vendor's Quality of Service			7		
a. Responsive b. Accuracy	H		V		
c. Deliverables			✓		
2. Vendor's Organization:			1		
a. Staff expertise b. Professionalism	H		7		
c. Turnover			✓		
3. Timeliness of:					
a. Projectb. Deliverables	H		✓		
Project completed within budget				✓	
Cooperation with: a. Your Firm			1		
b. Subcontractor(s)/Subconsultant(s)	Ħ	Ħ	V		
c. Regulatory Agency(ies)				\checkmark	
Additional Comments: (provide on additional sheet if needed)					
THIS SECT	ION FOR COUNTY U	SE ONLY			
Verified via: X EMAIL VERBAL Verified by: Trace	y A. Gordon	Division: H	Iuman Resource	es _{Date:}	

Broward County Board of County Commissioners





Vendor Reference Verification Form

Broward County Solicitation No. and Title: GEN2116451P1 ² - Group Dental Pre	ferred Provi	der Organiza	ation (PPC) Insurance
	Insurance Compan			h
Organization/Firm Name providing reference:	3.5 A. 5 A. 5		1	
Southern Glazer's Wine & Spirits				
Contact Name: Michelle Toney Ti	tle: VP, Emplo	yee Ben Refe	rence date:	05/24/2018
Contact Email: MToney@sgws.com	455			954) 602-2594
Name of Referenced Project: N/A			- 192	
Contract No. Date Services	Provided:		Project An	nount:
N/A 05/01/2002	to 05/01/	2018	\$ 0.00	
Vendor's role in Project: ✓ Prime Vendor ☐	Subconsultant/S	ubcontractor		-
Would you use this vendor again?	□No If No	o, please specify	y in Additional	Comments (below).
Description of services provided by Vendor:				
Dental self-funded plan administrator				
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable
Vendor's Quality of Service a. Responsive b. Accuracy c. Deliverables			✓ ✓	
Vendor's Organization: a. Staff expertise b. Professionalism c. Turnover			✓ ✓ ✓	
Timeliness of: a. Project b. Deliverables			✓	
Project completed within budget			\checkmark	
 5. Cooperation with: a. Your Firm b. Subcontractor(s)/Subconsultant(s) c. Regulatory Agency(ies) 				
Additional Comments: (provide on additional sheet if needed)				*
THIS SECT	TION FOR COUNTY L	SE ONLY		
Verified via: X EMAIL VERBAL Verified by: Trace	ey A. Gordon	Division: H	Human Resourc	es _{Date:} 1/15/2019





Broward County Solicitation No. and Title: GEN2116451P1 - Group Dental Preference	erred Provid	ler Organiza	ntion (PPO)	Insurance
Reference for: (Name of Proposer) Aetna Life Inst	urance Company			
Organization/Firm Name providing reference:			444	
Ultimate Software				
Contact Name: Mabel Cabrera Title	: Benefits Di	rector Refer	ence date:	05/21/2018
Contact Email: mcabrera@ultimatesoftware.com	<u>- (국무) (정점 :</u> 회)	Cont	act Phone: 95	4-331-6773
Name of Referenced Project:				
Contract No. Date Services Pr	ovided:		Project Amo	ount:
835274 06/01/2014	to present			¥)
Vendor's role in Project: ✓ Prime Vendor St	ubconsultant/Si	ubcontractor		79
Would you use this vendor again? ✓ Yes [No If No	, please specify	in Additional	Comments (below).
Description of services provided by Vendor:				
Aetna is our sole provider for medical, vision, de	ental and life in	surances as we	ell as basic lo	ng term disability.
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable
Vendor's Quality of Service				
a. Responsive b. Accuracy	H	H	✓	H
c. Deliverables		H	✓	
2. Vendor's Organization:				
a. Staff expertise b. Professionalism	H	H	V	H
c. Turnover		ä	✓	
3. Timeliness of:				
a. Project	H			
b. Deliverables	Ш		V	
Project completed within budget			\checkmark	
Cooperation with: a. Your Firm				
b. Subcontractor(s)/Subconsultant(s)	H		V	
c. Regulatory Agency(ies)			✓	
Additional Comments: (provide on additional sheet if needed)				
THIS SECTIO	N FOR COUNTY US	SE ONLY		
Verified via: X EMAIL VERBAL Verified by: Tracey	A. Gordon	Division: H	uman Resources	Spate: 1/15/2019



Broward County Solicitation No. and Title: GEN2116451P1 - Group Dental Pre	ferred Provid	der Organiza	ation (PPO) Insurance	
Reference for: Aetna Life Insurance Company	000000				-
Organization/Firm Name providing reference:					
Orlando Utilities Commission (OUC)					
Contact Name: Wendy Reynolds Tit	le: Manager, l	Benefits Refe	rence date:	05/17/2018	
Contact Email: wreynolds@ouc.com		Con	tact Phone: 4	07-434-2207	
Name of Referenced Project: Approximate da	tes below - Ae	tna is our curr	ent provider.		
Contract No. Date Services F	Provided:		Project Am	nount:	
01/01/1988	to 05/17/	2018			
Vendor's role in Project: ✓ Prime Vendor □ S	Subconsultant/S	ubcontractor			
Would you use this vendor again? Yes	□No If No	, please specif	y in Additional	Comments (below).	•
Description of services provided by Vendor:					
Aetna provides our Medical, Dental and Prescription over 30 years. We added prescription on 1/1/2015.	n coverage. They We are self-fund	have been our ed.	medical and de	ental provider for	
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable	
Vendor's Quality of Service					
a. Responsive b. Accuracy	H	H	V	H	
c. Deliverables			✓		
2. Vendor's Organization:			1		
a. Staff expertise b. Professionalism	H	H	\overline{\sqrt{1}}		
c. Turnover			✓		
3. Timeliness of:					
a. Projectb. Deliverables	H	H	✓	a	
Project completed within budget			\checkmark	. , , ,	
Cooperation with: a. Your Firm		П			
b. Subcontractor(s)/Subconsultant(s)	H	H	\overline{\sqrt{1}}	H	
c. Regulatory Agency(ies)			√		
Additional Comments: (provide on additional sheet if needed)					
THIS SECTION FOR COUNTY USE ONLY					
Verified via:	y A. Gordon	Division: I	Iuman Resource	es _{Date:} 1/17/2019	



Procurement Code.

Vendor Reference Verification Form

Broward County Solicitation No. and Title: GEN2116451P2 - Group Dental Preferred Provider Organization (PPO) Insurance Reference for: Cigna Dental Health, Inc. Organization/Firm Name providing reference: Palm Beach County Sheriff's Offie Contact Name: Gerald Peebles Reference date: Title: Division Manager 11/13/2018 Contact Phone: 561-688-3125 Contact Email: peeblesg@pbso.org Name of Referenced Project: PBSO Dental Contract No. Date Services Provided: Project Amount: N/A 01/01/2008 to Present Subconsultant/Subcontractor Vendor's role in Project: ✓ Prime Vendor No If No, please specify in Additional Comments (below). Would you use this vendor again? √ Yes Description of services provided by Vendor: DPPO, DHMO Excellent Satisfactory Not Needs Please rate your experience with the Improvement **Applicable** referenced Vendor: Vendor's Quality of Service a. Responsive b. Accuracy c. Deliverables Vendor's Organization: a. Staff expertise b. Professionalism c. Turnover 3. Timeliness of: a. Project b. Deliverables Project completed within budget Cooperation with: a. Your Firm b. Subcontractor(s)/Subconsultant(s) c. Regulatory Agency(ies) Additional Comments: (provide on additional sheet if needed) *** Please contact client directly for reference feedback and verification. Currently out of office and unable to complete form. Willing to provide reference upon request. ***THIS SECTION FOR COUNTY USE ONLY*** Verified by: Tracey A. Gordon Division: Human Resources Date: Verified via: X EMAIL VERBAL All information provided to Broward County is subject to verification. Vendor acknowledges that inaccurate, untruthful, or incorrect statements made in support of this response may be used by the County as a basis for rejection, rescission of the award, or termination of the contract and may also serve as the basis for debarment of Vendor pursuant to Section 21.119 of the Broward County



Broward County Solicitation No. and Title: GEN2116451P2 - Group Dental Preferred Provider Organization (DPPO) Insurance (rebid) Reference for: Cigna Dental Health, Inc. Organization/Firm Name providing reference: City of Miami Contact Name: Ann-Marie Sharpe Title: Director, Risk Mana Reference date: 11/09/2018 Contact Phone: (305) 416-1381 Contact Email: asharpe@miamigov.com Name of Referenced Project: City of Miami Dental Contract No. Date Services Provided: Project Amount: Present N/A 01/01/2013 to Vendor's role in Project: Prime Vendor Subconsultant/Subcontractor Would you use this vendor again? No If No, please specify in Additional Comments (below). Description of services provided by Vendor: provide fully insured group dental coverage with web access to claims and providers, communication and enrollment capabilities including online tools and account management staff. Needs Satisfactory Excellent Please rate your experience with the Not Improvement Applicable referenced Vendor: Vendor's Quality of Service a. Responsive b. Accuracy c. Deliverables 2. Vendor's Organization: a. Staff expertise b. Professionalism c. Turnover Timeliness of: a. Project b. Deliverables 4. Project completed within budget 5. Cooperation with: a. Your Firm b. Subcontractor(s)/Subconsultant(s) c. Regulatory Agency(ies) Additional Comments: (provide on additional sheet if needed) ***THIS SECTION FOR COUNTY USE ONLY*** Division: Human Resources Date: 1/22/2019 Verified via: X EMAIL VERBAL Verified by: Tracey A. Gordon



Broward County Solicitation No. and Title:				
GEN2116451P2 - Group Dental Prefer	red Provider	Organization	(DPPO) Ir	surance (rebid)
Reference for: Cigna Dental Health, Inc.				-
Organization/Firm Name providing reference:	(#)			
Lee County Sheriff's Office				
	le: Director		rence date:	11/08/2018
Contact Email: DHeikkila@sheriffleefl.org		Con	tact Phone: 2	39-258-3271
Name of Referenced Project: LCSO Dental		97		
Contract No. Date Services F			Project Am	nount:
N/A 01/01/2011	to Present			
Vendor's role in Project: ✓ Prime Vendor	Subconsultant/S	ubcontractor		3
Would you use this vendor again? \(\sqrt{e} \) res	No If No	, please specify	/ in Additional	Comments (below).
Description of services provided by Vendor:				
Medical, Dental, Vision and pharmacy.				
Diagon rate your experience with the	Needs	Satisfactory	Excellent	Not
Please rate your experience with the referenced Vendor:	Improvement	Satisfactory	LACCHEIL	Applicable
Vendor's Quality of Service	П			
a. Responsive b. Accuracy		Н	✓	
c. Deliverables			\checkmark	
2. Vendor's Organization:			1	
a. Staff expertise b. Professionalism	H		✓	
c. Turnover			\checkmark	
3. Timeliness of:				
a. Project b. Deliverables	H	\vdash	H	<u>v</u>
Project completed within budget				✓
Cooperation with: a. Your Firm				
b. Subcontractor(s)/Subconsultant(s)	H		V	
c. Regulatory Agency(ies)			\checkmark	
Additional Comments: (provide on additional sheet if needed)				
THIS SECTION FOR COUNTY USE ONLY				
Verified via:VERBAL Verified by:VERBAL Verified by:VERBAL Verified by:	A. Gordon	Division: H	uman Resource	esDate:



Broward County Solicitation No. and Title:				
GEN2116451P.X - Group Dental Pre	ferred Provid	ler Organiza	ation (PPC) Insurance
Reference for: Delta Dental Insurance Company	1000000	40.5	0-2 <u>- 20-20</u>	100
Organization/Firm Name providing reference:		VA120A1		
Broward College				
Contact Name: Leisa Orcutt Ti	tle: District Dire	ector, Be Refe	rence date:	11/20/2018
Contact Email: lorcutt@broward.edu	-	Con	tact Phone: 9	54-2010-7613
Name of Referenced Project: Delta Dental PR	PO Insurance			
Contract No. Date Services	Provided:		Project An	nount:
Group #06083 01/01/2009	to present			
Vendor's role in Project: ✓ Prime Vendor ☐	Subconsultant/S	ubcontractor		1 5007
Would you use this vendor again? ✓ Yes	☐No If No	, please specif	y in Additiona	Comments (below).
Description of services provided by Vendor:				
Dental benefits administration				
Please rate your experience with the	Needs	Satisfactory	Excellent	Not
referenced Vendor:	Improvement	Cullotationy	LAGOROTE	Applicable
Vendor's Quality of Service a. Responsive			1	
b. Accuracy			V	
c. Deliverables			\checkmark	
2. Vendor's Organization:	П		1	
a. Staff expertise b. Professionalism	H		V	
c. Turnover				✓
3. Timeliness of:				
a. Projectb. Deliverables	H		✓	
			<u>V</u>	
Project completed within budget			\checkmark	
Cooperation with: a. Your Firm			7	
b. Subcontractor(s)/Subconsultant(s)	H	H		7
c. Regulatory Agency(ies)				$\overline{\checkmark}$
Additional Comments: (provide on additional sheet if needed)				
THIS SECTION FOR COUNTY USE ONLY				
Verified via: X EMAIL VERBAL Verified by: Trace	ey A. Gordon	Division:	Human Resourc	ces _{Date:} 1/28/2019



Broward County Solicitation No. and Title:				
GEN2116451PA - Group Dental Pre	ferred Provid	ler Organiza	ation (PPO) Insurance
Reference for: Delta Dental Insurance Company				199.58 1999
Organization/Firm Name providing reference:				
City of Coral Springs		lance and the		
	tle: Director of			11/20/2018
Contact Email: dpazdra@coralsprings.org	*-	Con	tact Phone: 9	54-344-1152
Name of Referenced Project: Group PPO De				
Contract No. Date Services			Project Am	nount:
15640 (group number) 01/01/2012	to present			
Vendor's role in Project: ✓ Prime Vendor ☐	Subconsultant/S	ubcontractor		31 1000
Would you use this vendor again? ✓ Yes	□No If No	, please specify	y in Additional	Comments (below).
Description of services provided by Vendor:				
Dental benefits administration				
Please rate your experience with the	Needs	Satisfactory	Excellent	Not
referenced Vendor:	Improvement	ounoidotory	LXCONON	Applicable
Vendor's Quality of Service	П		1	
a. Responsive b. Accuracy	H	H	V	H
c. Deliverables			<u>~</u>	
2. Vendor's Organization:				
a. Staff expertise	H	H	./	H
b. Professionalismc. Turnover	H	H	V	Ħ
3. Timeliness of:				
a. Project			\checkmark	
b. Deliverables			\checkmark	
4. Project completed within budget			\checkmark	
5. Cooperation with:				
a. Your Firmb. Subcontractor(s)/Subconsultant(s)	님	H	∀	
c. Regulatory Agency(ies)	H	H	V	
			L V _1	
Additional Comments: (provide on additional sheet if needed)				
<u> </u>		o= 0.0.v		
T	TION FOR COUNTY U		D	1/16/2019
Verified via: X EMAIL VERBAL Verified by: Tracey	A. Gordon	Division: E	iuinan Kesource	es Date: 1/16/2019



Broward County Solicitation No. and Title: GEN2116451P4 - Group Dental Pre	eferred Provid	der Organiz	ation (PPO) Insurance	
Reference for: Delta Dental Insurance Company	10011-0				
Organization/Firm Name providing reference:			44.0		
Jackson Health System					
Contact Name: Tala Teymour Ti	tle: Senior Dire	ector Refe	rence date:	11/20/2018	
Contact Email: tteymour@jhsmiami.org		Con	tact Phone: 7	86-466-8384	
Name of Referenced Project: Dental PPO					
Contract No. Date Services	Provided:		Project Am	nount:	
19083 01/01/2018	to 12/31/2	2020	\$ 5,100,00	0.00	
Vendor's role in Project: ✓ Prime Vendor	Subconsultant/S	ubcontractor	310)		
Would you use this vendor again? Yes	□No If No	, please specif	y in Additional	Comments (below).	
Description of services provided by Vendor:					
Administer dental PPO product to employee	es and depende	nts			
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable	
Vendor's Quality of Service Responsive			J		
a. Responsive b. Accuracy	Ħ	H	7	H	
c. Deliverables			\checkmark		
2. Vendor's Organization:			7		
a. Staff expertise b. Professionalism	Ħ	H	7	Ħ	
c. Turnover			✓		
3. Timeliness of:					
a. Project	H	H	√		
b. Deliverables			▼		
4. Project completed within budget				\checkmark	
5. Cooperation with:					
a. Your Firmb. Subcontractor(s)/Subconsultant(s)	님	H	∀		
c. Regulatory Agency(ies)	H	H	▼		
				-	
Additional Comments: (provide on additional sheet if needed)					
TLIC CEC	***THIS SECTION FOR COUNTY USE ONLY				
Verified via: X EMAII VERBAL Verified by: Trace			Human Resource	es _{Date} 1/22/2019	



Broward County Solicitation No. and Title:					
GEN2116451P2 - Group Dental Prefer	red Provider	Organiza	ation (DPPO) Ir	surance (rebid))
Reference for: Broward County Government of Flo	orida Hu	mana Insura	nce Company		
Organization/Firm Name providing reference:	>				
Broward Sheriff's Office					
	e: Benefits M	Manager	Reference date:	11/14/2018	
Contact Email: elizabeth_parker@sheriff.org			Contact Phone: 9	54-831-8355	
Name of Referenced Project: DPPO					
Contract No. Date Services P	rovided:		Project An	nount:	
01/01/2018	to 12/31.	/2018	\$ 932,000.	00	
Vendor's role in Project: ✓ Prime Vendor S	Subconsultant/S	Subcontract	or		
Would you use this vendor again? √Yes	□No If N	o, please sp	pecify in Additional	Comments (below	<i>i</i>).
Description of services provided by Vendor:					
Dental PPO Insurance					
	Nevde	Catlefaste	Everlent	Not	
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfacto	ry Excellent	Applicable	
Vendor's Quality of Service					
Responsive Accuracy	H		<u>v</u>	H	
c. Deliverables	H		V		
2. Vendor's Organization:					
a. Staff expertise	H	님	V	- H	
b. Professionalismc. Turnover	H	님	<u>~</u>	片	
				\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
Timeliness of: a. Project			7		
b. Deliverables			V		
4. Project completed within budget			\checkmark		
5. Cooperation with:	174				
a. Your Firm			\checkmark		
b. Subcontractor(s)/Subconsultant(s)c. Regulatory Agency(ies)			\checkmark		
c. Regulatory Agendy (les)			\checkmark		
Additional Comments: (provide on additional sheet if needed)					
THIS SECTION	ON FOR COUNTY U	JSE ONLY		, ,	
Verified via: x EMAILVERBAL Verified by: Tracey	A. Gordon	Divis	ion.Human Resources	Date: 1/16/2019	
All information provided to Broward County is subject to verification. Vendor acknowled County as a basis for rejection, rescission of the award, or termination of the contract reprocurement Code.	lges that inaccurate, untru and may also serve as the	ithful, or incorrect sta e basis for debarme	atements made in support of this nt of Vendor pursuant to Section	s response may be used by the a 21,119 of the Broward County	



Broward County Solicitation No. and Title: GEN2116451P2 - Group Dental Prefer	rred Provider	Organization	(DPPO) Inc	surance (rehid)
Deference for	a Insurance Compa		(6110)111	surance (rebiu)
Organization/Firm Name providing reference:	a msurance Compa	ury		19
Town of Davie				
Contact Name: Grace Garagozzo Tit	tle: HR Directo	•	ence date:	
Contact Email: ggaragozzo@davie-fl.gov		Cont	act Phone: 95	54-797-1094
Name of Referenced Project:		20 400	****	
Contract No. Date Services	Provided:		Project Am	ount:
	to 11/13/2	2018		
Vendor's role in Project: ✓ Prime Vendor	Bubconsultant/S	ubcontractor		
Would you use this vendor again?	No If No	, please specify	in Additional	Comments (below).
Description of services provided by Vendor:				
Provides Town with group dental and vision	services for over	er 12 years		
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable
Vendor's Quality of Service a. Responsive b. Accuracy c. Deliverables			√ √	
Vendor's Organization: a. Staff expertise b. Professionalism c. Turnover			√ √	
Timeliness of: a. Project b. Deliverables			✓	
Project completed within budget			√	
 5. Cooperation with: a. Your Firm b. Subcontractor(s)/Subconsultant(s) c. Regulatory Agency(ies) 			√ √	
Additional Comments: (provide on additional sheet if needed)				
THIS SECT	TION FOR COUNTY U	SE ONLY		
Verified via: X EMAIL VERBAL Verified by: Trace	y A. Gordon	Division: H	uman Resources	Date: 1/18/2019
All information provided to Broward County is subject to verification. Vendor acknow County as a basis for rejection, rescission of the award, or termination of the contral Procurement Code.	ledges that inaccurate, untrut			



9	4						
Broward County Solicitation No. and Title:							
GEN2116451P2 - Group Dental Prefer	rred Provider	Organization	(DPPO) In	surance (rebid)		
Reference for: (Name of Proposer) Butw	gral Cor	intu B	mit of	Florid	a		
Organization/Firm Name providing reference: Humana Insurance Company							
Broward County Public Schools							
		nistratur Refe	rence date:	1/20/2018			
Contact Email: Shanra, Francisa	branceder	con Con	tact Phone:	154-321-3110)		
Name of Referenced Project:	DIDIGITIE SA,		AND COMMENTS OF	,			
Contract No. Date Services	Provided:		Project Am	ount:			
1/1/2017	to 12/31/2	2020					
Vendor's role in Project: Frime Vendor	Subconsultant/S	ubcontractor	ALCOHOL TO A				
Would you use this vendor again? Yes	No If No	o, please specif	y in Additional	Comments (below	v).		
Description of services provided by Vendor:	W/44/2						
They provide HMO and PPO dental and a Vision p	olan.			×.			
70.4	Naada	Catiofastani	Evanllant	Not			
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Applicable	÷		
Vendor's Quality of Service	П	id					
a. Responsive b. Accuracy	H						
c. Deliverables	Ħ		Ħ				
2. Vendor's Organization:							
a. Staff expertise	H		H	- H			
b. Professionalismc. Turnover	H		H				
3. Timeliness of:	l-and			Ш	,		
a. Project		<u>u</u>					
b. Deliverables							
4. Project completed within budget							
Cooperation with: a. Your Firm			r-1				
b. Subcontractor(s)/Subconsultant(s)		#/					
c. Regulatory Agency(ies)	H	7	H	H			
Additional Comments: (provide on additional sheet if needed)		•					
THIS SECTION FOR COUNTY USE ONLY							
Verified via: X EMAIL VERBAL Verified by: Trace	ey A. Gordon	Division: H	uman Resource	es _{Date} : 1/23/2019			
All information provided to Broward County is subject to verification. Vendor acknowledges that inaccurate, untruthful, or incorrect statements made in support of this response may be used by the County as a basis for rejection, rescission of the award, or termination of the contract and may also serve as the basis for debarment of Vendor pursuant to Section 21.119 of the Broward County Procurement Code.							



Broward County Solicitation No. and Title:

Reference for: Broward County Me	tLife Metropol	itan Life Insur	ance Compan	y
Organization/Firm Name providing reference:				
Certura Health				- Company
Contact Name: Michelle OderbachT	itle: Dir Ber	efits Refe	rence date:	5/23/18
Contact Email: Michellecolo whach @	A 1.	ra Con	tact Phone:	303 673 8
Name of Referenced Project:		J		
Contract No. Date Services	Provided:		Project Am	nount:
	to present	t		
endor's role in Project: Prime Vendor	Subconsultant/S	ubcontractor		
ould you use this vendor again? Yes	□No If No	o, please specif	y in Additional	Comments (be
escription of services provided by Vendor:				
Please rate your experience with the	Needs	Satisfactory	Excellent	Not
eferenced Vendor: 1. Vendor's Quality of Service	Improvement			Applicable
a. Responsive			X	
b. Accuracy c. Deliverables	H			H
	Ш	Ш	K	
Vendor's Organization: a. Staff expertise		П	X	
b. Professionalism			\boxtimes	
c. Turnover			⊠	
3. Timeliness of:			N	
a. Project b. Deliverables	H	H		H
	_		NG.	
Project completed within budget			×	
Cooperation with:	П		1XI	
1977 - 177 - 178 - 178 - 178 - 178 - 178 - 178 - 178 - 178 - 178 - 178 - 178 - 178 - 178 - 178 - 178 - 178 - 1		\vdash	\bowtie	H
a. Your Firm	H	1 1		
NOTE: 1914-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	Ħ	H	₹	
a. Your Firm b. Subcontractor(s)/Subconsultant(s) c. Regulatory Agency(ies)				
a. Your Firmb. Subcontractor(s)/Subconsultant(s)c. Regulatory Agency(ies)			₹	
a. Your Firm b. Subcontractor(s)/Subconsultant(s) c. Regulatory Agency(ies)	CTION FOR COUNTY L	ISE ONLY**		, .

Procurement Code.



Broward County Solicitation No. and Title:

Reference for: Broward County MetLife	Metropolitan Li	fe Insurance C	ompany			
Organization/Firm Name providing reference: Randstad US						
Contact Name: Theresa A. Lathrop Ti	tle: Director, Benefi	ts Refe	rence date:	5/22/2018		
Contact Email: theresa.lathrop@randstadusa.com		Con	tact Phone:	770-937-4610		
Name of Referenced Project: Employee Dental, Life	e and AD&D Benefit Co	overages				
Contract No. Date Services Provided: Project Amount:						
NA 2017	to Current		NA			
Vendor's role in Project: X Prime Vendor	Subconsultant/S	ubcontractor				
Would you use this vendor again? X Yes	□No If No	, please specif	y in Additiona	l Comments (below).		
Description of services provided by Vendor: MetLife provides a fully-insured dental plan for our employee population (Internal and External Talent) of approximately 15k eligible.						
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable		
Vendor's Quality of Service a. Responsive b. Accuracy c. Deliverables			X X			
Vendor's Organization: a. Staff expertise b. Professionalism c. Turnover			X X			
Timeliness of: a. Project b. Deliverables			X			
4. Project completed within budget			X			
Cooperation with: a. Your Firm b. Subcontractor(s)/Subconsultant(s) c. Regulatory Agency(ies)			X	X		
Additional Comments: (provide on additional sheet if needed)						
THIS SECT	ION FOR COUNTY U	SE ONLY				
Verified via: X EMAILVERBAL Verified by: Trace	ey A. Gordon	Division: H	luman Resou	rges 1/16/2019		



Broward County Solicitation No. and Title:

GEN2116451P2 - Group Dental Preferred Provider Organization (PPO) Insurance					
Reference for: Broward County MetLife	Metropolitan I	Life Insurance (Company		
Organization/Firm Name providing reference:					
School District of	E lu Cu	unty			
	le: Benefits	Coordin	rence date:	5/24/18	
Contact Name: Karen Cooley Title: Benefits Coordinate: 5/24/18 Contact Email: Karen CC D Lees Chools. net Contact Phone 331 33) - 8155					
Name of Referenced Project: Dertal	2001,100		(0)) 1 30 7 6 7 0 3	
Contract No. Date Services F	Provided:	18(1)	Project Am	nount:	
/ 41.114	to cu	rvent			
Vendor's role in Project: Prime Vendor	Subconsultant/S	ubcontractor			
Would you use this vendor again? Yes	No If No	, please specif	y in Additional	Comments (below).	
Description of services provided by Vendor:					
Please rate your experience with the	Needs	Satisfactory	Excellent	Not	
referenced Vendor:	Improvement			Applicable	
 Vendor's Quality of Service Responsive 			V		
b. Accuracy			V		
c. Deliverables			M		
Vendor's Organization:					
Staff expertise Professionalism		H	V		
c. Turnover				V	
3. Timeliness of:					
Project Deliverables	H	H		H	
Project completed within budget	Ш			$oldsymbol{\square}$	
Cooperation with: a. Your Firm				П	
 b. Subcontractor(s)/Subconsultant(s) 	Ħ		Ö		
c. Regulatory Agency(ies)				4	
Additional Comments: (provide on additional sheet if needed)					
THIS SECTION FOR COUNTY USE ONLY					
Verified via: X EMAILVERBAL Verified by: Trace	ey A. Gordon	Division.H	uman Resour	ces _{te:} 1/16/2019	



Broward County Solicitation No. and Title:		0	(0000)		
GEN2116451P2 - Group Dental Prefer	red Provider	Organizatio	on (DPPO) In	surance (rebid)	
Colotide Deficitto, Inc.					
Organization/Firm Name providing reference:					
City of Pembroke Pines		5,			
	e: Dir HR Ris	it ivigitit	ference date:	11/09/2018	
Contact Email: drotstein@ppines.com		Co	ontact Phone: (954) 392-2092	E (16)
Name of Referenced Project: Dental PPO insu	ırance			700	
Contract No. Date Services F	Provided:		Project Am	ount:	
12176 10/01/2014	to present	İ			
Vendor's role in Project: ✓ Prime Vendor	Subconsultant/S	ubcontractor	70		_
Would you use this vendor again? \(\sqrt{es} \)	No If No	o, please spec	cify in Additional	Comments (below).	
Description of services provided by Vendor:					
Section (Control Control Contr					
3					
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable	
Vendor's Quality of Service			./		
a. Responsive b. Accuracy	H		1	H	
c. Deliverables	H	H	√		
2. Vendor's Organization:	_				
 a. Staff expertise 	님	\vdash	V		
b. Professionalism	님		V	\vdash	
c. Turnover			V		
3. Timeliness of:			./		
a. Projectb. Deliverables	H		7	H	
Project completed within budget			▼.		
Cooperation with: a. Your Firm					
b. Subcontractor(s)/Subconsultant(s)	님	\vdash	V		
c. Regulatory Agency(ies)	님	H	£7	1	
Additional Comments: (provide on additional sheet if needed)					
TLIC CECTI	ON FOR COUNTY U	SE ONLY	4		
Verified via: _X EMAILVERBAL Verified by: Tracey			: Human Resource	Spate: 1/22/2019	
All information provided to Broward County is subject to verification. Vendor acknowled		NO COMPLETE VIOLENTIA		NAMES AND THE PERSON OF THE PE	
County as a basis for rejection, rescission of the award, or termination of the contract Procurement Code.	and may also serve as the	basis for debarment of	Vendor pursuant to Section	21.119 of the Broward County	



Broward County Solicitation No. and Title: GEN2116451P2 - Group Dental Prefer	red Provider	Organization	(DPPO) In	surance (rebid)		
Reference for: Solstice Benefits Inc.	70-4101	<u> </u>		()		
Organization/Firm Name providing reference:						
Palm Beach Board of County Commissione	ers					
	le: Group Insi			11/09/2018		
Contact Email: amackey@pbcgov.org		Conf	tact Phone: 50	61-233-5405		
Name of Referenced Project: Dental PPO Pla	ın					
Contract No. Date Services F	Provided:		Project Am	ount:		
13000 01/01/2016	to 01/01/	2020	\$ 725,856.0	00		
Vendor's role in Project: ✓ Prime Vendor	Subconsultant/S	ubcontractor				
Would you use this vendor again? ✓/es	No If No	o, please specify	in Additional	Comments (below).		
Description of services provided by Vendor:						
Administration of Dental PPO Plan and Cust	omer Service					
Please rate your experience with the	Needs Improvement	Satisfactory	Excellent	Not Applicable		
referenced Vendor: 1. Vendor's Quality of Service	improvement			Applicable		
a. Responsive			√			
b. Accuracy			V			
c. Deliverables		-15	\checkmark			
2. Vendor's Organization:			1			
a. Staff expertise b. Professionalism	H		1			
c. Turnover			\checkmark			
3. Timeliness of:						
a. Project		\vdash	V	\vdash		
b. Deliverables			✓			
4. Project completed within budget			\checkmark			
5. Cooperation with:						
a. Your Firmb. Subcontractor(s)/Subconsultant(s)		H	<u>v</u>	\vdash		
c. Regulatory Agency(ies)	\vdash		<u></u>	\Box		
			V			
Additional Comments: (provide on additional sheet if needed)						
THIS SECT	TION FOR COUNTY L	ISE ONLY				
Verified via:VERBAL Verified by: <u>Trace</u>	y A. Gordon	Division:H	uman Resources	Date: 1/16/2019		
All information provided to Broward County is subject to verification. Vendor acknowledges that inaccurate, untruthful, or incorrect statements made in support of this response may be used by the County as a basis for rejection, rescission of the award, or termination of the contract and may also serve as the basis for debarment of Vendor pursuant to Section 21.119 of the Broward County Procurement Code.						



Broward County Solicitation No. and Title:						
GEN2116451P2 - Group Dental Prefe	rred Provider	Organization	(DPPO) In	surance (rebid)		
Reference for: Solstice Benefits, Inc.		Williams				
Organization/Firm Name providing reference:						
United Teachers of Dade (UTD)						
Contact Name: Michael Molnar Title: Director Reference date: 11/09/2018						
Contact Email: Michael@utd.org Contact Phone: 305-854-0220						
Name of Referenced Project: Member Benef	its					
Contract No. Date Services	Provided:		Project Am	ount:		
10025 01/01/2013	to present					
Vendor's role in Project: ✓ Prime Vendor	Subconsultant/S	ubcontractor				
Would you use this vendor again?	No If No	, please specify	in Additional	Comments (below).		
Description of services provided by Vendor:	_					
They provide these benefits to our 15,000 m	nembers.					
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable		
Vendor's Quality of Service						
a. Responsive	님	-	<u>/</u>	H		
b. Accuracyc. Deliverables	H		<u>v</u>			
2 Vandaria Organization						
Vendor's Organization: a. Staff expertise			V			
b. Professionalism			√	\vdash		
c. Turnover			\checkmark			
3. Timeliness of:						
a. Projectb. Deliverables	H		<u>v</u>			
b. Deliverables			<u>V</u>			
Project completed within budget			\checkmark			
5. Cooperation with:						
a. Your Firmb. Subcontractor(s)/Subconsultant(s)		1	<u>v</u>	\vdash		
c. Regulatory Agency(ies)		H	1	\vdash		
Additional Comments: (provide on additional sheet if needed)						
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Verified via:X EMAILVERBAL Verified by: Trace	y A. Gordon	Division: H	uman Resource	S Date: 1/16/2019		



Broward County Solicitation No. and Title:					
GEN2116451P2 - Group Dental Pref		ler Organiz	ation (PPO) insurance	
Reference for: UnitedHealthcare Insurance Comp	any				
Organization/Firm Name providing reference:					
Greater Orlando Aviation Authority					
	e: HR Manag	J1	rence date:	11/21/2018	
Contact Email: dandrews@goaa.org		Cor	tact Phone: 40	07-825-3765	
Name of Referenced Project: Group Dental Co				· 	
Contract No. Date Services P			Project Am		
01/01/2015	to 12/31/2	2019	\$ 570,000.	9 0 \$511,000.	90
Vendor's role in Project: ✓ Prime Vendor S	Subconsultant/S	ubcontractor			
Would you use this vendor again? ✓ Yes	No If No	, please specif	y in Additional	Comments (below	<i>i</i>).
Description of services provided by Vendor:					
Dental coverage					
Please rate your experience with the referenced Vendor:	Needs Improvement	Satisfactory	Excellent	Not Applicable	
Vendor's Quality of Service		<u> </u>	[7]		
a. Responsive b. Accuracy		H	<u> </u>		
c. Deliverables			7		
2. Vendor's Organization:					
a. Staff expertise			V	H	
b. Professionalismc. Turnover	H		<u> </u>		
	Ш	-	V	1	
Timeliness of: a. Project			7		
b. Deliverables			✓		
4. Project completed within budget			V		
5. Cooperation with:	_			_	
a. Your Firm			∠		
b. Subcontractor(s)/Subconsultant(s)c. Regulatory Agency(ies)				∠	
, , , , , , , , , , , , , , , , , ,	1			\checkmark	
Additional Comments: (provide on additional sheet if needed)					
***THIS SECTION	ON FOR COUNTY US				
	A. Gordon	Division: H	Iuman Resource	Date:	
All information provided to Broward County is subject to verification. Vendor acknowled County as a basis for rejection, rescission of the award, or termination of the contract a Procurement Code.	ges that inaccurate, untruthl and may also serve as the l	ul. or incorrect statement	s made in support of this	response may be used by the	



Broward County Solicitation No. and Title:

Vendor Reference Verification Form

GEN2116451P2 - Group Dental Preferred Provider Organization (PPO) Insurance Reference for: UnitedHealthcare Insurance Company Organization/Firm Name providing reference: Miami-Dade County Public Schools Contact Name: Rosa Novo Reference date: Title: Executive Director 11/21/2018 Contact Phone: 305-995-7141 Contact Email: rnovo@dadeschools.net Name of Referenced Project: Group Dental Coverage Contract No. Date Services Provided: Project Amount: 01/01/2015 to 12/31/2018 \$5,600,000.00 Vendor's role in Project: ✓ Prime Vendor Subconsultant/Subcontractor Would you use this vendor again? No If No, please specify in Additional Comments (below). Description of services provided by Vendor: Dental DHMO and PPO services.

	se rate your experience with the renced Vendor:	Needs Improvement	Excellent	Not Applicable	
1.	Vendor's Quality of Service a. Responsive b. Accuracy c. Deliverables			✓ ✓ ✓	
2.	Vendor's Organization: a. Staff expertise b. Professionalism c. Turnover			✓ ✓ ✓	
3.	Timeliness of: a. Project b. Deliverables	A		✓	
4.	Project completed within budget				\checkmark
5.	Cooperation with: a. Your Firm b. Subcontractor(s)/Subconsultant(s c. Regulatory Agency(ies)				✓

Additional Comments: (provide on additional sheet if needed)

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Verified via:	EMAIL	X VERBAL	Verified by: Tracey A. Gordon	Division: Human Resources Date: 1/30/2019



Verified via: X EMAIL

VERBAL

Vendor Reference Verification Form

Broward County Solicitation No. and Title: GEN2116451P2 - Group Dental Preferred Provider Organization (PPO) Insurance Reference for: UnitedHealthcare Insurance Company Organization/Firm Name providing reference: The School District of Palm Beach County Contact Name: Dianne Howard Title: Director, Risk & Be Reference date: 11/21/2018 Contact Phone: 561-434-8414 Contact Email: dianne.howard@palmbeachschools.org Name of Referenced Project: Group Dental Coverage Date Services Provided: Contract No. Project Amount: 13C-008T 01/01/2009 to 12/31/2019 \$8,000,000.00 Vendor's role in Project: ✓ Prime Vendor Subconsultant/Subcontractor Would you use this vendor again? √ Yes □No If No, please specify in Additional Comments (below). Description of services provided by Vendor: Dental DHMO and PPO services. Satisfactory Excellent Please rate your experience with the Needs Not Improvement Applicable referenced Vendor: Vendor's Quality of Service a. Responsive b. Accuracy c. Deliverables Vendor's Organization: a. Staff expertise b. Professionalism c. Turnover 3. Timeliness of: a. Project b. Deliverables 4. Project completed within budget 5. Cooperation with: a. Your Firm b. Subcontractor(s)/Subconsultant(s) Regulatory Agency(ies) Additional Comments: (provide on additional sheet if needed) They work with us to modify policies when we see a need. ***THIS SECTION FOR COUNTY USE ONLY***

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Verified by: Tracey A. Gordon

Division: Human Resources_{Date}: 1/16/2019