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## Appendix 2.2-1: Offeror Information

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

**Instructions:** Please complete each cell 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.

|  |  |
| --- | --- |
| **I.** | **GENERAL PLAN INFORMATION** |
|  |  | **Response** |
| 1. | Offeror's Legal Name | Click here to enter text.  |
| 2. | Address | Click here to enter text. |
| 3. | City | Click here to enter text. |
| 4. | State | Click here to enter text. |
| 5. | Zip | Click here to enter text. |
| 6. | Web Address | Click here to enter text.  |
| 7. | Operational Date | Click here to enter a date. |
| 8. | Corporate Tax Status | Choose an item. |
| 9. | Federal Employer Identification Number | Click here to enter text. |
| 10. | Ownership/Controlling Interest | Click here to enter text. |
| 11. | Number of Locations | Click here to enter text. |
| 12. | Number of Employees | Click here to enter text. |
|  | **Group Life Insurance** |  |
| 13. | Years providing group life insurance | Click here to enter text. |
| 14. | For the year ending 2017, please provide |  |
|  | 1. the number of insured lives for which the Offeror provides Group Life Insurance services
 | Click here to enter text. |
|  | 1. the number of employers using Group Life Insurance services
 | Click here to enter text. |
| 15. | Number of additional insured lives expected in 2018 | Click here to enter text. |

|  |  |
| --- | --- |
| **II.** | **PLAN DESIGN** |
|  |  | **Select Response** |
|  1. | Offerors agrees to adhere to the proposed plan designs shown in **Section 2.2 and 2.3,** in preparing the quote and administering the Group Life benefits during the contract term. | Choose an item. |
| 2. | Confirm that the proposal is issued in accordance with the specifications, assumptions and information included in this Request for Proposal, the accompanying worksheets and standard services addressed in the Information Questionnaire. If "No,” indicate deviations in "**Appendix 2.2-2: Explanations and Deviations**" worksheet. | Choose an item. |
| 3. | Review and detail deviations from the proposed plan design shown in the worksheet, "**Appendix 2.2-4: Plan Design**.” | Choose an item. |
| **III.** | **ADMINISTRATIVE AND OPERATIONAL INFORMATION** |
| 1. | Provide addresses for the following activities. Use the "**Appendix 2.2-2: Explanations and Deviations**" worksheet if you need more space. |
|  | **Group Life** |
|  | **Activity** | **Location** | **City** | **State** |
|  | Corporate/ Firm Management | Click here to enter text. | Click here to enter text. | Click  |
|  | Customer Service Office | Click here to enter text. | Click here to enter text. | Click  |
|  | Claims Office | Click here to enter text. | Click here to enter text. | Click  |
|  | Account Management/ Client Services Office | Click here to enter text. | Click here to enter text. | Click  |
|  | Technical Support Office | Click here to enter text. | Click here to enter text. | Click  |

|  |  |
| --- | --- |
| 2. | Staff that will be Designated to Servicing the State of Maryland |
|  | **Group Life** |
|  | **Type of Service** | **Customer Service** | **Claims Processors** |
|  | Number of Full Time Employees | Click here | Click here |
|  | Number of Part Time Employees | Click here | Click here |
|  | Average Years of Experience | Click here | Click here |
|  | Number of New Employees to be Hired (if any) | Click here | Click here |

|  |  |
| --- | --- |
| 3. | Work Volume 17 |
|  | **Group Term Life** | **2015** | **2016** | **2017** |
|  | Provide your company’s total dollar volume of Life Insurance for the past three years. | Click here | Click here | Click here |
|  | Provide the total number of claims for benefits paid by your company for the past three years. | Click here | Click here | Click here |

|  |  |
| --- | --- |
| 4. | Based on Total Claims in Calendar Year 2017 provide: |
|  | **Group Life** | **Number of Claims** | **% Dollar Accuracy** | **% Error Frequency** |
|  | Valid Claims | Click here | Click here | Click here |
|  | Ineligible Claims | Click here | Click here | Click here |

|  |  |
| --- | --- |
| 5. | What Percentage of Your Business would this Contract represent? |
|  | **Group Life** | **Percentage** |
|  | Insured | Click here |
|  | Dollar Volume | Click here |

|  |  |
| --- | --- |
| **IV.** | **REFERENCES** |
|  | Please complete the following tables with the requested reference information. |
| 1. | Please provide three of your employer client references with a similar size enrolled population as defined in **Section 5.3.2.H**. If available, please provide at least one government client reference.  |
|  | **Group Life** |
|  | **Information** | **Reference #1** | **Reference #2** | **Reference #3** |
|   | Organization Name | Click here. | Click here. | Click here. |
|   | Contact Person | Click here. | Click here. | Click here. |
|   | Title | Click here. | Click here. | Click here. |
|   | Telephone # | Click here. | Click here. | Click here. |
|   | E-mail Address | Click here. | Click here. | Click here. |
|  | Value, type, duration and services provided | Click here. | Click here. | Click here. |
|  | Number of Employees/retirees of the clients | Click here. | Click here. | Click here. |
|  | Total Life volume insured | Click here. | Click here. | Click here. |
|   | Length of time they have been a client | Click here. | Click here. | Click here. |
|   |  Reason for terminating contract | Click here. | Click here. | Click here. |

| 2. | Please provide three of your terminated employer clients as defined in **Section 5.3.2.H.** |
| --- | --- |
|  |  **Group Term Life** |
|   | **Information** | **Reference #1** | **Reference #2** | **Reference #3** |
|   | Organization Name | Click here. | Click here. | Click here. |
|   | Contact Person | Click here. | Click here. | Click here. |
|   | Title | Click here. | Click here. | Click here. |
|   | Telephone # | Click here. | Click here. | Click here. |
|   | E-mail Address | Click here. | Click here. | Click here. |
|   | Value, type, duration and services provided | Click here. | Click here. | Click here. |
|   | Number of Employees/retirees of the clients | Click here. | Click here. | Click here. |
|  | Total Life volume insured | Click here. | Click here. | Click here. |
|   | Length of time they have been a client | Click here. | Click here. | Click here. |
|  |  Reason for terminating contract | Click here. | Click here. | Click here. |
|   | Organization Name | Click here. | Click here. | Click here. |
|   | Contact Person | Click here. | Click here. | Click here. |

**V. 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. |

## Appendix 2.2-2: Explanations and Deviations

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

**Instructions:** All deviations from the specifications of the Request for Proposal (RFP) must be clearly defined using this worksheet. Explanations must be numbered to correspond to the question number and section number to which it pertains. If additional space is required, submit a separate attachment labeled **“Appendix 2.2-2b: Explanations and Deviations”** using the same table format. **Most importantly, keep all explanations brief.** In the absence of any identified deviations, your organization will be bound to the terms of the RFP.

| **Section # / Question #** | **Indicate "Explanation" or "Deviation"** | **Offeror Response** |
| --- | --- | --- |
| Click here | Choose  | Click here to enter text. |
| Click here | Choose  | Click here to enter text. |
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| Click here | Choose  | Click here to enter text. |
| Click here | Choose  | Click here to enter text. |

Please indicate if **“Appendix 2.2-2b: Explanations and Deviations”** is provided: **Choose an item.**

## Appendix 2.2-3: Minimum Qualifications

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

**Instructions:** Please complete each cell with the requested information. Items in the response column with the words "Select one" contain a drop down list of options. Please select a response from those options, as applicable, to indicate whether the Offeror meets the corresponding requirement. If the Offeror selects "Yes," there cannot be a qualifier in **“Appendix 2.2-2: Explanations and Deviations.”**

| **Minimum Qualifications Checklist** | **Contractor's Response****Yes or No** |
| --- | --- |
| 1 | Qualified Offerors must 1.1.1.1 Have an A.M. Best or Standard & Poor’s insurance rating of no less than A; Provide a document (Internet document acceptable) reflecting an A.M. Best or Standard & Poor’s insurance rating of no less than A. An A– rating would not meet the requirement. The document must be originated by either A.M. Best or Standard & Poor’s. (Please submit as **Response Attachment Minimum Qualifications: A.M. Best or Standard & Poor insurance Rating.)** | Choose an item. |
| 2 | Qualified Offerors must 1.1.1.2 Have a minimum of $1 billion of value of in-force volume for the category proposed; Provide the information reported most recently to A.M. Best and the A.M. Best reporting showing the in-force volume of insurance for each Service Category proposed. Also provide the “net premium written” figure disclosed to A.M. Best and the date of submission. Provide a copy of the A.M. Best report showing the in-force volume of insurance for each Service Category proposed. (Please submit as **Response Attachment Minimum Qualifications: A.M. Best In-Force Volume**.) | Choose an item. |
| 3 | Qualified Offerors must 1.1.1.3 Be licensed in Maryland at the time of proposed submission to issue the kinds of policies for which the proposals are submitted. Provide the Certificate of Authority issued by the Maryland Insurance Administration (MIA). (Please submit as **Response Attachment Minimum Qualifications: Certificate of Authority.)** | Choose an item. |

## Appendix 2.2-4: Plan Design

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

**Instructions:** Please indicate your ability to administer the following plan provisions. Items in the response column with the words "Choose,” contain a drop down list of options. Please select a response from those options as applicable. NOTE: All "No" responses must be addressed in "**Appendix 2.2 2: Explanations and Deviations."** In the absence of any identified deviations, your organization will be bound to the terms of the RFP.

**Group Term Life Capabilities**

| **Group Term Life Capabilities** |
| --- |
| PD-1 | Comply with the **Current Plan** as defined in Section 2.2.1. | Choose |
| PD-2 | The optional 100% contributory group term life insurance program includes all eligible employees, retirees, and their Dependents as defined in this solicitation. The Contractor must agree to take over the accounts of the Participants currently enrolled in the program at their current coverage levels without evidence of insurability. | Choose |
| PD-3 | Annual renewable group life insurance must be offered to active employees and retirees (as continued from active employment) in $10,000 increments up to a maximum of $300,000. Up to a maximum of $500,000 must be offered to any employee who flies in a helicopter, scuba dives, or is involved in other high-risk services in the course of their employment with the State of Maryland. Dependent Children and Spouses must be offered insurance coverage in $5,000 increments up to a maximum of 50% of the employee’s elected coverage amount. Spouse coverage premiums must be based on the Spouse’s age; children’s coverage must be offered based on a flat Dependent Child premium and include all eligible children.  | Choose |
| PD-4 | Guaranteed issue amounts (no evidence of insurability) must be provided as follows: New employees within 60 days of hire may obtain up to $50,000, Spouse up to $25,000. | Choose |
| PD-4 | Guaranteed issue amounts (no evidence of insurability) must be provided as follows: Existing employees not previously enrolled may obtain up to $50,000, Spouse up to $25,000, during an annual Open Enrollment period. | Choose |
| PD-5 | Members must have the ability to change coverage amounts during Open Enrollment or when permitted during a Plan Year by the applicable federal cafeteria plan regulations (i.e., when a qualifying event occurs); amounts requested above the guaranteed issue amount are subject to medical underwriting. However, Members who do not make changes during Open Enrollment will have existing coverage automatically rolled over to the new benefit year without additional medical underwriting.  | Choose |
| PD-6 | Coverage must include a Living Benefit provision whereby the employee (or the employee on behalf of the Spouse or Dependent) may choose to access as much as 100% of the coverage amount if the employee or Spouse or Dependent is medically certified as being terminally ill with less than 12 months to live by any licensed physician excluding relatives of the insured. | Choose |
| PD-7 | Retirees who were employed on or after January 1, 1995, must be permitted to continue coverage for themselves and their Dependents at the amount carried at the time of retirement. | Choose |
| PD-8 | Members on paid and unpaid leave(s) of absence, including but not limited to military leave, from State service must be permitted to continue existing coverage for themselves and their Dependents while on leave, as long as premiums are paid to the State. | Choose |
| PD-9 | The Contractor shall provide conversion benefits for Members and Dependents that are at least as good as provided under State law. See Maryland Annotated Code Insurance Article §§17-310 et. seq. | Choose |
| PD-10 | Members on paid and unpaid leave(s) of absence, including but not limited to military leave, from State service must be permitted to continue existing coverage for themselves and their Dependents while on leave, as long as premiums are paid to the State. | Choose |
| PD-11 | The Contractor shall provide conversion benefits for Members and Dependents that are at least as good as provided under State law. See Maryland Annotated Code Insurance Article §§17-310 et. seq. | Choose |
| PD-12 | There shall be no maximum age for enrollment or claims payments for employees, Spouses, or their disabled Dependent Children. Non-disabled children must be covered until the end of the month in which the child reaches age 26. | Choose |
| PD-13 | The plan must include a Waiver of Premium provision (see definition) for employees, retirees, and Dependents. | Choose |
| PD-14 | The plan must include a Portability provision for employees and Dependents. | Choose |
| PD-15 | No exclusions are permitted under this Contract. | Choose |
| PD-16 | Benefit reductions for retirees and Dependents of retirees are based on the retiree’s age. Benefit reductions due to age cannot be greater than those provided below:

|  |  |
| --- | --- |
| **Age** | **Benefits Reduce to:** |
| 65 | 65% of the employee or Dependent amount |
| 70 | 45% of the employee or Dependent amount |
| 75 | 30% of the employee or Dependent amount |
| 80 | 20% of the employee or Dependent amount |

 | Choose |
| PD-17 | The Contractor shall provide medical underwriting services for the group term life insurance program. The Contractor’s medical underwriting criteria shall be used under the State contract to make coverage determinations. Material changes to such criteria originally submitted in the Contractor’s Technical Proposal, during the term of the Contract are permissible only as a Contract modification. | Choose |
| PD-18 | The Contractor will be receiving a weekly eligibility file from EBD to assist it in the processing of claims in order to meet the requirements in Attachment P (Performance Guarantees and Liquidated Damages). | Choose |
| PD-19 | The Contractor shall have a day-to-day Account Service Manager (ASM) assigned to the State account who shall act as a liaison between the Contractor and the State. | Choose |
| PD-20 | The ASM must have a minimum of five years of experience with the Contractor assisting with all facets of enrollment and claims services for enrollees and/or family members attempting to access their benefits. | Choose |
| PD-21 | The Contractor must agree to waive the Actively at Work provision for all currently enrolled Participants as of December 31, 2018. | Choose |

## Appendix 2.2-5: Compliance Checklist

**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”** contain a drop down list of options. Please select a response from those options as applicable. NOTE: All "No" responses must be addressed in **"Appendix 2.2-2: Explanations and Deviations.”**

| **Compliance Checklist** | **Contractor's Response****Yes or No** |
| --- | --- |
|  | The Contractor(s) agrees to the **Payment Terms for Both Services Categories** as described in **Section 2.5.** | Choose |
|  | The Contractor(s) agrees to the following **Specifications for All Plans** as described in **Section 2.6** |  |
| Section 2.6.1 | Choose |
| Section 2.6.2 | Choose |
| Section 2.6.3 | Choose |
| Section 2.6.4 | Choose |
| Section 2.6.5 | Choose |
| Section 2.6.6 | Choose |
| Section 2.6.7 | Choose |
| Section 2.6.7.1  | Choose |
| Section 2.6.7.2  | Choose |
| Section 2.6.7.3 | Choose |
| Section 2.6.8 | Choose |
| Section 2.6.8.1  | Choose |
| Section 2.6.8.2 | Choose |
| Section 2.6.9 | Choose |
| Section 2.6.10 | Choose |
| Section 2.6.11 | Choose |
| Section 2.6.12 | Choose |
| Section 2.6.13 | Choose |
| Section 2.6.14 | Choose |
|  | The Contractor(s) agrees to the **Implementation Schedule** as defined in Section 2.7. | Choose |
|  | The Contactor(s) agrees to the **Report Requirements** as defined in Section 2.8. | Choose |
|  | The Contractor(s) agrees to the **Annual Life Reports** as defined in Section 2.8.1 |  |
| Section 2.8.1.1 | Choose |
| Section 2.8.1.2 | Choose |
| Section 2.8.1.3 | Choose |
| Section 2.8.1.4 | Choose |
| Section 2.8.1.5 | Choose |
|  | The Contractor(s) agrees to the **Contract Initiation Requirements** as defined in Section 3.1 | Choose |
|  | The Contractor(s) agrees to the **End of Contract Transition** as defined in Section 3.2 |  |
| Section 3.2.1 | Choose |
| Section 3.2.2 | Choose |
| Section 3.2.3 | Choose |
| Section 3.2.4 | Choose |
| Section 3.2.5 | Choose |
|  | The Contractor(s) agrees to the **Invoicing** as defined in Section 3.3 |  |
| Section 3.3.1 | Choose |
| Section 3.3.2 | Choose |
| Section 3.3.3 | Choose |
| Section 3.3.4 | Choose |
|  | The Contractor(s) agrees to the **Liquidated Damages** as defined in Section 3.4 |  |
| Section 3.4.1 | Choose |
| Section 3.4.2 | Choose |
|  | The Contractor(s) agrees to the **Disaster Recovery and Data** as defined in Section 3.5 |  |
| Section 3.5.1 | Choose |
| Section 3.5.2 | Choose |
| Section 3.5.3 | Choose |
| Section 3.5.4 | Choose |
|  | The Contractor(s) agrees to the **Insurance Requirements** as defined in Section 3.6 |  |
| Section 3.6.1 | Choose |
| Section 3.6.2 | Choose |
| Section 3.6.3 | Choose |
| Section 3.6.4 | Choose |
| Section 3.6.5 | Choose |
| Section 3.6.6 | Choose |
|  | The Contractor(s) agrees to the **Security Requirements** as defined in Section 3.7 |  |
| Section 3.7.1 | Choose |
| Section 3.7.2 | Choose |
| Section 3.7.3 | Choose |
| Section 3.7.4 | Choose |
| Section 3.7.5 | Choose |
| Section 3.7.6 | Choose |
| Section 3.7.7 | Choose |
| Section 3.7.8 | Choose |
| Section 3.7.9 | Choose |
| Section 3.7.10 | Choose |
|  | The Contractor(s) agrees to the **Problem Escalation Procedure** as defined in Section 3.8 |  |
| Section 3.8.1 | Choose |
| Section 3.8.2 | Choose |
| Section 3.8.3 | Choose |
| Section 3.8.4 | Choose |
|  | The Contractor(s) agrees to the **SOC 2 Type 2 Audit Report** as defined in Section 3.9 | **N/A** |
|  | The Contractor(s) agrees to the **Experience and Personnel** as defined in Section 3.10 | **N/A** |
|  | The Contractor(s) agrees to the **Substitution of Personnel** as defined in Section 3.11 |  |
| Section 3.11.1 | Choose |
| Section 3.11.2 | Choose |
| Section 3.11.3 | Choose |
| Section 3.11.4 | Choose |
| Section 3.11.5 | Choose |
|  | The Contractor(s) agrees to the **Minority Business Enterprise (MBE) Reports** as defined in Section 3.12 | Choose |
|  | The Contractor(s) agrees to the **Veteran Small Business Enterprise (VSBE) Reports** as defined in Section 3.13 | Choose |
|  | The Contractor(s) agrees to the **Work Orders** as defined in Section 3.14 | **N/A** |
|  | The Contractor(s) agrees to the **No-Cost Extensions** as defined in Section 3.15 | Choose |

## Appendix 2.2-6: Questionnaire

**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. **Note: Answers that are not concise and directly relevant may receive a lower score.**

| **QUESTIONS** | **OFFEROR’S RESPONSE** |
| --- | --- |
|  | Provide a draft plan description to be included in the annual Benefits Guide. Each plan description must describe in detail the procedures to be used by eligible Members to obtain services. To assist Offerors in the preparation of this draft, a copy of the plan description included in the Term Life Insurance Section of the Benefits Guide for the plan year beginning January 1 can be found on the DBM Health Benefits website. | Please submit a Draft Plan Description and label as **“Response Attachment: Draft Plan Description.”** |
|  | Please provide a proposed benefit plan to be offered to State employees and retirees (as applicable) under the Contract, including all exclusions and limitations. Please note the plan design requirements of Section 2.3 (GTL). Please provide a sample of: 1) the Benefits Booklet to be distributed to each plan enrollee, and 2) the marketing brochure to be distributed during Open Enrollment and throughout the year to potential enrollees.  | Please submit a Proposed Benefit Plan and label as **“Response Attachment: Proposed Benefit Plan.”** |
|  | List and describe any additional or optional services that you offer without additional charge that have not been requested. Such services may include administrative services and/or additional benefits to Members. | Click here to enter text. |
|  | Describe the kind of internet-based customer service(s) that your company provides. Will Members be able to change or identify beneficiaries on-line? Please describe the Offeror’s website capabilities including services provided through the website. For example, will insureds be able to change or identify beneficiaries on-line?  | Click here to enter text. |
|  | Describe the selection of the persons and training that is provided to persons designated to represent your company at Open Enrollment benefit fairs. | Click here to enter text. |
|  | Describe the entire claims adjudication process for each service category proposed, i.e., the process that takes place from the time a claim is received until the time a check is issued to a beneficiary or employee. Describe the appeals process for claims that are fully or partially denied. | Click here to enter text. |
|  | Provide the physical location from which State of Maryland claims will be processed. Include the street address and phone number. For the proposed claim office, what is the average number of working days for a claim to be processed (check issued) from the date of receipt? What training is provided to claims processors? | Click here to enter text. |
|  | Indicate the turnover rate for employees responsible for claims processing and medical underwriting. Also describe the internal training processes for these individuals. | Click here to enter text. |
|  | Describe the medical underwriting criteria to be used under the State contract to make coverage determinations. | Click here to enter text. |
|  | Are calls monitored for quality control? If Yes, how often are they monitored?  | Click here to enter text. |
|  | What actions are taken if customer service complaints are received? Include in your answer a description of how these are reported to the State. | Click here to enter text. |
|  | Describe your fraud detection process and procedures. How will you report evidence of fraud to the State? What actions do you take if a participant is suspected of submitting a fraudulent claim? | Click here to enter text. |
|  | Describe your backup system for disaster recovery of data files. | Click here to enter text. |
|  | What security measures are used to guard against unauthorized access to participant PHI and personal data? | Click here to enter text. |
|  | Please describe the Offeror’s Quality Assurance Activities including quality assurance initiatives completed over the past 12 months and results.  | Click here to enter text. |
|  | Provide a sample Reporting Package including all standard reports provided by the Offeror to clients without additional charge. Please submit a sample Management Reporting Package and label as **“Response Attachment: Management Reporting Package.”** | Please submit a sample Management Reporting Package and label as **“Response Attachment: Management Reporting Package.”** |
|  | Describe the process for benefit determinations including approvals, denials, and pended claims based on the receipt of complete documentation of each claim. | Click here to enter text. |
|  | How do you identify and handle mistaken reimbursements? | Click here to enter text. |
|  | How will you enforce the requirements for filing claims for services? How do you verify eligible expenses? | Click here to enter text. |
|  | Describe procedures in place for changing beneficiaries and terminations. | Click here to enter text. |

## Appendix 2.2-7a: Subcontractors Questionnaire

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

**Instructions:** Please complete one **"Appendix 2.2-7(a-d): 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 a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

**Subcontractor's Name (if applicable)** Click here to enter text.

**Subcontractor's MDOT Number (if applicable)** Click here to enter text.

| **Questions** | **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 | Please describe the Offeror’s current relationship with the proposed subcontractor, including any current common customers. | Click here to enter text. |
| SQ-4 | 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-5 | 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-6 | 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. |
| SQ-7 | 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-8 | 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-9 | 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. |

## Appendix 2.2-7b: Subcontractors Questionnaire

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

**Instructions:** Please complete one **"Appendix 2.2-7(a-d): 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 a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

**Subcontractor's Name (if applicable)** Click here to enter text.

**Subcontractor's MDOT Number (if applicable)** Click here to enter text.

| **Questions** | **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 | Please describe the Offeror’s current relationship with the proposed subcontractor, including any current common customers. | Click here to enter text. |
| SQ-4 | 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-5 | 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-6 | 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. |
| SQ-7 | 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-8 | 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-9 | 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. |

## Appendix 2.2-7c: Subcontractors Questionnaire

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

**Instructions:** Please complete one **"Appendix 2.2-7(a-d): 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 a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

**Subcontractor's Name (if applicable)** Click here to enter text.

**Subcontractor's MDOT Number (if applicable)** Click here to enter text.

| **Questions** | **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 | Please describe the Offeror’s current relationship with the proposed subcontractor, including any current common customers. | Click here to enter text. |
| SQ-4 | 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-5 | 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-6 | 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. |
| SQ-7 | 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-8 | 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-9 | 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. |

## Appendix 2.2-7d: Subcontractors Questionnaire

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

**Instructions:** Please complete one **"Appendix 2.2-7(a-d): 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 a MBE certified by the State of Maryland, if responding for an MBE subcontractor.

**Subcontractor's Name (if applicable)** Click here to enter text.

**Subcontractor's MDOT Number (if applicable)** Click here to enter text.

| **Questions** | **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 | Please describe the Offeror’s current relationship with the proposed subcontractor, including any current common customers. | Click here to enter text. |
| SQ-4 | 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-5 | 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-6 | 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. |
| SQ-7 | 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-8 | 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-9 | 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. |

## Appendix 2.2-8: Attachment P - 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 collectively for both plan types. 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:** For any recoveries as a result an audit, the Contractor shall pay the State any portion due it via a separate check payment and provide documented substantiation. Payments to the State of Maryland Department of Budget and Management shall be made no later than thirty (30) calendar days after the Contractor's receipt of invoice for Audit recoveries. All payments shall be submitted to: The Department of Budget and Management, Employee Benefits Division, P.O. Box 1516, Baltimore, Maryland 21201.

**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 **"Appendix 2.2-2: Explanations and Deviations.”**

| **GROUP LIFE** | **Willing to Comply** |
| --- | --- |
| **PG** | **Performance Indicator** | **Standard/Goal** | **Reporting Measurement1** | **Liquidated Damages** |
|  | 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 have knowledge of the State of Maryland and be able to address the member’s issue/question. Time over which standard is measured: Quarter | Quarterly Plan Performance Measurement Self ReportedFrequency of report: Quarterly | 0.10% of premiums for each percentage point, or fraction thereof, below. | Choose an item. |
|  | Telephone Call Abandonment Rate | Abandonment Rate of 3% or less | Self Reported Frequency of report: Quarterly | $500 per percentage point over 5% per reporting period. | Choose an item. |
|  | Contractor attendance at State-sponsored annual Open Enrollment meetings and orientation meetings | Attendance by plan representative(s) trained on State of Maryland plan benefits 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 behavior. | Sign-in sheets at Open Enrollment meetings Frequency of report: Annually | $500 per scheduled meeting not attended. | Choose an item. |
|  | Claims processing time | Upon receipt of all required documentation, 95% claims processed accurately within five business days; 98% within 10 business days. | Self Reported Frequency of report: Quarterly | $500 per period in which standard is not met. | Choose an item. |
|  | Complaint Resolution Time | Plan will:1. acknowledge receipt of the written complaint to the State and Member within two business days of receipt of the complaint letter; and
2. provide a written complaint response to the State and Member within 21 business days of receipt of the initial complaint letter
 | Self Reported and State correspondence logs | $250 for each late acknowledge- ment letter, and$250 for each late written complaint response. | Choose an item. |
|  | Provision of Draft Plan Documents Certificate/Evidence of Coverage of Self-Insured plans and Summary Plan Description for the fully-insured plans | Draft Plan Document (Certificate/Evidence of Coverage or Summary Plan Description as appropriate by plan) including all required updates is provided to the State at least three months prior to the first day of the plan year. For example, if the plan year effective date is January 1st, the vendor must provide the State the draft by October 1st of the prior year. | 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. |
|  | Provision of Final Plan Documents | Final Plan Document (Certificate/Evidence of Coverage or Summary Plan Description as appropriate by plan) including all of the required edits and in the format ready for posting to State intranet is returned to the State no later than 45 days before the start of the plan year within 30 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.$1000 per day for each day the draft plan document is not received for the fourth calendar day and beyond. | Choose an item. |
|  | Client Satisfaction | Account management team survey results must achieve a score of “satisfied” | Annual survey | 1% of premiums | Choose an item. |

1 Subject to audit by State and/or contract auditors.