

| FUNCTIONAL AREA 2 – DPPO Fully Insured |
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| FA2 ATTACHMENT F DPPO FULLY INSURED (FI) FINANCIAL PROPOSAL Filename: FA2 Attachment F_DPPO-FI Financial Proposal.xlsx |
| FA2 Attachment F-1: Financial Proposal |
| FA2 Attachment F-2: Financial Compliance Checklist |
| FA2 Attachment F-3: Explanations and Deviations |
| FA2 Attachment F-4: DPPO-FI Maximum Premium Rates |
| FA2 Attachment F-5: DPPO-FI Offeror Premium Analysis |

FA2 Attachment T-1: Proposal Request

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: The State of Maryland is requesting proposals for a Fully Insured dental PPO product, a Self Funded (DPPO) and a Fully Insured Dental HMO product (DHMO). Please complete each item with the requested information for your proposed **Fully Insured DPPO plan**. Items in the response column with the words **"Choose an item"** contain a drop down list of options. Please select a response from those options as applicable.

I. GENERAL PLAN INFORMATION

| | Response | |
|-----|---|-----------------------------|
| 1. | Offeror's Legal Name | Click here to enter text. |
| 2. | Plan Name | Click here to enter text. |
| 3. | Proposed Plan Type | DPPO Fully Insured |
| 4. | Address | Click here to enter text. |
| 5. | City | Click here to enter text. |
| 6. | State | Click here to enter text. |
| 7. | Zip | Click here to enter text. |
| 8. | Web Address | Click here to enter text. |
| 9. | Operational Date | Click here to enter a date. |
| 10. | Corporate Tax Status | Choose an item. |
| 11. | Federal Employer Identification Number | Click here to enter text. |
| 12. | Ownership/Controlling Interest | Click here to enter text. |
| 13. | Year Network Organized | Click here to enter text. |
| 14. | DPPO membership totals as of 1/1/2011 | Click here to enter text. |
| | DPPO membership totals as of 1/1/2012 | Click here to enter text. |
| 15. | Amount of professional liability insurance maintained | Click here to enter text. |

II. PLAN DESIGN

Offerors must adhere to the proposed plan designs shown in **"FA2 Attachment T-3: DPPO-FI Plan Design"** in preparing the quote.

| | Select Response | |
|----|---|-----------------|
| 1. | Confirm that the proposal is issued in accordance with the specifications, assumptions and information included in this Request for Proposal, accompanying attachments and standard services addressed in the Information Questionnaire. If "No," indicate deviations in "FA2 Attachment T-2: Explanation and Deviations." | Choose an item. |
| 2. | Review and detail deviations from the proposed plan design shown "FA2 Attachment T-3: DPPO-FI Plan Design." | Choose an item. |

III. DENTAL DELIVERY SYSTEM

| Select Response | |
|---|-----------------|
| Complete the two (2) charts in "FA2 Attachment T-5: Dental Providers." For the counties shown, list the total number of participating providers by specialty. Also indicate the number of dentists accepting new patients, by specialty. For the states listed, provide the total number of participating providers. | Choose an item. |

Members’ Access to Providers

The State would like to determine the availability of key dental providers to its employee and retiree population. Please prepare GeoAccess® GeoNetworks® report(s) for the DPPO plan that you are proposing using census data provided by the State and the parameters in the table below. **Provide the reports using two separate formats: 1. using current DPPO enrollment, and 2. using entire census population.** Note that it is important that you follow the exact parameters. The report should show the availability by specialty for each zip code (or community). Report output is required for those with access and those without access, based upon the stipulated parameters. The report output should show the average distance to each provider group. See "FA2 Attachment T-4: Access" for the required format of the output. Hard copy reports need only contain the aggregated provider access information. In addition to the hard copy report, the data must be supplied in electronic format that has read/write capabilities (i.e. Microsoft Excel). Do not send the data in a read-only file.

Use only physicians accepting new patients in your Geo-Access provider file. The census you need to perform this mapping will be available via secure FTP upon execution of the confidentiality agreement (see Section 1.30). Label the completed GeoAccess® GeoNetworks® report as **"Response FA2 Attachment T-1: GeoAccess GeoNetwork Report."**

| Practice Specialty | Number of Providers Available | Miles from Employees Residence |
|-------------------------|-------------------------------|--------------------------------|
| General/Family dentists | 2 | 8 |
| Specialists | 2 | 10 |

| | | Select Response |
|----|--|-----------------|
| 2. | Has the GeoAccess® GeoNetworks® reporting been completed using the requested parameters? | Choose an item. |
| 3. | Please note the Geo-mapping method used: | Choose an item. |
| 4. | Was GeoAccess® GeoNetworks® Release 3.0, 2012 used to create the Accessibility Analysis? | Choose an item. |

IV. ADMINISTRATIVE AND OPERATIONAL ISSUES

Other Services

- List the location(s) of your service centers (separately identify claims processing centers and customer service centers if in different locations) that would be servicing the State's members and the corresponding geographic areas/regions covered by the respective location. Use "FA2 Attachment T-2: Explanations and Deviations" if you need more space.

| Service Center Location(s) | Geographic Region(s) Covered |
|----------------------------|------------------------------|
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |

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| | | Select Response |
|----|--|-----------------|
| 2. | Please attach copies of your standard report suite, including monthly paid claims reports, which would be provided to the State at no additional cost. At a minimum, your package should include the report format for the reports requested in the Reporting Section of the Compliance Checklist. In addition, please provide the frequency of each of your standard reports. Label these reports " FA2 Attachment T-1: Management Reporting Package " in your proposal. | Choose an item. |
| 3. | Offeror has disclosed their claims appeals (claims decision or coverage) protocols as well as actual response time statistics for the most recent year. Label these reports " FA2 Attachment T-1: Claims Appeals Protocols " in your proposal. | Choose an item. |

V. REFERENCES

Please complete the following tables with the requested reference information.

1. Please provide three of your current employer client references of similar size (a minimum of 50,000 covered lives) offering DPPO services in the area that will be serving most of the State's employees.

| Information | Reference #1 | Reference #2 | Reference #3 |
|----------------------------------|-----------------------------|-----------------------------|-----------------------------|
| Company Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Contact Person | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Title | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Telephone # | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| E-mail Address | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Network Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| # DPPO Members enrolled | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Effective date of contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Description of services provided | Click here to enter text. | Click here to enter text. | Click here to enter text. |

2. Please provide three of your terminated employer clients of similar size (a minimum of 50,000 covered lives) that offered DPPO services in the area that will be serving most of the State's employees.

| Information | Reference #1 | Reference #2 | Reference #3 |
|--|-----------------------------|-----------------------------|-----------------------------|
| Company Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Contact Person | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Title | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Telephone # | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| E-mail Address | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Network Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| # DPPO Members enrolled at date of termination | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Effective date of contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Termination date of contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Reason for termination | Click here to enter text. | Click here to enter text. | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

3. Please provide your three largest employer client references in the DPPO service area that will be serving most of the State's employees.

| Information | Reference #1 | Reference #2 | Reference #3 |
|----------------------------------|-----------------------------|-----------------------------|-----------------------------|
| Company Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Contact Person | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Title | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Telephone # | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| E-mail Address | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Network Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| # DPPO Members enrolled | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Effective date of contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| Description of services provided | Click here to enter text. | Click here to enter text. | Click here to enter text. |

VI. CONTACT INFORMATION

| Primary contact of person authorized to execute this proposal | |
|--|---------------------------|
| Name | Click here to enter text. |
| Title | Click here to enter text. |
| Address | Click here to enter text. |
| City | Click here to enter text. |
| State | Click here to enter text. |
| Zip Code | Click here to enter text. |
| Telephone # | Click here to enter text. |
| Cell Phone # | Click here to enter text. |
| E-mail Address | Click here to enter text. |

FA2 Attachment T-3: DPPO Plan Design

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: Any deviations between the State's current plan design and the proposed plan design of the Offeror must be noted in the space provided below. If there are no deviations in the Offeror's proposed plan design, please enter the phrase "**No Deviations**" in the space provided.

| Service Type | Current DPPO Plan | Deviations from Current DPPO Plan |
|--|-------------------|-----------------------------------|
| Class I (Preventive) | 100% | Click here to enter text. |
| Class II (Basic Restorative Services) | 70% | Click here to enter text. |
| Class III (Major Services) | 50% | Click here to enter text. |
| Class IV (Orthodontia – Child Only) | 50% | Click here to enter text. |
| Annual Deductible* | \$50; 3x Family | Click here to enter text. |
| Annual Maximum* | \$1,500 | Click here to enter text. |
| Orthodontia Lifetime Maximum (Per Dependent Child) | \$2,000 | Click here to enter text. |

* Applies only to Class II and III services.

Class I – Preventive services including, but not limited to:

Initial, periodic (twice in 12 months), and emergency examinations
 Radiographs
 Prophylaxis-(Adult and Child)
 Fluoride Treatments
 Sealants
 Emergency palliative treatment

Class II – Basic Restorative services including, but not limited to:

Fillings
 Inlays
 Endodontic Services
 Periodontal Services
 Oral Surgery Services
 Space Maintainers
 General Anesthesia
 Prosthodontic Maintenance-Relines and repairs to bridges, partial dentures and complete dentures.

Class III – Major Restorative services including, but not limited to:

Crown and Bridge
 Dentures (complete and partial)
 Fixed Prosthetics
 Implants

Class IV – Orthodontia

Only for Dependent Children through age 18.

FA2 Attachment T-4: DPPO Provider Network Access AMENDMENT 6

Instructions: Provide the following access information for each type of in-network provider listed in the access request (General/Family dentists, Endodontists, Oral Surgeons, Prosthodontists, Pedodontists, Periodontists, Orthodontists, and Other Specialist Dentists). **Provide access two ways: 1) all employees and retirees currently enrolled in the DPPO and 2) all employees and retirees (entire census population).** *(Please note that the total number of employees/retirees excludes those employees/retirees located in Guam, Puerto Rico, Virgin Islands, countries other than the United States and APO addresses.)*

A. All employees and retirees currently enrolled in DPPO

| Provider Type | Access Criteria | Average Distance to Providers | Total Number of Employees / Retirees | Employees Matched | | Employees Not Matched | |
|--------------------------|-----------------|-------------------------------|--------------------------------------|-------------------|------------|-----------------------|------------|
| | | | | Number | Percent | Number | Percent |
| General/Family Dentist | 2 in 8 | Click here | 72,060 <u>71,680</u> | Click here | Click here | Click here | Click here |
| Endodontists | 2 in 10 | Click here | 72,060 <u>71,680</u> | Click here | Click here | Click here | Click here |
| Oral Surgeon | 2 in 10 | Click here | 72,060 <u>71,680</u> | Click here | Click here | Click here | Click here |
| Prosthodontist | 2 in 10 | Click here | 72,060 <u>71,680</u> | Click here | Click here | Click here | Click here |
| Pedodontist | 2 in 10 | Click here | 72,060 <u>71,680</u> | Click here | Click here | Click here | Click here |
| Periodontist | 2 in 10 | Click here | 72,060 <u>71,680</u> | Click here | Click here | Click here | Click here |
| Orthodontist | 2 in 10 | Click here | 72,060 <u>71,680</u> | Click here | Click here | Click here | Click here |
| Other Specialist Dentist | 2 in 10 | Click here | 72,060 <u>71,680</u> | Click here | Click here | Click here | Click here |

B. All employees and retirees

| Provider Type | Access Criteria | Average Distance to Providers | Total Number of Employees / Retirees | Employees Matched | | Employees Not Matched | |
|--------------------------|-----------------|-------------------------------|--------------------------------------|-------------------|------------|-----------------------|------------|
| | | | | Number | Percent | Number | Percent |
| General/Family Dentist | 2 in 8 | Click here | 119,000 <u>119,272</u> | Click here | Click here | Click here | Click here |
| Endodontists | 2 in 10 | Click here | 119,000 <u>119,272</u> | Click here | Click here | Click here | Click here |
| Oral Surgeon | 2 in 10 | Click here | 119,000 <u>119,272</u> | Click here | Click here | Click here | Click here |
| Prosthodontist | 2 in 10 | Click here | 119,000 <u>119,272</u> | Click here | Click here | Click here | Click here |
| Pedodontist | 2 in 10 | Click here | 119,000 <u>119,272</u> | Click here | Click here | Click here | Click here |
| Periodontist | 2 in 10 | Click here | 119,000 <u>119,272</u> | Click here | Click here | Click here | Click here |
| Orthodontist | 2 in 10 | Click here | 119,000 <u>119,272</u> | Click here | Click here | Click here | Click here |
| Other Specialist Dentist | 2 in 10 | Click here | 119,000 <u>119,272</u> | Click here | Click here | Click here | Click here |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

FA2 Attachment T-5: DPPO Dental Providers

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: For the counties shown below, list the total number of participating in-network providers by specialty. Also indicate the number of providers accepting new patients, by specialty.

| County/ Metro Area | Category | General/ Family Dentist | Orthodontist | Pedodontist | Prosthodontist | Periodontist | Oral Surgeon | Endodontist | Total Dental Providers |
|--------------------------|--------------------------|-------------------------------|--------------|-------------|----------------|--------------|--------------|-------------|---------------------------|
| Central Maryland | | | | | | | | | |
| Anne Arundel County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Baltimore City | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Baltimore County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Carroll County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Harford County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Howard County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Eastern Shore | | | | | | | | | |
| Caroline County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Cecil County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Dorchester County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Kent County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Queen Anne's County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Somerset County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Talbot County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Wicomico County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Worcester County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Southern Maryland | | | | | | | | | |
| Calvert County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Charles County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| County/ Metro Area | Category | General/ Family Dentist | Orthodontist | Pedodontist | Prosthodontist | Periodontist | Oral Surgeon | Endodontist | Total Dental Providers |
|------------------------------|--------------------------|-------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| St. Mary's County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Washington Metro | | | | | | | | | |
| District of Columbia | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Montgomery County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Prince George's County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Western Maryland | | | | | | | | | |
| Allegany County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Frederick County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Garrett County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| Washington County | # of providers | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |
| | # accepting new patients | Click here | Click here | Click here | Click here | Click here | Click here | Click here | Click here |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

Instructions: For the states and locations shown below, list the total number of participating providers by specialty.

| State | General Dentist | Orthodontist | Pedodontist | Prosthodontist | Periodontist | Oral Surgeon | Endodontist |
|----------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| Alabama | Click here |
| Alaska | Click here |
| Arizona | Click here |
| Arkansas | Click here |
| California | Click here |
| Colorado | Click here |
| Connecticut | Click here |
| Delaware | Click here |
| District of Columbia | Click here |
| Florida | Click here |
| Georgia | Click here |
| Hawaii | Click here |
| Idaho | Click here |
| Illinois | Click here |
| Indiana | Click here |
| Iowa | Click here |
| Kansas | Click here |
| Kentucky | Click here |
| Louisiana | Click here |
| Maine | Click here |
| Massachusetts | Click here |
| Michigan | Click here |
| Minnesota | Click here |
| Mississippi | Click here |
| Missouri | Click here |
| Montana | Click here |
| Nebraska | Click here |
| Nevada | Click here |
| New Hampshire | Click here |
| New Jersey | Click here |
| New Mexico | Click here |
| New York | Click here |
| North Carolina | Click here |
| North Dakota | Click here |
| Ohio | Click here |
| Oklahoma | Click here |
| Oregon | Click here |
| Pennsylvania | Click here |
| Rhode Island | Click here |
| South Carolina | Click here |
| South Dakota | Click here |
| Tennessee | Click here |
| Texas | Click here |
| Utah | Click here |
| Vermont | Click here |
| Virginia | Click here |
| Washington | Click here |
| West Virginia | Click here |
| Wisconsin | Click here |
| Wyoming | Click here |
| Total | Click here |

FA2 Attachment T-6: DPPO - Fully Insured Compliance Checklist AMENDMENT 6

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete each item with the requested information. Items in the response column with the words "Choose an item," contain a drop down list of options. Please select a response from those options as applicable. All "No" responses must be addressed in "FA2 Attachment T-2: Explanations and Deviations."

| Compliance Checklist | | Offeror's Response |
|-------------------------|---|--------------------|
| | | Yes or No |
| Customer Service | | |
| CC-1 | Offeror agrees to permit all eligible Members, as determined by the State, to obtain dental benefits for themselves and their Dependents. | Choose an item. |
| CC-2 | Offeror agrees to no loss/no gain provision: All members and dependents covered under the prior plan as of December 31, 2014, will be covered as of January 1, 2015. | Choose an item. |
| CC-3 | Offeror agrees to establish and provide a dedicated, state-of-the-art customer service operation (including a toll-free line) that is available to plan Participants (both in-state and out-of state) 24 hours a day, seven days a week, staffed by live customer service representatives. | Choose an item. |
| CC-4 | This toll-free customer service line will be supported by an automated voice-response system 24 hours a day, seven days a week. Participants (both in-state and out-of state) can access this system directly to request and receive service authorizations or other pertinent data. This operation should be in accordance with PG-1 and PG-2 on "FA1 Attachment T-9: Performance Guarantees." | Choose an item. |
| CC-5 | During call center hours, as indicated above, the customer service phone intake system should be an automatic answering system that picks up within 30 seconds and directs Participants into a queue to be serviced, with an available opt-out to a live representative at any time during the call. | Choose an item. |
| CC-6 | Automated call answer system will provide estimated wait time until live operator pick-up to Participant. | Choose an item. |
| CC-7 | Claim forms (if used) must be mailed to Participants within two business days from the date of request. | Choose an item. |
| CC-8 | The member services and provider relations operations must include: | |
| | a.) Knowledgeable staff available to answer questions on plan eligibility, plan guidelines, benefit levels, and claims procedures. | Choose an item. |
| | b.) The ability to access an eligibility file that identifies eligible Participants as well as certain other pertinent information regarding Participants. | Choose an item. |
| | c.) A system for providing Explanations Of Benefits to eligible Participants detailing payments to providers for services rendered and the amounts applicable to each service. | Choose an item. |
| | d.) A procedure for handling emergency requests or non-office hour services. | Choose an item. |
| | e.) An integrated claims and customer service system enabling both claims and service team members to view all screens. | Choose an item. |

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| Compliance Checklist | | Offeror's Response |
|---|--|---------------------------|
| | f.) Adequate access to the customer service system for individuals with disabilities. (TTY and online access for deaf, full-service phone access for blind) | Choose an item. |
| CC-9 | Offeror agrees to establish on-line web access for members to securely look up plan information, participating providers, claim status and history of processed claims. | Choose an item. |
| CC-10 | Offeror agrees to accurately convert State data files, which are transmitted in HIPAA 834 format. This includes the State master enrollment file and any other relevant files to the Offeror's data system. | Choose an item. |
| CC-11 | Offeror agrees to offer support services during the Open Enrollment period preceding the initial plan year of the contract and all subsequent open enrollments during the contract term. Offeror will provide services in accordance with PG-5 on " FA2 Attachment T-9: Performance Guarantees. " | Choose an item. |
| CC-12 | Offeror will provide representatives to attend Benefit Fairs, who will be trained on the State-specific benefit plans, in accordance with PG-5 on " FA2 Attachment T-9: Performance Guarantees. " | Choose an item. |
| CC-13 | Offeror agrees to assume a share of the expenses for printing and mailing the State of Maryland Open Enrollment booklet and universal enrollment forms, cost for which will be shared equally among all benefit plans. For 2012 Open Enrollment, each State vendor's share was approximately \$19,800 per plan. | Choose an item. |
| CC-14 | Offeror agrees to assume a share of the cost of an annual State-conducted Participant satisfaction survey of its dental plan. Approximate share of the cost is \$4,850 per year per plan. | Choose an item. |
| CC-15 | Offeror shall prepare and provide identification cards and a detailed plan description to Members. ID cards are to be mailed to members at least ten business days before the program is operational. ID cards must be mailed to new members within three business days of notification by the State or receipt of the add/change/delete enrollment file that reflects the new enrollment, whichever is earlier. The detailed plan description will be provided electronically (and via paper upon request). | Choose an item. |
| CC-16 | Offeror will use a unique identification number (that is not a social security number) on all Participant communications, including, but not limited to, membership cards, EOBs, etc. | Choose an item. |
| CC-17 | Evidence of Coverage is available to members both via US Mail and online. Evidence of Coverage shall be mailed within 30 days from the date of enrollment. | Choose an item. |
| CC-18 | Upon request, Offeror will submit forms for the State's approval, and print forms with the State's logo for claims submission. | Choose an item. |
| Network Compliance/Reimbursement | | |
| CC-19 | Offeror agrees to provide Participant support services for selecting and/or locating network providers, including but not limited to contacting providers to ensure that they are still in the network when requested by a Member and answering provider credential questions that Participants may have. | Choose an item. |
| CC-20 | Offeror agrees to provide on-line access to up-to-date network provider listings and locations to assist Participants with provider selection as well as assist with other Participant services with regard to provider selection. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | | Offeror's Response |
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| CC-21 | Offeror agrees to notify plan Participants, in writing with at least 45 days advance notice, in the event that the contract for a Participant's network provider terminates for any reason. The State will review and approve the communications provided to State Participants for this purpose. | Choose an item. |
| CC-22 | Offeror agrees to notify the State, in writing with at least 60 days advance notice, in the event that the contract for a dentist terminates for any reason. | Choose an item. |
| CC-23 | Offeror has a procedure in place to allow the State and/or plan Participants to nominate providers to be considered for inclusion in the network panel, and if included, made available to Participants. | Choose an item. |
| CC-24 | Offeror agrees to notify the State immediately if the Offeror loses any licenses, certificate of insurance, liability insurance coverage or certificate of authority from the Maryland Insurance Administration or any other state insurance department. | Choose an item. |
| CC-25 | Offeror commits that all provider contracts for its network have a "continuation of care" clause that says if for any reason a provider's contract is terminated, including but not limited to if a provider cancels or fails to renew their contract, a course of treatment which began with a network provider will continue to be provided and reimbursed by that provider at the contract rate previously in effect. | Choose an item. |
| CC-26 | Offeror will track Reasonable and Customary (R&C) and claim payment data by most current CDT code and zip code. | Choose an item. |
| CC-27 | Offeror agrees to make changes to CDT codes on dental procedures and nomenclature when updated by the American Dental Association. Offeror further agrees to confirm these changes, in writing to the State, no later than 90 days after the effective date of the changes. | Choose an item. |
| CC-28 | Offeror agrees that all services included in the State's benefit program will be covered at the same benefit level regardless of CDT procedure code changes. | Choose an item. |
| CC-29 | Offeror has and will maintain a Pre-Determination process for Participants to contact customer service to find out the maximum allowance for a specific procedure in advance of having the procedure done. | Choose an item. |
| CC-30 | Offeror confirms that procedures are in place for ensuring that a network provider does not bill participants and/or the plan sponsor any amount in excess of the network allowance. | Choose an item. |
| CC-31 | Offeror's contracts with network providers prohibit providers from balance billing patients above the network allowance. | Choose an item. |
| CC-32 | Offeror will guarantee that a Participant will not be liable for any amounts over and above the scheduled plan benefit in the event a network provider is not paid accurately for services rendered. | Choose an item. |
| CC-33 | Offeror will guarantee that the network allowance will always be the basis for determining the member's liability (coinsurance, etc.), if applicable, for in-network services rendered. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | | Offeror's Response |
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| Audits | | |
| CC-34 | The Offeror agrees to have an annual audit performed by an independent audit firm of its handling of the Department’s critical functions and/or sensitive information, which is identified as Insurance Claims Processing Services (collectively referred to as the “Information Functions and/or Processes”). Such audits shall be performed in accordance with audit guidance: <i>Reporting on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality, or Privacy (SOC 2)</i> as published by the American Institute of Certified Public Accountants (AICPA) and as updated from time to time, or according to the most current audit guidance promulgated by the AICPA or similarly-recognized professional organization, as agreed to by the Department, to assess the security of outsourced client functions or data (collectively, the “Guidance”) | Choose an item. |
| CC-35 | Offeror agrees to provide the State or its designated representative the right to audit the performance of the plan and services provided (including quality of care and HIPAA compliance). Offeror will make available all services, records and access to the auditors at no extra charge. Offeror will be given 2 months written advance notice of an impending audit. The State or its designated representative will audit operations at least once annually. | Choose an item. |
| HIPAA (Terms herein shall have meaning provided in 45 CFR, Parts 160, 162 and 164.) | | |
| CC-36 | The Contractor agrees to comply with HIPAA security regulations, 45 CFR Part 164, subpart C, including the following: | |
| | a.) The Contractor agrees to develop and implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that the Contractor creates, receives, maintains or transmits in the Contractor's administration of the plan, as required by the HIPAA security standards. | Choose an item. |
| | b.) The Contractor agrees to comply with the HIPAA security standards. | Choose an item. |
| | c.) The Contractor agrees to maintain documentation of the policies and procedures and safeguards implemented to comply with the HIPAA security standards. | Choose an item. |
| | d.) In compliance with 45 CFR 164.308(b), the Contractor agrees to ensure through written contract that any agent, including a subcontractor, to whom the Contractor provides electronic PHI agrees to implement reasonable and appropriate safeguards. | Choose an item. |
| | e.) The Contractor agrees to report to the State within 10 days any security incident of which the Contractor becomes aware during the term of the Contract and any mitigation or remedial plans to address such security incidents. | Choose an item. |
| | f.) The Contractor agrees to make the Contractor's policies and procedures, and its documentation required by the HIPAA security standards, available to the State and the Department of Health and Human Services for purposes of determining if the plan complies with the HIPAA security standards. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | | Offeror's Response |
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| CC-37 | The Contractor agrees to comply with HIPAA privacy standards, 45 CFR Parts 160 and 164, including the following: | |
| | a.) The Contractor shall not use or disclose PHI except to fulfill the requirements of this RFP and the contract, or as required by law. In doing so, the Contractor shall use, disclose or request the minimum amount of PHI necessary and act in compliance with §164.502(b) as if a covered entity. Further, the Contractor shall use limited data sets when possible and comply with DHHS guidance in determining minimum necessary standards to accomplish intended use, purpose or disclosure as if a covered entity. | Choose an item. |
| | b.) The Contractor shall implement and use appropriate and reasonable administrative, physical and technical safeguards to prevent Use or Disclosure of PHI other than (1) as provided in this RFP and the contract, (2) permitted by the HIPAA Privacy Regulation for a Covered Entity, and (3) permitted by the Medical Records Act. In the event that the HIPAA Privacy Regulation and the Medical Records Act conflict regarding the degree of protection provided for PHI, the Contractor shall comply with the more restrictive protection requirements. | Choose an item. |
| | c.) The Contractor shall report to the State any Use or Disclosure of PHI that is not permitted within 10 days of when the Contractor becomes aware of such Use and Disclosure. | Choose an item. |
| | d.) The Contractor shall use reasonable efforts to mitigate the effect of any Use or Disclosure of PHI known to Contractor that is not permitted. | Choose an item. |
| | e.) The Contractor shall comply with the administrative requirements of 45 CFR § 164.530 as if the Contractor were the Covered Entity in relation to the plan. | Choose an item. |
| | f.) In compliance with 45 CFR § 164.504(e)(5), the Contractor shall ensure, through written contract, that any agent, including a subcontractor, to whom it provides PHI received from, created by, or received by the Contractor agrees to the same restrictions and conditions that apply to the Contractor with respect to such information. This obligation shall apply in connection with PHI created, retained, used, disclosed, or transmitted in connection with the group plan(s) administered by the Contractor. | Choose an item. |
| | g.) The Contractor shall provide a Notice of Privacy Practices to all individuals enrolled in the plan in compliance with 45 CFR §164.520 as if the Contractor were the Covered Entity with regard to the plan. (1) This Notice of Privacy Practices shall comply with the requirements of 45 CFR §164.520 as if the Contractor were the Covered Entity with regard to the plan. (2) A copy of this Notice of Privacy Practices shall be provided to the State with certification that the notice has been provided to the Members. | Choose an item. |
| | h.) The Contractor shall permit an individual enrolled in the plan to request restricted Uses and Disclosures of PHI related to that individual in accordance with 45 CFR §164.522(a)(1)(i). The Contractor shall comply with 45 CFR §164.522(a)(1)(iii)-(iv) and HITECH §13.405(a) in the event that a request for restricted Uses and Disclosures is granted as if the Contractor were the Covered Entity with regard to the plan. The Contractor may refuse such request to restrict Uses and Disclosures or terminate a restriction on Uses and Disclosures | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | Offeror's Response |
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| provided that the Contractor complies with the provisions of 45 CFR §164.122(a)(1)(ii), §164.522(a)(2)-(3) and HITECH §13.405(a) as if the Contractor were the Covered Entity with regard to the plan. | |
| i.) The Contractor shall accommodate reasonable requests by individuals enrolled in the plan or by the State on behalf of such individuals to receive confidential communications in compliance with 45 CFR §164.522(b)(ii) as if the Contractor were the Covered Entity with regard to the plan. The Contractor may condition providing confidential communications as permitted by 45 CFR §164.522(b)(2). | Choose an item. |
| j.)The Contractor shall maintain PHI in a Designated Record Set and make available to an individual the PHI relating to that individual in compliance with 45 CFR §164.524 and the HITECH Act as if the Contractor were the Covered Entity with regard to the plan. | Choose an item. |
| k.) The Contractor shall make available for amendment and amend PHI at the request of the State or the individual to whom the PHI relates in compliance with 45 CFR §164.526 as if the Contractor were the Covered Entity with regard to the plan. | Choose an item. |
| l.) Contractor shall document and track Disclosures and provide an accounting of Disclosures of PHI to the individual about whom it relates in compliance with 45 CFR §165.528 and the HITECH Act as if the Contractor were the Covered Entity with regard to the drug plan. | Choose an item. |
| m.) The Contractor shall make the Contractor’s internal practices, books and records, including privacy and confidentiality policies and procedures and PHI, available to the State and the Federal Department of Health and Human Services, for purposes of determining whether the State is compliant with the HIPAA Privacy Regulation in the administration of the plan. | Choose an item. |
| n.) Upon termination of the Contract, for any reason, the Contractor shall maintain all records created under the Contract as required by the Contract and shall extend the protections of the HIPAA privacy standards to the PHI contained in those records for so long as the Contractor maintains the PHI. All such records containing PHI shall be destroyed at the expiration of the record retention period required by the Contract or, if retained by the Contractor, protected, used and disclosed only in accordance with this RFP and the Contract. | Choose an item. |
| o.) The Contractor shall provide a certification to the State that the Contractor's HIPAA Privacy Standards obligations have been met, to occur no more frequently than quarterly, upon the State's request for certification. | Choose an item. |
| p.) The Contractor shall disclose PHI to the State and to the State's agents for the State's use in treatment, payment and health care operations related to the plan, and the State's other related plans. | Choose an item. |
| q.) The Contractor may Disclose PHI as required by law in compliance with 45 CFR §164.512. | Choose an item. |
| r.) The Contractor may Use and Disclose PHI to conduct data aggregation services as permitted by 45 CFR §164.501 and §164.504(e)(2)(i)(B). | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | | Offeror's Response |
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| | s.) The Contractor may Use and Disclose PHI for the proper management and administration of the Contractor or to carry out its legal responsibilities as permitted by 45 CFR §164.504(e)(4), provided that: (a) such Uses and Disclosures would be permitted by the HIPAA Privacy Regulation if the Contractor were a Covered Entity regulated by the HIPAA Privacy Regulation and (b) the Contractor obtains reasonable written assurances from the person, agency, or entity to which such Disclosures are made that all PHI will remain confidential and be Used or Disclosed further only as required by law, for the purposes of Disclosure by the Contractor, and the person, agent or entity notifies the Contractor of any instances in which the confidentiality of the PHI has been breached. | Choose an item. |
| | t.) The Contractor may Use or Disclose PHI to report violations of the law to appropriate State and Federal authorities consistent with 45 CFR §164.502(j). | Choose an item. |
| | u.) The Contractor may Disclose PHI in response to an authorization executed by the individual who is the subject of the PHI or that individual's personal representative in accordance with 45 CFR §502(g) and 45 CFR §164.508. | Choose an item. |
| CC-38 | The Contractor shall comply with 45 CFR 164.508(a)(4) and §13405(d)(1) and (2) of the HITECH Act as if it were a covered entity in connection with the benefits plan administered by the Contractor pursuant to this RFP and Contract. The Contractor shall prohibit its business associates, agents and subcontractors who receive, use, disclose, create, retain, maintain, or transmit PHI from receiving remuneration in exchange for PHI on the same terms. | Choose an item. |
| CC-39 | The Contractor shall comply with the limitations on marketing and fundraising communications provided in 45 CFR 164.508(a)(3) and §13406 of the HITECH Act as if it were a covered entity in connection with the benefits plan. | Choose an item. |
| CC-40 | Breaches of Unsecured PHI | |
| | a.) A breach shall be treated as discovered in the terms described in 45 CFR §164.410. | Choose an item. |
| | b.) Notice to the Department | |
| | (1) The Business Associate shall promptly notify the Department of a breach of unsecured PHI in its possession following the first day on which the Contractor (or Contractor's employee, officer, agent or subcontractor) knows of such breach or following the first day on which Contractor (or Contractor's employee, officer, agent or subcontractor) should have known of such breach. Such notice shall occur without unreasonable delay and in no event more than 30 days following discovery of the breach. Such notice shall occur even if the breach is not of a Member of the State's Plan. | Choose an item. |
| | (2) In the event that Contractor determines that there is no risk of an unauthorized access, acquisition, use, or disclosure compromises the security or privacy of the PHI of a Participant, Contractor shall promptly notify the Department of the event and the basis for that determination. Such notice shall occur as soon as is reasonable but in no event more than 30 days following discovery of the unauthorized access, acquisition, use or disclosure of PHI of a Participant. Such determination shall be in writing and signed by an appropriate officer or employee of Contractor. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | Offeror's Response |
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| (3) Contractor's notice to the Department pursuant to this section concerning breaches shall include, at a minimum: | |
| (i) the number of individuals overall affected by the breach and the number of Participants in the State's Plan affected by the breach; | Choose an item. |
| (ii) if applicable, the identification of each State Plan Participant whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, disclosed, or otherwise the subject of the breach; | Choose an item. |
| (iii) a description of what happened, the date of the breach, if known, and the date of the discovery of the breach; | Choose an item. |
| (iv) a brief description of the types of unsecured PHI that were involved in the breach (such as name, social security number, date of birth, claims or health care services information, etc.); | Choose an item. |
| (v) identification of an individual who can provide additional information concerning the breach; and | Choose an item. |
| (vi) a brief description of the steps Contractor is taking to mitigate the breach, investigate the breach, and to protect against further breaches. | Choose an item. |
| (4) Contractor's notice to the Department pursuant to this section may be provided on a rolling basis, with information provided to the Department as it becomes available. | Choose an item. |
| c.) Notice to Participants. | |
| (1) Business Associate shall provide notice to affected members and to the media in the form, content, manner, method, and timing required to meet the requirements of §§13400-13402 of the HI TECH Act and 45 CFR §§164.404 and 164.406, applied as if Business Associate were a covered entity in connection with the group plan(s) administered by Business Associate pursuant to the Underlying Agreement. | Choose an item. |
| (2) The notice(s) required by this section may not be issued until the Department has reviewed and approved the notice(s). Such approval may not be unreasonably delayed or withheld. | Choose an item. |
| d.) Contractor may delay the notice(s) required pursuant to sections 164.404(b) and 164.406(b) only if permitted pursuant to 45 CFR §164.412. | Choose an item. |
| e.) In the event of an unauthorized use or disclosure of PHI or a breach of Unsecured PHI, Contractor shall use reasonable efforts to mitigate any harmful effects of said disclosure that are known to it. | Choose an item. |
| f.) Notices to DHHS. | |
| (1) In the event of a breach described in 45 CFR §164.408(b), Contractor shall provide to Department all information required by that subsection to be submitted to the Secretary of DHHS. The information shall be provided without unreasonable delay and in no event more than 30 days following discovery of the breach. Upon request, Contractor shall submit the required breach notice to the Secretary of DHHS on behalf of the Department, the State, the group plan(s), and the Program. | Choose an item. |
| (2) Contractor shall maintain a log of breaches described in 45 CFR §164.408(c) and that affect members and the group plan(s) administered by Business Associate pursuant to the Underlying Agreement. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

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| | g.) In fulfilling its obligations pursuant under this Contract in connection with 45 CFR §164.530, Business Associate shall address the provisions of 45 CFR Part 164, subpart D in the manner provided in 45 CFR §164.414, as if Contractor were a covered entity in connection with the benefits plan administered by the Contractor pursuant to this Contract and RFP. | Choose an item. |
| | h.) Business Associate agrees to review any guidance from DHHS specifying the technologies and methodologies that render PHI unusable, unreadable, or indecipherable to unauthorized individuals. BA further agrees, to the extent practical, appropriate and reasonable, to incorporate such guidance into its administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of PHI. | Choose an item. |
| | i.) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the Contractor, agrees to provide notice of a breach and the information necessary for the Contractor to comply with its notice requirements in sections (a) through (h) above. | Choose an item. |
| CC-41 | Electronic Health Records | |
| | a.) Contractor shall notify the Department if and when Contractor uses or maintains electronic health record(s) with respect to PHI. | Choose an item. |
| | b.) As of the applicable effective date identified in HITECH §13405(c)(4), when complying with the obligations to respond to requests for an accounting under 45 CFR §164.528, Contractor shall respond to requests for an accounting of disclosures of PHI, in compliance with the requirements of §13405(c)(1) and (3) of the HITECH Act and any regulations promulgated by the Secretary of DHHS pursuant to §13405(c)(2) of the HITECH Act. The requirements of this section shall apply if Contractor uses or maintains an electronic health record with respect to PHI. | Choose an item. |
| | c.) When complying with the obligation to provide access to PHI under 45 CFR §164.524, Contractor shall respond to requests for access to PHI in compliance with the requirements of §13405(e) of the HITECH Act. The requirements of this section shall apply if Contractor uses or maintains an electronic health record with respect to PHI. | Choose an item. |
| CC-42 | The Contractor agrees to provide all HIPAA certificates of creditable coverage, at no extra cost, within the timeframe required by the regulations (see 45 CFR §146.115). | Choose an item. |
| CC-43 | The Contractor confirms that its proposal, and plan design offered, is in compliance with all federal and state laws and regulations that pertain to employee benefit plans. | Choose an item. |
| CC-44 | The Contractor understands, has the necessary systems capability and complies with HIPAA's administrative simplification standards related to electronic data interchange (EDI), including the code set/transactions requests of 45 CFR Part 162. | Choose an item. |
| CC-45 | The Contractor requires any agents/subcontractors it brings onto the project(s) covered by this RFP to comply with the HIPAA standards for EDI. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | | Offeror's Response |
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| Special Provisions | | |
| CC-46 | Offeror will provide at least 6 months' notice to the State of Maryland for any planned systems upgrades or changes (to include claims, customer service, eligibility, corporate operating system). | Choose an item. |
| CC-47 | Offeror agrees to retain records in excess of the period required by the Contract, if required by State and Federal regulations for group dental plans. | Choose an item. |
| CC-48 | Offeror agrees that there will be no restrictions or benefit limitations for pre-existing conditions applied to any eligible Participants under the plan. | Choose an item. |
| CC-49 | Offeror agrees to prepare and file all legal documents necessary to implement and maintain the plan, including policies, amendments, contracts, required state filings, and development of booklet/certificate formats. | Choose an item. |
| CC-50 | Offeror agrees to monitor federal and state legislation affecting the delivery of dental benefits under the plan and to report to the State on those issues in a timely fashion prior to the effective date of any mandated benefit changes. | Choose an item. |
| CC-51 | Offeror will absorb the cost of programming any benefit design changes. | Choose an item. |
| CC-52 | Member service operations must include an information system capable of electronically transmitting, receiving, and updating Participant profile information regarding demographics, coverage, and other information (e.g. eligibility, change of address, etc.). | Choose an item. |
| CC-53 | Offeror agrees to have a process in place for resolving complaints operable on the date of contract commencement. The State expects an expeditious, written resolution will normally be mailed within 10 workdays of receipt of the complaint. | Choose an item. |
| Claim Processing | | |
| CC-54 | Offeror agrees that all claims will be paid in accordance with the benefit program described in " FA2 Attachment T-3: DPPO Plan Design " in this Request for Proposal. | Choose an item. |
| CC-55 | Offeror agrees to use the NAIC 120-1 Model COB Contract Provisions, as excerpted in Attachment Q of the RFP, for determining when to pay as primary coverage. | Choose an item. |
| CC-56 | Notwithstanding anything in the attachments to the contrary, Offeror agrees to administer the plan to provide Coordination of Benefits (COB) under a "pay and pursue" basis with other employee, retiree, and/or dependent dental coverage. | Choose an item. |
| CC-57 | Offeror will verify and update Participant records with information on other coverage at least annually and more frequently if notified by the State or Participants. | Choose an item. |
| CC-58 | Offeror agrees to use its R&C profiles, reduced network fees, or those of the primary carrier in determining its level of reimbursement when it is the secondary payor in a COB situation. | Choose an item. |
| CC-59 | To the extent permitted under state law, no fault auto insurance, governmental plans (Medicaid) coordination and negligent third party subrogation will be included in the contract. | Choose an item. |
| CC-60 | Offeror certifies that it is able to and will administer the dental plans in compliance with all State laws, regulations and mandates. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | | Offeror's Response |
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| CC-61 | Offeror certifies that it will comply with the Department of Labor's final claims procedure regulations, including: | |
| | a) The notice requirements for improper and incomplete claims | Choose an item. |
| | b) The appropriate timeframes for adjudicating urgent, pre-service and post-service claims | Choose an item. |
| | c) The appropriate timeframes for notice of appeal decisions. | Choose an item. |
| | d) Offeror will agree to exhaust this appeals process prior to turning it over to the State of Maryland. | Choose an item. |
| CC-62 | Offeror agrees to provide written updates to State of changes in claims appeal process. | Choose an item. |
| CC-63 | The claims system maintains on-line eligibility files that are updated at least weekly. | Choose an item. |
| CC-64 | Offeror agrees to claims fiduciary responsibilities, including appeals, for claims adjudication and defense of "utilization review" decisions. | Choose an item. |
| CC-65 | Network members never have to submit claim forms for in-network services. | Choose an item. |
| CC-66 | Each of your networks serving State members is supported by a computerized, on-line direct access claims processing system containing plan/claim information storage and retrieval. | Choose an item. |
| CC-67 | Offeror will obtain the advice and consultation of qualified experts (internal or external, as needed) to review unusual charges or claims at no additional cost to the State. | Choose an item. |
| CC-68 | Offeror will review claims history for benefits issued during retroactive and in eligible periods and initiate overpayment recovery efforts. | Choose an item. |
| CC-69 | Offeror agrees to provide claims adjudication at 90th R&C percentile based on a <u>Maximum Allowable Charges schedule</u> for non-network DPPO services. | Choose an item. |
| CC-70 | Offeror agrees to provide EOB's by mail for both in-network and out-of-network services. | Choose an item. |
| CC-71 | Offeror agrees to process 99% of claims dollars accurately and provide to the State evidence of such processing during quarterly vendor meetings. | Choose an item. |
| CC-72 | Offeror agrees to process 97% of claims accurately and provide to the State evidence of such processing during quarterly vendor meetings. | Choose an item. |
| CC-73 | Offeror agrees to adjudicate 95% of claims within 10 business days and 98% of claims within 20 business days and provide to the State evidence of such processing during quarterly vendor meetings. | Choose an item. |
| Reporting | | |
| CC-74 | Offeror agrees to deliver the required management information reporting in the format specified by the State that provides utilization, claims reporting, and administrative services data by subgroup to the State of Maryland. The required subgroups are: State Actives, State Retirees, Direct Pay, Satellite Account, and in Total. See CC-75 through CC-87 for data elements and format for each report. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | | Offeror's Response |
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| CC-75 | The State requires a number of regular quarterly and annual claim reports. The Offeror will provide these reports in an electronic format upon data availability following the end of the accounting period to both the State and the State's benefit consultant. | Choose an item. |
| CC-76 | Offeror agrees to provide separate reports for each Functional Area, including performance guarantee reports. | Choose an item. |
| CC-77 | Offeror shall supply, on a monthly basis, a full file of all claim activity to the State's data warehouse vendor. This file shall include unique identification number and member Social Security Number. This file shall be transmitted electronically to a designated VPN connection. | Choose an item. |
| | Quarterly reports include: | |
| CC-78 | A report showing paid claims by month, service category, number of enrolled employees/retirees, number of enrolled participants (including employees/retirees and their dependents) for the following groups: (1) In and Out-of-Network. (2) State employees, Direct Pay, Satellites, Retirees, and in Total. (3) The paid claim service categories are: Class I (Preventive), Class II (Basic/Restorative), Class III (Major) and Class IV (Orthodontia). This report shall be due on the same schedule described in PG-8 in " FA2 Attachment T-9: Performance Guarantees. " | Choose an item. |
| CC-79 | Offeror must self-report on each of the Performance Guarantee measurements as defined in the Quarterly Plan Performance Measurement Report Card to the State on a calendar quarter basis, in the format requested. See PG-7 in " FA2 Attachment T-9: Performance Guarantees. " | Choose an item. |
| CC-80 | The data elements shown on " Attachment U-1a: Utilization and Cost Schedule, Attachment U-1b: Membership Analysis and Attachment U-1c: DPPO Network Utilization " must be reported on a calendar quarter basis, in the format requested. See PG-8 in " FA2 Attachment T-9: 'Performance Guarantees.' " | Choose an item. |
| CC-81 | A network summary report showing number of providers with a change in network status, including additions, terminations and those dentists no longer accepting new patients. This report should separate data based on plan and specialty type. | Choose an item. |
| CC-82 | A report describing network development activities for the previous quarter and a network development plan for the upcoming quarter. | Choose an item. |
| CC-83 | A report including the number and dollar value of outstanding overpayments. | Choose an item. |
| | Annual reports include: | |
| CC-84 | A rate renewal report, as required by PG-9 on " FA2 Attachment T-9: Performance Guarantees, " including, but not limited to: | |
| | a.) Projection of incurred and paid claim costs for renewal year; | Choose an item. |
| | b.) Complete documentation of the methodology and assumptions used to develop the projected costs, including a break out of all expenses; | Choose an item. |
| | c.) Disclosure of supporting data used in calculations, including monthly paid claims and enrollment, large claims analysis, trend analysis, demographic analysis, etc.; | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | | Offeror's Response |
|--|---|---------------------------|
| | d.) Substantiation of any proposed increase in fixed costs via a thorough analysis of activities and costs covered by those fees; | Choose an item. |
| | e.) Explanations for any unusual trend results (high/low relative to the market). | Choose an item. |
| CC-85 | A report summarizing the outcomes of the Offeror's Quality Management initiatives (as detailed in the Quality Assurance section below) for the prior plan year and areas of focus for the upcoming plan year. | Choose an item. |
| Other reporting requirements include: | | |
| CC-86 | For the DPPO, Offeror will track and report accumulation toward calendar maximum and lifetime orthodontia maximum by Participant for reporting to State on a quarterly basis and to Participant at certain accumulation milestones, as determined by the State. | Choose an item. |
| CC-87 | Offeror will provide Ad Hoc reporting flexibility to accommodate up to 15 requests annually, at no additional charge. | Choose an item. |
| Implementation Schedule | | |
| CC-88 | Offeror agrees to comply with the implementation schedule as described in the RFP Section 3.2, Project Implementation Milestones and Due Dates | Choose an item. |
| Payment Specifications | | |
| CC-89 | Offeror agrees to accept premium payments in accordance with the dental payment procedures described in RFP Section 3.5, Payment Terms. | Choose an item. |
| CC-90 | Offeror agrees to accept payment processed through normal State transmittal process (i.e., transmittal sent to Annapolis, EFT transfer to Offeror.) (See Section 1.371.47 Non-Disclosure Agreement of the RFP document.) | Choose an item. |
| CC-91 | Offeror agrees that the only compensation to be received by or on behalf of its organization in connection with this Plan shall be that which is paid directly by the State. | Choose an item. |
| Account Management/Customer Service | | |
| CC-92 | Upon request by the State, the Offeror agrees to change the designated account manager, claim supervisor, claim processor and/or claim facility for any reason at any time. | Choose an item. |
| CC-93 | Offeror will provide a dedicated (but not exclusive) account management team for the State. | Choose an item. |
| CC-94 | Offeror will provide a succession plan upon request for the account management team. | Choose an item. |
| CC-95 | Offeror will provide a dedicated (but not exclusive) customer service team for the State that is separate from the claim processing unit. | Choose an item. |
| CC-96 | Offeror will provide a designated senior eligibility contact for the State. | Choose an item. |
| CC-97 | Offeror will provide a designated senior underwriting contact for the State. | Choose an item. |
| CC-98 | Offeror will provide a designated senior premium payment contact for the State. | Choose an item. |
| CC-99 | Offeror will provide a designated senior reporting contact for the State. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Compliance Checklist | | Offeror's Response |
|--|---|---------------------------|
| CC-100 | Offeror will provide a designated senior claims/customer service contact for the State. | Choose an item. |
| CC-101 | Offeror will provide a designated senior billing contact for the State. | Choose an item. |
| CC-102 | Offeror will provide a dedicated (but not exclusive) claim processing unit for the State. | Choose an item. |
| CC-103 | Offeror will provide complete contact information for the contacts indicated in items CC-96 through CC-102 above. | Choose an item. |
| CC-104 | Offeror will attend quarterly meetings to discuss plan administration and any other concerns the State may have. Meetings will be set with the State in advance on a designated day each quarter. Meeting reporting content will include but not be limited to financial performance, performance guarantee results, customer services issues and process improvement, Offeror will attend meetings in accordance with PG-5 on "FA2 Attachment T-9: Performance Guarantees." | Choose an item. |
| CC-105 | Offeror agrees to review two drafts each year of the plan description contained in the State's Open Enrollment booklet each year, upon request by the State, and at no extra cost. | Choose an item. |
| CC-106 | Offeror agrees to meet or exceed established performance standards as described in "FA2 Attachment T-9: Performance Guarantees." | Choose an item. |
| Provider Contracting/ Relations | | |
| CC-107 | Offeror provides routine education to network providers regarding the plan's policies and procedures through a manual, periodic newsletters, and special meetings, as needed. | Choose an item. |
| CC-108 | Offeror agrees to develop and adhere to a detailed network development plan based on the State's needs and agreed to by the State. | Choose an item. |
| CC-109 | Offeror agrees to perform annual visits to all network providers. | Choose an item. |
| CC-110 | Offeror agrees to provide upon request by State a periodic "at-risk" provider report at no additional cost to the State. | Choose an item. |

REMINDER: All "No" responses must be addressed in **"FA2 Attachment T-2: Explanations and Deviations."**

FA2 Attachment T-7: Questionnaire AMENDMENT 6

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: Please provide a response to each of the following questions. Items in the response column with the words "**Choose an item**," contain a drop down list of options. Please select a response from those options as applicable. NOTE: All "No" responses must be addressed in "**FA2 Attachment T-2: Explanations and Deviations.**"

| Question | | Offeror's Response |
|----------|---|---|
| General | | |
| Q-1 | Briefly describe your company's experience in providing DPPO Fully Insured dental benefits. | Click here to enter text. |
| Q-2 | How long he you offered DPPO Fully Insured dental plans to Maryland based clients? | Click here to enter text. |
| Q-3 | Is your organization compliant with all applicable HIPAA administrative simplification rules? | Choose an item. |
| Q-4 | a.) Will your organization be involved in any acquisitions or mergers within the next 12 months? | Choose an item. |
| | If yes, please describe. | Click here to enter text. |
| | b) Has your organization been involved in any recent acquisitions or mergers? | Choose an item. |
| | • Within the last 12 months? | Choose an item. |
| | • 1-2 years ago? | Choose an item. |
| | • 2-5 years ago? | Choose an item. |
| | • None in the last five years | Choose an item. |
| | If yes, please describe. | Click here to enter text. |
| Q-5 | Confirm that your organization has Errors and Omissions Insurance and Commercial General Liability Insurance. | Please submit a copy of your certificate(s) of insurance indicating coverage limits and label as " Response FA2 Attachment T-7: Certificates of Insurance. " |
| | • E & O | Choose an item. |
| | • Commercial General Liability | Choose an item. |
| Q-6 | Provide the following aggregate claims information for 2011 and 2012: | |
| | Calendar Year 2011 | |
| | • Total claim dollars paid under all dental plans administered or insured | Click here to enter text. |
| | • Total claim dollars paid under all DPPO plans administered or insured | Click here to enter text. |
| | • Total members covered under all dental plans administered or insured | Click here to enter text. |
| | • Total members covered under all DPPO plans administered or insured | Click here to enter text. |
| | • Total claim dollars paid under dental plans administered or insured in the State of Maryland | Click here to enter text. |
| | • Total claim dollars paid under DPPO plans administered or insured in the State of Maryland | Click here to enter text. |
| | • Total members covered under all dental plans administered or insured in the State of Maryland | Click here to enter text. |
| | • Total members covered under all DPPO plans administered or insured in the State of Maryland | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | Offeror's Response |
|---|---|
| <p>Calendar Year 2012</p> <ul style="list-style-type: none"> ● Total claim dollars paid under all dental plans administered or insured ● Total claim dollars paid under all DPPO plans administered or insured ● Total members covered under all dental plans administered or insured ● Total members covered under all DPPO plans administered or insured ● Total claim dollars paid under dental plans administered or insured in the State of Maryland ● Total claim dollars paid under DPPO plans administered or insured in the State of Maryland ● Total members covered under all dental plans administered or insured in the State of Maryland ● Total members covered under all DPPO plans administered or insured in the State of Maryland | <p>Click here to enter text.</p> |
| <p>Q-7 On average, by what percentage have premiums for the DPPO plan proposed increased over the last three years?</p> | |
| <p>Q-8 For your proposed network for the State of Maryland, what percentage of participating providers in your proposed network were not accepting new patients during the following calendar years?</p> <p>Calendar Year 2011</p> <ul style="list-style-type: none"> ● General/Family dentists ● Orthodontists ● Pedodontist ● Periodontist ● Oral Surgeon ● Endodontist <p>Calendar Year 2012</p> <ul style="list-style-type: none"> ● General/Family dentists ● Orthodontists ● Pedodontist ● Periodontist ● Oral Surgeon ● Endodontist | <p>Click here to enter text.</p> |
| <p>Q-9 Does your provider directory (both on-line and hardcopy) indicate the following information for each network provider?</p> <ul style="list-style-type: none"> ● Handicap accessible ● Multi-lingual ● Distance from member location ● If accepting new patients ● Specialty | <p>Choose an item.</p> |
| <p>Q-10 Are you anticipating any material changes (+/- 5%) in network size (for either general/family dentists or specialists) in the network area serving State of Maryland employees and retirees during the next 12 months?</p> | <p>Choose an item.</p> |
| NETWORK MANAGEMENT | |
| <p>Q-11 Who conducts the provider credentialing process? Please indicate the qualifications of the person(s) or organization(s) responsible for conducting this review.</p> | <p>Click here to enter text.</p> |
| <p>Q-12 Are onsite visits conducted during the credentialing process?</p> | <p>Choose an item.</p> |
| <p>Q-13 How are Specialty dentists re-credentialed? How often?</p> | <p>Click here to enter text.</p> |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|----------------------------|---|---|
| Q-14 | Do you conduct provider satisfaction surveys? | Choose an item. |
| | If yes, please provide a copy of the results of your latest survey. | Please submit response and label as "Response FA2 Attachment T-7: Provider Satisfaction Survey." |
| | If yes, what percentage of providers are satisfied with your plan? | Click here to enter text. |
| Q-15 | List the top five most common complaints by your network providers: | |
| | ● #1 Complaint | Click here to enter text. |
| | ● #2 Complaint | Click here to enter text. |
| | ● #3 Complaint | Click here to enter text. |
| | ● #4 Complaint | Click here to enter text. |
| Q-16 | Are general/family dentists at any financial risk for specialty services? | Choose an item. |
| | If so, please explain. | Click here to enter text. |
| Q-17 | What is your annual dental turnover rate for the following? | |
| | Calendar Year 2010 | |
| | ● # of dentists joining the plan | Click here to enter text. |
| | ● General/Family dentists | |
| | Voluntarily terminated | Click here to enter text. |
| | Non-voluntarily terminated | Click here to enter text. |
| | ● Specialists | |
| | Voluntarily terminated | Click here to enter text. |
| | Non-voluntarily terminated | Click here to enter text. |
| | Calendar Year 2011 | |
| | ● # of dentists joining the plan | Click here to enter text. |
| | ● General/Family dentists | |
| | Voluntarily terminated | Click here to enter text. |
| | Non-voluntarily terminated | Click here to enter text. |
| | ● Specialists | |
| | Voluntarily terminated | Click here to enter text. |
| | Non-voluntarily terminated | Click here to enter text. |
| | Calendar Year 2012 | |
| | ● # of dentists joining the plan | Click here to enter text. |
| ● General/Family dentists | | |
| Voluntarily terminated | Click here to enter text. | |
| Non-voluntarily terminated | Click here to enter text. | |
| ● Specialists | | |
| Voluntarily terminated | Click here to enter text. | |
| Non-voluntarily terminated | Click here to enter text. | |
| Q-18 | How do you monitor judicial or regulatory restrictions imposed on your providers? Explain your process for identifying, monitoring and terminating problem providers. | Click here to enter text. |
| Q-19 | How often do you pay providers? Describe the payment process(es); identify separately processes for each provider type quoted, if it differs. | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|--|--|--|
| Q-20 | Does your organization perform provider profiling or other quality measures to identify providers with patterns of over/under treatment to members? | Choose an item. |
| | If yes, give examples. | Click here to enter text. |
| Q-21 | Please provide responses to the following items that apply when an individual provider or group practice notifies your plan of an intent to terminate participation in your network: | |
| | • Describe what actions are taken by your plan to retain the individual provider or group practice in the network. | Click here to enter text. |
| | • Describe what actions are taken to recruit individual providers or another group practice for the network in place of terminated providers. | Click here to enter text. |
| | • Describe what notices are sent to members concerning termination of their provider. | Click here to enter text. |
| | • Provide a copy of a sample member letter concerning provider termination. | Please provide a copy "Response FA2 Attachment T-7: Sample Member Letter-Provider Termination." |
| Q-22 | Please describe your plan's defined program and process to systematically evaluate participating General Dentists for cost, utilization, clinical outcomes, administration cooperation and member services satisfaction. | Click here to enter text. |
| Q-23 | Describe the specific measures used by your organization in the development of your networks and to monitor dentist access. | Click here to enter text. |
| Q-24 | Describe your policy for dealing with patients who complain that they cannot be seen by a participating provider as soon as they desire. How do you handle patients who cannot wait for the next available appointment? | Click here to enter text. |
| Q-25 | Under what circumstances and how are dependents covered outside of your service area? | Choose an item. |
| CARE MANAGEMENT | | |
| Q-26 | Describe the staffing, qualifications, training programs and monitoring for your Utilization Review (UR) staff. | Click here to enter text. |
| Q-27 | How are dental emergencies (both in and out of area) and accidental dental services provided? | Click here to enter text. |
| QUALITY OF CARE | | |
| Q-28 | Describe any quality improvement initiatives, including results, undertaken in the last 12 months. | Click here to enter text. |
| Q-29 | Describe specific examples of how your quality assurance program has led to improved care in the following areas: | |
| | • Monitoring adherence to treatment guidelines and protocols. | Click here to enter text. |
| | • Ongoing maintenance and evaluation of the quality and appropriateness of care. | Click here to enter text. |
| | • Utilization management. | Click here to enter text. |
| | • Reviewing and approving credentials of patient care professionals. | Click here to enter text. |
| | • Clinical aspects of risk management. | Click here to enter text. |
| | • Infection control. | Click here to enter text. |
| | • Facility quality (i.e., appointment timeliness, location, cleanliness, parking, etc.) | Click here to enter text. |
| • Formal committee that sets quality assurance policy and reviews outcomes on a regular basis. | Click here to enter text. | |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|------------------------------|---|---|
| SYSTEMS | | |
| Q-30 | Are there any electronic system changes planned for the contract term? If yes, please describe. | Choose an item. Click here to enter text. |
| Q-31 | Does your system track referrals to specialists or non-contracted providers? If yes, please describe. | Choose an item. Click here to enter text. |
| Q-32 | Is there a contingency plan(s), procedure, and system in place to provide backup service in the event of strike, natural disaster or backlog? If yes, please describe. | Choose an item. Click here to enter text. |
| Q-33 | How often are the systems backup and disaster recovery systems tested? | Click here to enter text. |
| Q-34 | When were the systems last tested and what were the results? | Click here to enter text. |
| Q-35 | What system down time have you experienced during the most recent 12 months? | Click here to enter text. |
| Q-36 | How long are records maintained? | Click here to enter text. |
| Q-37 | How quickly can the State's services be reinstated in the event of permanent disaster to both the hardware and software? | Click here to enter text. |
| CLAIMS ADMINISTRATION | | |
| Q-38 | Provide the following information regarding your Dental Director: <ul style="list-style-type: none"> • Name • Specialty • The current percentage of time as Dental Director versus private practice • Number of years as Dental Director • Number of years in private practice • If not currently practicing dentistry, indicate the last year in private practice. • Provide resume for the Dental Director | Click here to enter text. Click here to enter text. Please submit resume and label as " Response FA2 Attachment T-7: Dental Director Resume. " |
| Q-39 | How many claims processors will be assigned to handle the State's account? | Click here to enter text. |
| Q-40 | Do customer service representatives (CSRs) have authority to approve claims? What access do CSRs have to the dental director? | Choose an item. Click here to enter text. |
| Q-41 | Describe the initial and ongoing training programs for the claim administration team (e.g. claim processors, supervisors and other management staff). | Click here to enter text. |
| Q-42 | What is the average amount of time Claims staff spends in annual ongoing training? | Click here to enter text. |
| Q-43 | Please note the source of your R&C information (e.g. HIAA, MDR, internally developed, other). | Click here to enter text. |
| Q-43 | <u>Please describe how you develop and maintain the Maximum Allowable Charge schedule for out-of-network claims. What is the relationship between this schedule and contracted reimbursement schedules for participating in-network providers? How often is your MAC schedule updated?</u> | <u>Click here to enter text.</u> |
| Q-44 | List the locations of all claims offices that you propose to process claims for the State. | Click here to enter text. |
| Q-45 | What is the most recent annual turnover rate for your claims processing | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|------------------------|---|---------------------------|
| | staff in your proposed location(s)? | |
| Q-46 | For each of the claims offices that will service the State, what were the claims financial accuracy rates during 2011 and 2012? | Click here to enter text. |
| Q-47 | For each of the claims offices that will service the State, what were the claims procedural error rates during 2011 and 2012? | Click here to enter text. |
| Q-48 | For each of the claims offices that will service the State, what are the target claim error rates? | |
| | • % financial accuracy | Click here to enter text. |
| | • % procedural accuracy | Click here to enter text. |
| Q-49 | For each of the claims offices that will service the State, what are the average and target turnaround times for clean claims? | |
| | • Calendar days | Click here to enter text. |
| | • Current Average % | Click here to enter text. |
| | • Target % | Click here to enter text. |
| Q-50 | Describe the claims payment process from date of receipt to full adjudication of checks to providers or patients. | Click here to enter text. |
| Q-51 | When and under what circumstances are claims pended? | Click here to enter text. |
| | Does a pending notice go into the system? | Click here to enter text. |
| | Is there an automatic follow-up? | Choose an item. |
| | What is the frequency of the follow-up? | Click here to enter text. |
| | How many follow-ups are performed? | Click here to enter text. |
| Q-52 | Describe your administrative requirements with respect to claims filed directly by members. | Click here to enter text. |
| Q-53 | Provide your claims processing standards for claim adjudication financial accuracy versus actual for 2012. | Click here to enter text. |
| Q-54 | Provide your claims timeliness standards for claim adjudication versus actual for 2012. | Click here to enter text. |
| Q-55 | What percent of claims are automatically adjudicated? | Click here to enter text. |
| Q-56 | Describe your Ad Hoc reporting capabilities. | Click here to enter text. |
| Q-57 | What is the suggested pre-determination of benefits threshold amount? | Click here to enter text. |
| | How is this communicated to participants and providers? | Click here to enter text. |
| MEMBER SERVICES | | |
| Q-58 | Describe the member services unit that will be assigned to the State. | |
| | • Structure | Click here to enter text. |
| | • Number of representatives | Click here to enter text. |
| | • Qualifications | Click here to enter text. |
| | • Average years of experience | Click here to enter text. |
| | • Toll-free contact number | Click here to enter text. |
| | • Hours of operation | Click here to enter text. |
| | • Type of unit | Choose an item. |
| Q-59 | What is the most recent annual turnover rate of the member services unit that will be assigned to the State? | Click here to enter text. |
| Q-60 | Please describe the training of a member service representative. | Click here to enter text. |
| Q-61 | What percentage of your member services representatives speak the following languages: | |
| | • English | Click here to enter text. |
| | • Spanish | Click here to enter text. |
| | • Other (please specify) | Click here to enter text. |
| Q-62 | What is the average speed to answer in seconds? | Click here to enter text. |
| Q-63 | What is the percent call abandonment rate? | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|--|---|---------------------------|
| Q-64 | What percentage of member calls are recorded? | Click here to enter text. |
| Q-65 | Identify which of the following functions are automatically tracked and reported by the system. Note that the State requires these data on a quarterly basis. Select all that apply. | |
| | • Call abandonment rate | Choose an item. |
| | • Length of call | Choose an item. |
| | • Number of calls taken | Choose an item. |
| | • On-line call recording | Choose an item. |
| | • Speed of call response | Choose an item. |
| | • Type of call/complaint | Choose an item. |
| Q-66 | Does your system utilize an Interactive Voice Response (IVR) system? | Choose an item. |
| Q-67 | Do you have a correspondence tracking system to log in, assign and track correspondence? | Choose an item. |
| Q-68 | Describe your procedure for referrals to providers outside the network. | Click here to enter text. |
| | How long are referrals valid? | Click here to enter text. |
| Q-69 | What assistance do you provide plan members if a network provider terminates his or her contract during the plan year? | Click here to enter text. |
| | How and when are members notified of the termination? | Click here to enter text. |
| | What happens to patients who had been receiving ongoing treatment from a former network provider? | Click here to enter text. |
| Q-70 | Describe your formal member grievance process, including time frames from the initial receipt of a grievance until resolution. | Click here to enter text. |
| | Describe your grievance tracking system. | Click here to enter text. |
| WEB BASED SERVICES | | |
| Q-71 | Describe your web-based capabilities. | Click here to enter text. |
| Q-72 | Have you implemented, or do you plan to implement within the next 12 months, an Internet or other electronic connection for the following? Describe all that apply. | |
| | • Enrollment administration | Click here to enter text. |
| | • Eligibility administration | Click here to enter text. |
| | • Reporting | Click here to enter text. |
| | • Employer access to real time claim status | Click here to enter text. |
| | • EOB Look Up | Click here to enter text. |
| | • Other (please explain) | Click here to enter text. |
| Q-73 | Have you implemented, or do you plan to implement within the next 12 months, an Internet or other electronic connection that will be available to members for the following? Describe all that apply. | |
| | • Access member services | Click here to enter text. |
| | • Access a provider selection database | Click here to enter text. |
| | • Make claim inquiries | Click here to enter text. |
| | • Access other information (please specify) | Click here to enter text. |
| | • Download member identification card | Click here to enter text. |
| Q-74 | Please provide the website address for the provider directory. | Click here to enter text. |
| | Provide its password, if necessary. | Click here to enter text. |
| Q-75 | Is provider information, in addition to contact information, available to members via the internet? | Choose an item. |
| | If yes, please describe. | Click here to enter text. |
| IMPLEMENTATION PROGRAM / TRANSITION | | |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|----------|--|---|
| Q-76 | Please discuss your procedures and processes for handling the employee communications regarding the change in plans during the initial vendor transition period. | Click here to enter text. |
| Q-77 | Implementation Plan | |
| | <ul style="list-style-type: none"> • Please provide the Name of the person with overall responsibility for planning, supervising and implementing the program for the State. | Click here to enter text. |
| | <ul style="list-style-type: none"> • Please provide the Title of the person named above. | Click here to enter text. |
| | <ul style="list-style-type: none"> • What other duties, if any, will this person have during implementation? Please include the number and size of other accounts for which this person will be responsible during the same time period. | Click here to enter text. |
| | <ul style="list-style-type: none"> • What percentage of this person's time will be devoted to the State during the implementation process? | Click here to enter text. |
| | <ul style="list-style-type: none"> • Please provide an organizational chart identifying the names, functions and reporting relationships of key people directly responsible for implementing the State of Maryland account. | Please submit organization chart and label as "Response FA2 Attachment T-7: Implementation Team Organizational Chart." |
| | <ul style="list-style-type: none"> • Provide a detailed implementation plan that clearly demonstrates the Offeror's ability to meet the State's requirements to have a fully functioning program in place and operable on January 1, 2015. This implementation plan should include a list of specific implementation tasks/transition protocols and a time-table for initiation and completion of such tasks, beginning with the contract award and continuing through the effective date of operation (January 1, 2015). The implementation plan should be specific about requirements for information transfer as well as any services or assistance required from the State during implementation. The implementation plan should also specifically identify those individuals, by area of expertise, responsible for key implementation activities and clearly identify their roles. A detailed organizational chart as well as resumes should be included. | Please submit the Offeror's description of account management support and label as "Response FA2 Attachment T-7: Implementation Plan." |
| Q-78 | Do you anticipate any major transition issues during implementation? | Choose an item. |
| | If yes, please describe. | Click here to enter text. |
| Q-79 | Account Management Plan | |
| | <ul style="list-style-type: none"> • Please provide the Name of the person with overall responsibility for planning, supervising and performing account services for the State. | Click here to enter text. |
| | <ul style="list-style-type: none"> • Please provide the Title of the person named above. | Click here to enter text. |
| | <ul style="list-style-type: none"> • What other duties, if any, does this person have? Please include the number and size of other accounts for which this person is responsible. | Click here to enter text. |
| | <ul style="list-style-type: none"> • What percentage of this person's time will be devoted to the State? | Click here to enter text. |
| | <ul style="list-style-type: none"> • Please provide an organizational chart identifying the names, functions and reporting relationships of key people directly responsible for account support services to the State. It should also document how many account executives and group services representatives will work full-time on the State's account and how many will work part-time on the State's account. | Please submit organization chart and label as "Response FA2 Attachment T-7: Account Management Team Organizational Chart." |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|-----------------|---|--|
| | <ul style="list-style-type: none"> Describe account management support, including the mechanisms and processes in place to allow State personnel to communicate with account service representatives, hours of operation; types of inquiries that can be handled by account service representatives; and a brief explanation of information available on-line. The State requires identification of an account services manager to respond to inquiries and problems, and a description of how the Offeror's customer service and other support staff will respond to subscriber or client inquiries and problems. The management plan should include the names, resumes and description of functions and responsibilities for all supervisors and managers that will provide services to the State with respect to this contract. | Please submit the Offeror's description of account management support and label as " Response FA2 Attachment T-7: Account Management Support. " |
| Q-80 | The State of Maryland would like direct access to the Offeror's eligibility systems for review and input purposes. Please describe your ability to provide the State with direct access to the eligibility system only. | Click here to enter text. |
| Q-81 | Are you able to receive eligibility data via the Internet? | Choose an item. |
| Q-82 | Is eligibility processing real-time with the claim system? If no, what is the delay time? | Choose an item. Choose an item. |
| Q-83 | Briefly describe how your organization will process the HIPAA 834 file layout internally (convert to proprietary file specification, dump to paper, etc.) | Click here to enter text. |
| Q-84 | Briefly describe your process for correcting data in the event of a data tape which contains "bad data." | Click here to enter text. |
| Q-85 | Provide a complete listing of all services which are subcontracted and the subcontractor used. (Please complete " FA2 Attachment T-8 Subcontractor Questionnaire " for each of the subcontractors listed here.) | Click here to enter text. |
| Q-86 | Are all subcontractors compliant with all applicable HIPAA administrative simplification rules? What procedures do you have in place to ensure subcontractor compliance? | Choose an item. Click here to enter text. |

REMINDER: All "No" responses must be addressed in **FA2 Attachment T-2: Explanations and Deviations.**

FA2 Attachment T-8a: Subcontractor Questionnaire

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete one "FA2 Attachment T-8: Subcontractors Questionnaire" for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is an MBE certified by the State of Maryland, if responding for a MBE subcontractor.

Subcontractor's Name (if applicable) [Click here to enter text.](#)

Subcontractor's MDOT Number (if applicable) [Click here to enter text.](#)

| Question | | Offeror's Response |
|----------|---|---|
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what roles will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
| | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Provide the following information about the subcontractor's company: | |
| | • Organization's legal name | Click here to enter text. |
| | • State of incorporation | Click here to enter text. |
| | • Date of incorporation | Click here to enter text. |
| | • Insurance certification from the Maryland Insurance Administration | Click here to enter text. |
| SQ-5 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|-----------------|--|---------------------------|
| SQ-6 | Provide the addresses, including city and state, for the subcontractor's following activities: | |
| | • Corporate/ Firm Management Office | Click here to enter text. |
| | • Customer Service Office | Click here to enter text. |
| | • Provider Service Office | Click here to enter text. |
| | • Account Management/ Client Services Office | Click here to enter text. |
| | • Technical Support Office | Click here to enter text. |
| SQ-7 | Does the subcontractor have contractual relationships with third party administrators/ organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-8 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

FA2 Attachment T-8b: Subcontractor Questionnaire

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete one "FA2 Attachment T-8: Subcontractors Questionnaire" for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is an MBE certified by the State of Maryland, if responding for a MBE subcontractor.

Subcontractor's Name (if applicable) [Click here to enter text.](#)

Subcontractor's MDOT Number (if applicable) [Click here to enter text.](#)

| Question | | Offeror's Response |
|----------|---|---|
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what roles will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
| | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Provide the following information about the subcontractor's company: | |
| | • Organization's legal name | Click here to enter text. |
| | • State of incorporation | Click here to enter text. |
| | • Date of incorporation | Click here to enter text. |
| | • Insurance certification from the Maryland Insurance Administration | Click here to enter text. |
| SQ-5 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|-----------------|--|---------------------------|
| SQ-6 | Provide the addresses, including city and state, for the subcontractor's following activities: | |
| | • Corporate/ Firm Management Office | Click here to enter text. |
| | • Customer Service Office | Click here to enter text. |
| | • Provider Service Office | Click here to enter text. |
| | • Account Management/ Client Services Office | Click here to enter text. |
| | • Technical Support Office | Click here to enter text. |
| SQ-7 | Does the subcontractor have contractual relationships with third party administrators/ organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-8 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

FA2 Attachment T-8c: Subcontractor Questionnaire

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete one "FA2 Attachment T-8: Subcontractors Questionnaire" for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is an MBE certified by the State of Maryland, if responding for a MBE subcontractor.

Subcontractor's Name (if applicable) [Click here to enter text.](#)

Subcontractor's MDOT Number (if applicable) [Click here to enter text.](#)

| Question | | Offeror's Response |
|----------|---|---|
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what roles will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
| | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Provide the following information about the subcontractor's company: | |
| | • Organization's legal name | Click here to enter text. |
| | • State of incorporation | Click here to enter text. |
| | • Date of incorporation | Click here to enter text. |
| | • Insurance certification from the Maryland Insurance Administration | Click here to enter text. |
| SQ-5 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|-----------------|--|---------------------------|
| SQ-6 | Provide the addresses, including city and state, for the subcontractor's following activities: | |
| | • Corporate/ Firm Management Office | Click here to enter text. |
| | • Customer Service Office | Click here to enter text. |
| | • Provider Service Office | Click here to enter text. |
| | • Account Management/ Client Services Office | Click here to enter text. |
| | • Technical Support Office | Click here to enter text. |
| SQ-7 | Does the subcontractor have contractual relationships with third party administrators/ organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-8 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

FA2 Attachment T-8d: Subcontractor Questionnaire

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete one "FA2 Attachment T-8: Subcontractors Questionnaire" for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is an MBE certified by the State of Maryland, if responding for a MBE subcontractor.

Subcontractor's Name (if applicable) [Click here to enter text.](#)

Subcontractor's MDOT Number (if applicable) [Click here to enter text.](#)

| Question | | Offeror's Response |
|----------|---|---|
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what roles will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
| | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Provide the following information about the subcontractor's company: | |
| | ● Organization's legal name | Click here to enter text. |
| | ● State of incorporation | Click here to enter text. |
| | ● Date of incorporation | Click here to enter text. |
| | ● Insurance certification from the Maryland Insurance Administration | Click here to enter text. |
| SQ-5 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|-----------------|--|---------------------------|
| SQ-6 | Provide the addresses, including city and state, for the subcontractor's following activities: | |
| | • Corporate/ Firm Management Office | Click here to enter text. |
| | • Customer Service Office | Click here to enter text. |
| | • Provider Service Office | Click here to enter text. |
| | • Account Management/ Client Services Office | Click here to enter text. |
| | • Technical Support Office | Click here to enter text. |
| SQ-7 | Does the subcontractor have contractual relationships with third party administrators/ organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-8 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

FA2 Attachment T-8e: Subcontractor Questionnaire

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete one "FA2 Attachment T-8: Subcontractors Questionnaire" for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is an MBE certified by the State of Maryland, if responding for a MBE subcontractor.

Subcontractor's Name (if applicable) [Click here to enter text.](#)

Subcontractor's MDOT Number (if applicable) [Click here to enter text.](#)

| Question | | Offeror's Response |
|----------|---|---|
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what roles will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
| | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Provide the following information about the subcontractor's company: | |
| | ● Organization's legal name | Click here to enter text. |
| | ● State of incorporation | Click here to enter text. |
| | ● Date of incorporation | Click here to enter text. |
| | ● Insurance certification from the Maryland Insurance Administration | Click here to enter text. |
| SQ-5 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|-----------------|--|---------------------------|
| SQ-6 | Provide the addresses, including city and state, for the subcontractor's following activities: | |
| | • Corporate/ Firm Management Office | Click here to enter text. |
| | • Customer Service Office | Click here to enter text. |
| | • Provider Service Office | Click here to enter text. |
| | • Account Management/ Client Services Office | Click here to enter text. |
| | • Technical Support Office | Click here to enter text. |
| SQ-7 | Does the subcontractor have contractual relationships with third party administrators/ organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-8 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

FA2 Attachment T-8f: Subcontractor Questionnaire

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete one "FA2 Attachment T-8: Subcontractors Questionnaire" for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is an MBE certified by the State of Maryland, if responding for a MBE subcontractor.

Subcontractor's Name (if applicable) [Click here to enter text.](#)

Subcontractor's MDOT Number (if applicable) [Click here to enter text.](#)

| Question | | Offeror's Response |
|----------|---|---|
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what roles will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
| | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Provide the following information about the subcontractor's company: | |
| | • Organization's legal name | Click here to enter text. |
| | • State of incorporation | Click here to enter text. |
| | • Date of incorporation | Click here to enter text. |
| | • Insurance certification from the Maryland Insurance Administration | Click here to enter text. |
| SQ-5 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| Question | | Offeror's Response |
|-----------------|--|---------------------------|
| SQ-6 | Provide the addresses, including city and state, for the subcontractor's following activities: | |
| | • Corporate/ Firm Management Office | Click here to enter text. |
| | • Customer Service Office | Click here to enter text. |
| | • Provider Service Office | Click here to enter text. |
| | • Account Management/ Client Services Office | Click here to enter text. |
| | • Technical Support Office | Click here to enter text. |
| SQ-7 | Does the subcontractor have contractual relationships with third party administrators/ organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-8 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

FA2 Attachment T-9: Performance Guarantees

Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Offeror will report results on all performance measurements quarterly per the requirements of the Report Card and separately for each plan type. Performance results will also be audited annually by the State's contract auditor.

Note: It is critical to the success of the State's programs that services be maintained in accordance with the schedules agreed upon by the State. It is also critical to the success of the State's programs that the Contractor operates in an extremely reliable manner. It would be impracticable and extremely difficult to fix the actual damage sustained by the State in the event of delays or failures in claims administration, service, reporting, and attendance of Contractor personnel on scheduled work and provision of services to the citizens of the State. The State and the Contractor, therefore, presume that in the event of certain delay(s) or failure(s), the amount of damage which will be sustained from the delay or failure will be the amount set forth below, and the Contractor agrees that in the event of any such failure of performance, the Contractor shall pay such amount as liquidated damages and not as a penalty. The State, at its option for amount due the State as liquidated damages, may deduct such from any money payable to the Contractor or may bill the Contractor as a separate item.

NOTE: Items in the response column with the words "Willing to Comply" contain a drop down list of options including Yes or No. Please select a response from those options as applicable. All "No" responses must be addressed in "Attachment O-2: Explanations and Deviations."

| | Performance Indicator | Standard/Goal | Reporting Measurement (subject to audit by State and/or contract auditors) | Liquidated Damages* | Willing to Comply |
|------|---|--|---|--|-------------------|
| PG-1 | Telephone Call Availability Measurements must be State-specific or for only the service center handling the State account. | 98% of telephone calls are answered by a live service representative (with knowledge of State of Maryland account) within 30 seconds. The representative must be able to address the member's issue/question. Time over which standard is measured: Quarter | Plan Performance Measurement Report Card and supporting data (to be submitted by the Vendor). Frequency of report: Quarterly | 0.10% of fees for each percentage point, or fraction thereof, below 98%. | Choose an item. |
| PG-2 | Telephone Call Abandonment Rate Measurements must be State-specific or for only | Abandonment rate of less than 3%. Time over which standard is measured: Quarter | Report Card and supporting data (to be submitted by the Vendor). Frequency of report: Quarterly | 0.10% of fees for each percentage point, or fraction thereof, over 3%. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| | Performance Indicator | Standard/Goal | Reporting Measurement (subject to audit by State and/or contract auditors) | Liquidated Damages* | Willing to Comply |
|------|---|---|---|--|--------------------------|
| | the service center handling the State account. | | | | |
| PG-3 | Processing of Enrollment Eligibility Update Information | Plan will process tape or electronic interchange of State enrollment information by 7:00 AM of the second business day after receipt . If tape is received after 12 noon, record will reflect it as having been received as of the next business day. Time over which standard is measured: Quarter | Report Card - Vendor to maintain log and system generated reports for review by the State's contract auditor. Frequency of report: Quarterly | 0.20% of fees for each calendar day, or portion thereof, of delay. | Choose an item. |
| PG-4 | Accuracy of Processing Enrollment Eligibility Information | Plan will process electronic interchange of State enrollment with at least 98% accuracy. Time over which standard is measured: Quarter | Report Card - Vendor to maintain log and system generated reports for review by the State's contract auditor. Frequency of report: Quarterly | 0.20% of fees for each percentage point, or fraction thereof, under 98%. | Choose an item. |
| PG-5 | Contractor attendance at State plan management meetings and State-sponsored open enrollment meetings. | Attendance by plan representatives at 100% of meetings scheduled by the State, for 100% of the meeting's duration. Representative must arrive early enough to have their table set-up prior to meeting start time. Display must be organized and include appropriate covering of table. Representative must have detailed plan knowledge, interact with members, and exhibit professional appearance and | Sign-in sheets at meetings or minutes of State meetings. Frequency of report: Quarterly | 0.05% of fees for each scheduled meeting date that vendor fails to attend. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| | Performance Indicator | Standard/Goal | Reporting Measurement (subject to audit by State and/or contract auditors) | Liquidated Damages* | Willing to Comply |
|------|--|---|---|---|--------------------------|
| | | behavior. Time over which standard is measured: Quarter | | | |
| PG-6 | Account Management | Plan representatives will return all messages received from DBM (whether voice mail, e-mail or other communication method) promptly. Messages received before 12 Noon will be replied to the same day. Messages received after 12 Noon will be replied to by 12 Noon of the following business day. Time over which standard is measured: Quarter | Report Card - Vendor to maintain log for review by the State's contract auditor. Frequency of report: Quarterly | 0.01% of fees for each delayed response. | Choose an item. |
| PG-7 | Delivery of Quarterly Plan Performance Measurement Report Card to the State | Delivery to the State by 6:00 pm on the following dates**: First Quarter (Jan – Mar) Due: May 1st Second Quarter (Apr – Jun) Due: August 1st Third Quarter (Jul – Sep) Due: November 1st Fourth Quarter (Oct – Dec) Due: February 1st | Date-stamp of receipt by the State. Frequency of report: Quarterly | .20% of fees for each week, or fraction thereof that Report Card is not received. | Choose an item. |
| PG-8 | Delivery of Quarterly Utilization and Case Management Data Reports to the State and the State's Consultant (see Attachment U-1 exhibits) | Delivery to the State by 6:00 pm on the following dates**: First Quarter (Jan – Mar) Due: May 1st Second Quarter (Apr – Jun) Due: August 1st | Documentation of receipt by State's Benefit Consultant, i.e., date-stamp of mailing package for data information and verification of completeness. (All required fields | 0.20% of fees for each week, or fraction thereof, the data report is not received or is incomplete. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| | Performance Indicator | Standard/Goal | Reporting Measurement (subject to audit by State and/or contract auditors) | Liquidated Damages* | Willing to Comply |
|------|----------------------------------|---|--|---|---|
| | | Third Quarter (Jul – Sep) Due: November 1st | must be filled in correctly.) | | |
| | | Fourth Quarter (Oct – Dec) Due: February 1st | Frequency of report: Quarterly | | |
| PG-9 | Delivery of Rate Renewal Reports | <p>Delivery to the State and to the State's actuarial consultant of reports required for annual rate renewal process by 6:00 PM May 31st of each contract year for the next contract year. At a minimum, the renewal reports must include (but not be limited to) the following**:</p> <ul style="list-style-type: none"> ● projection of incurred claim costs for renewal year ● estimate of IBNR reserves at end of current year; including the most recent 36 months of incurred/paid triangular reports ● complete documentation of the methodology and assumptions utilized to develop the projected costs ● disclosure of supporting data used in the calculations, including monthly paid claims and enrollment, large claims analysis, trend analysis, demographic analysis, etc. | <p>Date-stamp of receipt by the State and verification of completeness of required documentation.</p> <p>Frequency of report: Annually</p> | 0.20% of fees for each week, or fraction thereof, that the rate renewal reports are not received or are incomplete. | <p>Choose an item.</p> <p>Choose an item.</p> <p>Choose an item.</p> <p>Choose an item.</p> |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| | Performance Indicator | Standard/Goal | Reporting Measurement (subject to audit by State and/or contract auditors) | Liquidated Damages* | Willing to Comply |
|-------|------------------------------|--|---|---|--------------------------|
| | | <ul style="list-style-type: none"> substantiation of any proposed increase in fixed costs via a thorough analysis of activities and costs covered by those fees explanations for any unusual trend results (high relative to the market, low relative to the market) | | | Choose an item. |
| | | | | | Choose an item. |
| PG-10 | Provider Turnover | A turnover rate of less than 5% annually will be maintained for both the general dentist and specialty network. Calculation should include all terminations regardless of reason for termination. | Quarterly vendor report | 3% of fees if turnover is greater than 5%, 6% of fees if greater than 7%. | Choose an item. |
| PG-11 | Network Access | Urban: 2 open locations within 8 miles = 99%. Time over which standard is measured: Quarter | Quarterly vendor report | 3% of fees if not met. | Choose an item. |
| | | Suburban: 2 open locations within 8 miles = 95%. Time over which standard is measured: Quarter | Quarterly vendor report | 3% of fees if not met. | Choose an item. |
| | | Rural: 2 open locations within 8 miles = 60%. Time over which standard is measured: Quarter | Quarterly vendor report | 3% of fees if not met. | Choose an item. |
| PG-12 | Employee Satisfaction | A 90% or higher member satisfaction rate. Time over which standard is measured: Annual | Survey results of the State’s annual Customer Satisfaction Survey. Frequency of report: Annually | 1% of fees if performance is less than standards. | Choose an item. |

DENTAL BENEFITS: FUNCTIONAL AREA 2 – DPPO Fully Insured

| | Performance Indicator | Standard/Goal | Reporting Measurement (subject to audit by State and/or contract auditors) | Liquidated Damages* | Willing to Comply |
|-------|---|---|--|--|--------------------------|
| PG-13 | Member call resolution | 85% of member calls resolved on first call. Time over which standard is measured: Quarter | Quarterly vendor report including phone and customer service system reporting. | 1% of fees if performance is less than the standard. | Choose an item. |
| PG-14 | Provision of Draft Plan Documents Evidence of Coverage for Self-Insured plans and Summary Plan Description for the fully-insured plans | Draft Plan Document Provided to the State at least 2 months prior to the first day of the plan year. This should be an error-free (content and grammar) document. | Receipt date as documented by vendor and confirmed by State. | \$500 per day for the first three calendar days that the draft document is not received. \$1,000 per calendar day for each day the draft document is not received for the fourth calendar day and beyond. | Choose an item. |
| PG-15 | Provision of Final Plan Documents Evidence of Coverage for Self-Insured plans and Summary Plan Description for the fully-insured plans | Final Plan Document Includes all of the required edits and in the format ready for posting to State intranet. Returned to the State within 10 calendar days of the carrier's receipt of the State's edits. | Receipt date as documented by vendor and confirmed by State. | \$500 per day for each calendar day the draft plan document is not received for the first 3 calendar days. \$1,000 per day for each day the draft plan document is not received for the fourth calendar day and beyond. | Choose an item. |

* Determination of results and any applicable damages will be conducted by the State's contract auditor and be based on actual administrative fees included in the total premium rates.

** If due date falls on a state / vendor holiday or a weekend, Report Card and reports are due next business day.

REMINDER: All "No" responses must be addressed in **FA2 Attachment T-2: Explanations and Deviations.**