



SOLICITATION INFORMATION
February 12, 2016

RFP#: 7550291

TITLE: Dental Plan Administration for State Employees

SUBMISSION DEADLINE: March 10, 2016 at 2:00 PM (Eastern Time)

PRE-BID/ PROPOSAL CONFERENCE: NO

MANDATORY:

If YES, any Vendor who intends to submit a bid proposal in response to this solicitation must have its designated representative attend the mandatory Pre-Bid/ Proposal Conference. The representative must register at the Pre-Bid/ Proposal Conference and disclose the identity of the vendor whom he/she represents. A vendor's failure to attend and register at the mandatory Pre-Bid/ Proposal Conference shall result in disqualification of the vendor's bid proposals as non-responsive to the solicitation.

DATE:

LOCATION:

Questions concerning this solicitation must be received by the Division of Purchases at DOA.PurQuestions8@purchasing.ri.gov no later than **February 22, 2016 at 3:00 PM (Eastern Time)**. Questions should be submitted in a *Microsoft Word attachment*. Please reference the **RFP# 7550291** on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

Meredith Skelly
Interdepartmental Project Manager

Gail Walsh
Buyer

Applicants must register on-line at the State Purchasing Website at www.purchasing.ri.gov

Note to Applicants:

Offers received without the entire completed three-page RIVIP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

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SECTION 1: INTRODUCTION

The Rhode Island Department of Administration/Division of Purchases is soliciting proposals from qualified organizations to provide dental benefits for the State of Rhode Island's (the State) approximately fourteen thousand (14,000) eligible employees and retirees as described in detail in Section 2 in accordance with the terms of this Request for Proposals and the State's General Conditions of Purchase, which may be obtained at the Rhode Island Division of Purchases Home Page by Internet at www.purchasing.ri.gov.

Specifically, the State seeks a dental benefit partner that will meet the following objectives:

- Provide coverage to eligible State employees, retirees, and their dependents;
- Provide a high level of accountability around the member experience both in terms of quality care and administration; and
- Manage the finances of the dental benefit program to optimize the cost/value.

The initial contract period will begin July 1, 2016 for 30 months through December 31, 2018. The initial contract may be renewed for up to two additional 12-month periods based on vendor performance and State needs, at the sole option of the State.

This is a Request for Proposals, not an Invitation for Bid. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to price; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

1. Potential vendors are advised to review all sections of this RFP carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.
2. Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this RFP will be rejected as being non-responsive.
3. All costs associated with developing or submitting a proposal in response to this RFP, or to provide oral or written clarification of its content shall be borne by the vendor. The State assumes no responsibility for these costs.
4. Proposals are considered to be irrevocable for a period of not less than sixty (60) days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.
5. All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.
6. Proposals misdirected to other state locations, or which are otherwise not present in the Division at the time of opening for any cause will be determined to be late and will not be considered. For the purposes of this requirement, the official time and date shall be that of the time clock in the reception area of the Division.

7. It is intended that an award pursuant to this RFP will be made to a prime vendor, or prime vendors in the various categories, who will assume responsibility for all aspects of the work. Joint venture and cooperative proposals will not be considered. Subcontracts are permitted, provided that their use is clearly indicated in the vendor's proposal and the subcontractor(s) to be used is identified in the proposal.
8. All proposals should include the vendor's FEIN or Social Security number as evidenced by a W9, downloadable from the Division's website at www.purchasing.ri.gov.
9. The purchase of services under an award made pursuant to this RFP will be contingent on the availability of funds.
10. Vendors are advised that all materials submitted to the State for consideration in response to this RFP will be considered to be Public Records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island, without exception, and will be released for inspection immediately upon request once an award has been made.
11. Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP.
12. Equal Employment Opportunity (G.L. 1956 § 28-5.1-1, et seq.) – § 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies to all areas where State dollars are spent, in employment, public services, grants and financial assistance, and in state licensing and regulation.
13. In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful vendor(s).
14. The vendor should be aware of the State's Minority Business Enterprise (MBE) requirements, which address the State's goal of ten percent (10%) participation by MBE's in all State procurements. For further information visit the website www.mbe.ri.gov.
15. Under HIPAA, a "business associate" is a person or entity, other than a member of the workforce of a HIPAA covered entity, who performs functions or activities on behalf of, or provides certain services to, a HIPAA covered entity that involves access by the business associate to HIPAA protected health information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits HIPAA protected health information on behalf of another business associate. The HIPAA rules generally require that HIPAA covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard HIPAA protected health information. Therefore, if a Contractor qualifies as a business associate, it will be required to sign a HIPAA business associate agreement.
16. In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSourceRI), the vendor hereby certifies that it is an "eligible entity," as defined by 45 C.F.R. § 155.110, in order to carry out one or more of the responsibilities of a health insurance exchange. The vendor agrees to indemnify and hold the State of Rhode Island harmless for all expenses that are deemed to be unallowable by the Federal government because it is determined that the vendor is not an "eligible entity," as defined by 45 C.F.R. § 155.110.

SECTION 2: BACKGROUND AND PURPOSE

Population and Historical Information

Information was gathered from the current vendor, Delta Dental of Rhode Island, to assist in the preparation of the proposal.

The description for each file is:

- Census (Appendix A) (Complete Confidentiality and Nondisclosure Agreement and Data Request Form)
- Detailed Claims Data (Appendix B) (Complete Confidentiality and Nondisclosure Agreement and Data Request Form)
- Utilized Providers (Appendix C) (Complete Confidentiality and Nondisclosure Agreement and Data Request Form)
- Claims and Enrollment Data (Appendix D.1)
- Claim Payments by Procedure Classification (Appendix D.2)
- Certificate of Coverage (Appendix E.1)
- Benefit Summary (Appendix E.2)
- Current Contract and Amendments (Appendix F)

There have been no dental benefit changes to the State dental plan since January 2013, the beginning of the claims experience period provided.

The State makes no representation regarding the data or the format in which the data is prepared.

The State is committed to the concept of managing dental benefits for value, appropriateness and cost-effectiveness.

Eligible Populations

The following populations are eligible for dental coverage:

- All classified, non-classified and unclassified active employees, excluding specific part-time personnel, seasonal and limited period personnel, as set forth in Rhode Island General Laws 36-12-1
- Employees on a medical leave of absence
- COBRA terminations
- Judge and legislator retirees
- State police retirees (pre-65 only)
- Office of Higher Education
- Disabled retirees (closed group)
- Members of the general assembly (excluding clerks, pages and doorkeepers)
- Spouses and unmarried dependent children through the end of the calendar year following their nineteenth birthday. Full-time unmarried students are covered to the end of the calendar year in which they turn 25
- Unmarried dependent children who are mentally or physically disabled and cannot earn a living.

Employee contributions are 15%, 20%, 25%, or 35%, depending on employment status (full-time or part-time), salary band, and coverage tier (individual or family).

Proposals should mirror current eligibility criteria as outlined in the Certificate of Coverage (Appendix E).

Service Profile

The State seeks a vendor to provide dental benefit services including:

- Provision of a comprehensive provider network with uniform quality;
- Effective, efficient, and accurate claim processing;
- Payment of claims on a scheduled basis including issuance of reimbursement checks;
- Provision of best-in-class member services and customer support;
- Superior level of account management and service;
- Commitment to successful implementation; and
- Commitment to both oral and general health

In addition, the vendor will absorb the cost of all types of communications.

SECTION 3: SCOPE OF WORK

Plan Design

Type of Plan(s) to be Offered:

The State seeks to continue to offer a passive PPO dental plan to all eligible active employees, eligible retirees, and their dependents.

Proposed Plan Design:

At this time no plan design changes are being requested. Please quote the current plan design as summarized below and outlined in detail in the current Certificate of Coverage and Benefit Summary (Appendix E). The State reserves the right to make plan design changes, including offering additional plans, during the life of the Contract.

Currently, the State recommends prior treatment estimates for services that are likely to cost more than \$300. This includes treatment such as crowns; periodontic; prosthodontic; and orthodontic services. The State is looking to continue this provision. For more details, please refer to the current Certificate of Coverage and Benefit Summary (Appendix E).

Plan Provision	Coverage
Annual Deductible	None
Maximum Annual Benefit	\$1,200
Orthodontia Lifetime Maximum	\$850
Class I – Preventive exams, cleanings, x-rays, space maintainers	100%
Class II – Minor Restorative: Fillings, simple extractions, denture repairs, biopsies, minor treatment for acute dental pain, endodontics, oral surgery	100%
Class III – Major Restorative: Crowns and inlays	80%
Class III – Major Restorative: Periodontics	50%; up to \$400 per member per calendar year
Class IV – Orthodontics: Braces	Children up to age 19; 50%

Certain oral surgery procedures do not count towards the annual maximum.

Passive Dental Network Plan – As illustrated in the plan design information provided, the State’s current dental plan is a passive dental network plan, in which a member is subject to the same plan design regardless of whether dental care is performed by a network or non-network dentist. Participating/network dentists will accept the carrier’s allowance as full payment less any applicable copayments (that is, members are protected against balance billing). If a non-participating provider is utilized, the member pays the charges and will be reimbursed up to the allowable charge to participating dentists, less any applicable copayments.

The following are not covered under the dental plan:

- Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trustee or similar person or group
- Services rendered by someone other than a licensed dentist or a licensed hygienist operating as authorized by applicable law
- Specialty exams
- Consultations
- Disorders related to the temporomandibular joint (TMJ) including night guards and surgery
- Service to increase the height of teeth or restore occlusion
- Restorations required because of erosion, abrasion or attrition
- Services meant primarily to change or improve appearance
- Occlusal guards
- Implants
- Bone grafts
- Splinting and other services to stabilize teeth
- Prescriptions drugs, lab exams or reports
- Guided tissue regeneration
- Temporary bridges or crowns
- Services related to congenital abnormalities
- General anesthesia/intravenous sedation for non-surgical extractions, diagnostic, preventive or any restorative services
- General anesthesia/intravenous sedation administered by anyone other than a dentist

See attached Certificate of Coverage and Benefit Summary in Appendix E for additional details.

Please sign below indicating your ability to duplicate the benefit plan requested and outlined in the attached Certificate of Coverage and Benefit Summary.

The signed Plan Design form should be included as attachment to the transmittal letter in order to be considered in the carrier evaluation process.

Accepted this _____ day of _____, 2016

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

SECTION 4: TECHNICAL PROPOSAL

Narrative and format: The separate technical proposal should address specifically each of the required elements:

General:

This section includes instructions for preparing the technical section of the proposal. Offerors are cautioned to review the instructions carefully. Failure to comply with these instructions in full may result in disqualification.

Responses should be in the order as presented in the RFP. Responses to 4.1, 4.2 and 4.3 may be included within the RFP document. Responses to 4.4 and 4.5 should be provided on a separate electronic Microsoft Excel format as referenced in Appendix C. Additional pages relevant to your proposal should be placed in an appendix with an organized Table of Contents. Responses are required for all questions. Failure to respond to any question may result in rejection of the proposal.

The proposal must provide evidence of the offeror's ability to provide the services described in Section 2 of this RFP. **The proposal must consist of a transmittal letter and sections, each of which is outlined in detail below:**

Section	Title
4.1	Transmittal Letter and Bid Form
4.2	Vendor Accountability and Performance Guarantees
4.3	Questionnaire
4.4	Geographic Network Match
4.5	Provider Disruption

Offerors are advised to be concise and to the point in their responses.

SECTION 4.1: Transmittal Letter and Bid Form

The transmittal letter is required and must be on official business letterhead and signed by an individual with legal authority to bind the offeror. It must include:

- A statement indicating that the offeror is a corporation or other legal entity and where it is incorporated
- A statement that the offeror has read, understands and accepts the requirements, responsibilities, and terms and conditions of the RFP
- A statement indicating that prices quoted are valid for ninety (90) days from the date the proposal is opened
- A statement of affirmative action that the offeror does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or disability status, and complies with all applicable provisions of Public Law 101-335, Americans with Disabilities Act
- A statement identifying all amendments to the RFP received by the offeror. If no amendments have been received, a statement to that effect should be included
- Identification of the person who will serve as primary contact for the State, and that person's title, address, and telephone and fax numbers
- The following forms should be included as attachments to the transmittal letter and signed as requested
 - Plan Design
 - Fully-Insured Rates
 - Self-Funded Rates

SECTION 4.2: Vendor Accountability and Performance Guarantees

Respond to the following vendor accountability and performance guarantee standards outlined in this section. Please outline any deviations from the proposed standards. Deviations will be considered but only granted when in the best interests of the State. Offeror's are cautioned that failure to respond in full, or in part, to all standards may negatively affect the evaluation of the offeror's proposal, up to and including disqualification.

This RFP sets forth the terms and conditions under which the State wishes to purchase dental benefits for its employees. Your written proposal will be your offer to provide the requested services.

Any requested clarification of your proposal shall be provided in writing. Similarly, any modification of proposal terms that may occur during the proposal process shall be provided in writing.

Your proposal and the written responses described above shall be the offer on which the State bases its acceptance decision. The State reserves the right to accept, reject, or modify the specifications stated herein to best meet the needs of the State and its employees.

The exhibit below identifies the specific performance guarantees that shall be the basis of performance responsibilities for any resulting contract. The State will be looking for a flat dollar (\$) amount for each performance guarantee listed below.

Bidders are encouraged to place a material amount at risk per contract year; a bidder's willingness to offer meaningful guarantees will be reflected in their score.

Performance guarantee metrics may be self-reported, but are subject to independent audit by the State. All guarantees shall be set and measured annually.

Provide the total amount per contract year at risk for performance guarantees. At time of contract, the parties shall mutually agree to the allocation of the at risk funds.

\$ _____

Important Note: Bids that place nothing at risk for performance guarantees will receive 0 out of the total points allocated for performance guarantees.

You are required to respond to each performance guarantee by indicating your organization’s willingness to agree to each performance guarantee. Bidders are required to provide the measurement basis by specifying for each proposed performance guarantee (in the far right column in the chart following) whether the guarantee will be measured based on State account specific performance or the bidder’s book-of-business performance. Bidders are strongly encouraged to provide guarantees on the State account specific performance for the majority of the measurements. Using a book-of-business measurement for many of the guarantees diminishes or eliminates their value to the State and this will be reflected in the bidder’s score.

	Standard	Confirm Your Willingness to Guarantee [Yes/No]	Measurement Basis [Indicate State account specific or book-of-business]
Implementation			
Clean Implementation	No systems errors, ID card delays, and the State online access to all tools prior to effective date		
Implementation Timeline	Implementation team will be assigned and introduced to the State within 5 business days of vendor approval		
Implementation Team	Implementation team members will not change and will be responsible for the accurate installation of all administrative, clinical and financial parameters for the State’s program		
ID Card Mailing	All ID cards will be mailed at least 10 days prior to the effective date and will be 99% accurate (provided that a valid eligibility file was received at least 15 days prior to the effective date)		
Implementation Satisfaction Scorecard	Assigned Account Executive will work with the State prior to the start of implementation to agree on terms of a satisfaction		

	Standard	Confirm Your Willingness to Guarantee [Yes/No]	Measurement Basis [Indicate State account specific or book-of-business]
	scorecard to be issued to the State after effective date for completion		
Payment Accuracy & System Performance			
Financial accuracy	Percentage of claim payments made without error relative to the total dollars paid will be at least 99%		
Claim Processing Errors, Duplicates, Reversals	Percentage of claims processed without procedural or payment errors will be at least 98%		
Claims Eligibility Data	Eligibility loads not to exceed 2 business days after receipt		
Eligibility Data Error Reporting	Eligibility file error reporting on all eligibility file updates will be provided to the State within 2 business days		
Payments for Individuals Not Eligible	The State will not be held responsible to make payments for covered services paid on individuals who were not eligible. Within 30 business days after the end of each calendar month following the implementation date, you agree to provide the State with a report showing the results of such eligibility reviews and claim payment recovery completed for that calendar month.		
Invoicing Errors	All invoicing errors will be credits back to the State by next billing cycle or vender will pay interest		
Account Management			
State Approval of Member Communications	100% of all member communications will be approved by the State		
Member communication mailing errors	100% of all member communications shall be accurate. Should a mailing be		

	Standard	Confirm Your Willingness to Guarantee [Yes/No]	Measurement Basis [Indicate State account specific or book-of-business]
	sent in error or contain erroneous information regarding any aspect of the plans administration the vendor shall pay a penalty per erroneous document.		
Account Team's Performance	The State may assess a penalty per Contract Year if, after the first Contract Year and each successive Contract Year, the State's benefits staff do not rate vendor account team's performance for such Contract Year an average of 3 or better on a scale of 1 to 5 (5 being the best based on a range of performance criteria agreed to between the State and vendor at the beginning of such Contract Year)		
Account Management Turnover	Account team members will remain constant for at least the first 18 months of the contact period		
Network Changes Notification	The State will be notified of additions or deletions of providers and associated member impact on a weekly basis.		
Member Services			
Telephone call availability and answering speed	100% of all calls are answered within 45 seconds between 8:00 a.m. and 8:00 p.m. EDT/EST on business days		
Phone Abandonment Rate	100% of calls to the State-specific toll free line shall be answered with an abandonment rate of 3% or less		
Member Satisfaction Survey	The vendor agrees to conduct a Member Satisfaction Survey for each contract year and that the Satisfaction Rate will be 90% or greater. A yearly penalty may be assessed against the vendor for failure to meet this standard. "Member Satisfaction Rate" means (i) the number of Eligible		

	Standard	Confirm Your Willingness to Guarantee [Yes/No]	Measurement Basis [Indicate State account specific or book-of-business]
	Persons responding to vendor's annual standard Patient Satisfaction Survey as being satisfied with the overall performance under the Integrated Program divided by (ii) the number of Eligible Persons responding to such annual Patient Satisfaction Survey; the State must provide timely approvals and responses, and a minimum of 20% of surveys must be returned for the Performance standard to be applicable.		
Reports			
Ad-hoc Reports	A minimum of 90% of Ad-hoc reports will be delivered to State within 7 business days of the request. Ad-hoc reports are defined as reports that are not part of the vendor's standard reporting package		
Standard Reports	A minimum of 95% of standard reports will be delivered to the State within 3 business days of the request or as required herein		
Benefit Documents			
Benefit Summaries	Final benefit summaries will be delivered to the State by October 15 th of each year or within 10 business days of the delivery to the vendor of the detailed collectively bargained benefit design, as applicable		
Benefit Book (Plan Description)	Final benefit books, approved by the State, will be delivered to the State by December 15 th of each contract year		
Other Guarantees			

	Standard	Confirm Your Willingness to Guarantee [Yes/No]	Measurement Basis [Indicate State account specific or book-of-business]

Allowances			
Implementation Allowance	Place the dollar (\$) per employee amount or the flat dollar amount you are offering the State		
Audit Allowance	Place the dollar (\$) per employee amount or the flat dollar (\$) amount you are offering the State to be used annually for the State to hire an auditor to verify that you are administering the State’s dental program as contracted.		

SECTION 4.3: Questionnaire

Offerors must answer the following questions:

If you do not answer a question, please state your reason(s) for not doing so. Alternatives will be considered but only granted when in the best interests of the State. Offerors are cautioned that failure to respond in full to all questions will affect the evaluation of the offeror’s proposal.

This RFP sets forth the terms and conditions under which the State wishes to purchase dental benefits for its employees. Your written proposal will be your offer to provide the requested services.

Any requested clarification of your proposal shall be provided in writing. Similarly, any State modification of proposal terms that may occur during the proposal process shall be provided in writing.

Your proposal and the written responses described above shall be the offer on which the State bases its acceptance decision. The State reserves the right to accept, reject, or modify the specifications stated herein to best meet the needs of the State and its employees.

The questionnaire is organized into the following sections;

- A. Administrative, Claims Paying, Reporting, and Network Provider Management
- B. Experience, Stability, and Contractual
- C. Implementation
- D. References

A. Administrative, Claims Paying, Reporting, and Network Provider Management

Account Service

1. What is the location and hours of operation of the office that would provide day-to-day account service? How long has it been operational? What types of services does it provide?
2. Describe the staffing of the proposed administration office. How many employees work in that location? What was the turnover rate for customer service and programming/system development staff in the last 12 months? What was your total turnover? (Express as a percentage of total staff members.) What is the average number of years of experience of these employees?
3. Describe the supervision function. Who would be responsible for daily ongoing administrative issues? How would account service for the State be coordinated? If your organization is selected, do you anticipate hiring additional staff? If so, how many and in what category?
4. A) Will the State have internet access to the following? (Check all that apply)
 - a. Claims Summary by Bargaining Unit
 - b. Billing History
 - c. Premium/Administrative Rates
 - d. Provider Directory
 - e. Eligibility Summary by Union/Bargaining Unit
 - f. Enrollment Counts by Union/Bargaining Unit
 - g. Plan Details
 - h. Health Topics/Dental Information
 - i. Address Changes
 - j. Standard and/or Ad Hoc Eligibility Reports by Union/Bargaining Unit
 - k. Standard and/or Ad Hoc Dental Reports by Union/Bargaining Unit (e.g., utilization, claim, etc...)
 - l. Other
- B) Please describe what training and support will be offered to the State for these internet services.
- C) Provide name of web site and sample password, if applicable.
5. Complete the following table (Check all that apply)

Forms	Cost: Included in Fee?	Cost: Additional
A. Benefit Booklets	<input type="checkbox"/> Included in Basic Fee <input type="checkbox"/> Not Available	<input type="checkbox"/> Indicate additional cost in Section 5
B. Claims Forms	<input type="checkbox"/> Included in Basic Fee <input type="checkbox"/> Not Available	<input type="checkbox"/> Indicate additional cost in Section 5
C. EOBs	<input type="checkbox"/> Included in Basic Fee <input type="checkbox"/> Not Available	<input type="checkbox"/> Indicate additional cost in Section 5
D. Network Directory	<input type="checkbox"/> Included in Basic Fee <input type="checkbox"/> Not Available	<input type="checkbox"/> Indicate additional cost in Section 5
E. Other, please describe:	<input type="checkbox"/> Included in Basic Fee <input type="checkbox"/> Not Available	<input type="checkbox"/> Indicate additional cost _____

6. The State requires direct access to a client/account team within your organization who can handle the following topics. Please indicate whether you can provide direct access to a person or person(s) who

would be dedicated to the State of Rhode Island Health Benefits Program management team, Human Resource representatives or others designated by the State who may need these types of assistance.

a. **Customer Service Manager/Supervisor** for complaints (e.g. misquotes, courtesy etc.)

___ **Yes** ___ **No**

If yes, what percentage of their time would be dedicated to the State's account? _____%

b. **Claim Processing Manager/Supervisor** for claim processing issues

___ **Yes** ___ **No**

If yes, what percentage of their time would be dedicated to the State's account? _____%

c. **Eligibility manager/supervisor** for access to care issue resolution.

___ **Yes** ___ **No**

If yes, what percentage of their time would be dedicated to the State's account? _____%

d. **Quality Improvement manager/supervisor** for collaborating and addressing those processes surrounding the proposed performance guarantees within this RFP.

___ **Yes** ___ **No**

If yes, what percentage of their time would be dedicated to the State's account? _____%

e. **Please describe any additional dedicated staff you would be willing to allow direct access to for the State.**

ASO Banking/Claim Reimbursement Arrangements

7. At the State's direction, are you able to accommodate a financial arrangement where either: (1) the State is invoiced on a weekly basis for the prior week of claims, or (2) you maintain an advance deposit for paying claims that would be replenished on a weekly basis? Confirm you agree to either of these arrangements at the State's direction.

8. Confirm you will invoice the State on a monthly basis for administrative costs for the prior month.

9. Confirm that no penalties or interest will be charged to the State for late funding or late payment.

Member Service (i.e. Customer service, Internet access, etc.)

10. Confirm a dedicated toll-free number will be made available to enrollees to handle claims or other service issues at no additional cost.

11. What hours will the telephone lines be staffed by actual customer service representatives? (*Please do not include hours the telephone line will be staffed by an answering service. Include weekend hours.*)

Hours: _____

- a. Do customer service representatives have on-line access to real-time claim status information? (Check only one)
- a. Yes
 - b. No
- b. Indicate the ways in which your organization is able to accommodate the special needs of enrollees. (Check all that apply)
- a. No special accommodations
 - b. Have a TDD (Telecommunications Device for the Deaf) or other voice capability for the hearing impaired
 - c. We accommodate non-English speaking enrollees by contracting with an independent translation company
 - d. We maintain customer service staff with the ability to translate Spanish
 - e. AT&T language line
 - f. We maintain customer service staff with the ability to translate the following languages: _____

12. Which of the following Member Functions do you provide via the internet? (Check all that apply)

Functions	
A. Eligibility Status/Changes	
B. Provider Directory	
C. Provider Profiles	
D. Plan Details	
E. Claim Status	
F. Explanation of Benefits	
G. Other (List)	

13. Do your provider directories include the following: (Check all that apply)

- a. Dentist office address and phone number
- b. Specialty designation
- c. Office hours
- d. Languages spoken in office
- e. Notation whether the dentist is accepting new patient
- f. Provider satisfaction rating

14. Confirm that you agree to notify members if a network provider terminates their contract during the plan year.

- A. Describe the process and provide a sample of correspondence used upon such a network provider termination.
- B. How far in advance will you notify members if a network provider terminates their contract during the plan year?

15. Are you willing to mail reminders to enrollees about routine care (e.g. fluoride treatment, cleanings and x-rays) to assist enrollees with seeking regular preventative care? If yes, please describe this process and include frequency of mailings and samples of these mailings.
16. Are you willing to attend meetings held at the State to discuss your performance, timely topics, or other issues as needed, on a monthly basis or as required?
17. Are you willing to attend open enrollment meetings at various locations throughout the State to assist employees with making their dental elections?
18. Are you willing to attend benefit fairs organized by the State that include representation from all of the State's health benefit administrators?
19. Are you willing to provide educational materials for the State's Human Resource Representatives to distribute to new hires or upon request?
 - A. Are these materials available in electronic format?
 - B. Will you allow the State to post these materials on its web site?
20. Do you send copies of benefit booklets to new participants? If yes, please provide a sample of the materials provided.
 - A. Can the State tailor any of the materials sent out to new participants?

Claims Processing

21. Explain your Coordination of Benefits (COB) procedures.
22. Do you pursue COB prospectively or retrospectively to payments?
 - a. Prospectively
 - b. Retrospectively
23. How often are records updated for new information on other coverage? Please describe how this data is gathered.
24. With regard to the claim offices that will be used, provide the following:
 - A) Location
 - B) Average Claims/Processor/Day
 - C) Annual Claim Volume
 - D) Staffing: *Complete the following table:*

Position	A. Number of Staff	B. Average Years of Claims Administration Experience	C. Annual Turnover (%)
Processors			
Supervisors			
Managers			

<i>For specialists assigned responsibility for the State account:</i>			
Claims specialist			
Eligibility specialist			
Clinical specialist			
Appeals specialist			

25. Based upon the latest 12 month period: (Please answer all parts of this question)

- A) **Average** number of business days to process a claim from date received to date check/EOB issued: _____
- B) What percent of all claims submitted (regardless of information provided on claim) are processed (from date received to date check/EOB issued) within 10 business days? ____%
- C) What percent of all claims submitted (regardless of information provided on claim) are processed (from date received to date check/EOB issued) within 30 business days? ____%
- D) Have you been penalized by any clients for failing to meet state average claim turnaround requirements?
 - a. Yes. List state where you were sanctioned in the last 12 months: _____
 - b. No

26. For the claim office proposed, please provide the following data:

Financial and Coding Accuracy	Latest 12 months
Financial accuracy as a percent of total claims dollars paid (include over/underpayments)	%
Coding accuracy (claims without error) as a percent of total claims submitted	%

27. What control measures do you have in place to verify that claims are paid only for treatments that were actually provided?

28. Confirm you agree to return all recovered monies from overpayments or duplicate payments to the State. *Check only one and describe how you will report recoveries to the State.*

- a. 100% of recovery will be returned
- b. All recovery will be returned to the State, less a recovery collection fee of: _____

29. Confirm the State will be permitted to have an independent audit performed, using an auditor of its choosing, of your claim operation and will not be charged by your organization (the State would be responsible for the fees of the independent auditor).

30. Please complete the following table of fraud detection programs:

Task	Formal Written Program	If yes, provide total # of events per 1,000 covered lives)	Describe Program
A. Ineligible Claimant	<input type="checkbox"/> Yes <input type="checkbox"/> No		
B. Assure that service billed is actually rendered	<input type="checkbox"/> Yes <input type="checkbox"/> No		
C. Over billings	<input type="checkbox"/> Yes <input type="checkbox"/> No		

System Management, Data Reporting, and Interfaces

31. If the State were to implement a health promotion plan that would require enrollees to obtain an annual dental exam or cleaning to be eligible for enhanced medical/dental benefits, would you be able to provide a report to the State’s medical carrier to assist in determining an enrollee’s eligibility for enhanced benefits? If so, please describe how you could provide this and any requirements you would have to provide this data. If no, would you be willing to develop and implement a process to assist the State with providing this data to its medical benefits carrier?
32. List all data elements captured by your claims system so that the State can gain an understanding of what information/reporting might be available if needed.
33. The State requires approximately 12 group break-outs for purposes of reporting and reserves the right to add additional break-outs if necessary. Confirm that you can meet this requirement.
34. Will you provide the State with a copy of your most recent financial report, independent auditor’s report, or equivalent external audit of bidder’s operations, on an annual basis by June 30th?
- a. Yes.
- b. No
35. The State requests a number of regular monthly and quarterly claims reports. Descriptions of reports possibly required by the State are listed below. Please indicate for each: whether or not you can provide such a report; that you can provide the report at the requested frequency; the availability as an online report; and if the report will be provided at no additional charge*.

	Can you Provide? (Yes/No)	Confirm Frequency of Report	Available as online report? (Yes/No)	Included in Fees?*(Yes/No)
a. <u>Monthly</u> paid claims summary for all benefit payments made during the month. The summary shall show claims separately for employees, spouses, and dependents, and by type of service category (Preventive, Basic, Major, etc.), the eligible charges submitted, amount paid during the month, member out-of-pocket expenses, and the number of claims (e.g., the number of checks or drafts issued).				
b. <u>Monthly</u> in and out-of-network utilization showing information noted above in (a) by in and out-of-network.				

c. <u>Monthly</u> call center reports including average speed to answer, call abandon rate, and calls by issue type				
d. <u>Monthly</u> paid claims summary for all benefit payments made during the month. The summary shall show the following information by patient: claimant ID, last name, first name, date of birth, claim number, date of service, date of payment, procedure(s), amount paid by the plan, amount paid by the patient.				
e. <u>Quarterly</u> paid claims summary for all benefit payments made during the quarter. The summary shall show, by dental procedure code, the total number of claims, eligible charges, amount paid by the plan, amount paid by the patient.				
f. <u>Monthly</u> summary of gross submitted charge amounts, amounts determined to be ineligible, amounts applied to coinsurance, and amounts adjusted for COB.				

* If additional fees apply, indicate in your response to the Financial Section of this RFP. Indicate which reports are available via on-line access.

36. Are there reports available to the State that will summarize the overall oral health of the State’s membership? These reports may include (but not be limited to) placing members into dental disease risk categories, monitoring and reporting the frequency of checkups / cleanings / fluoride treatments, reporting this information by age bucket, and comparing this information to benchmarks. Please explain.

If these reports are not available, are you willing to commit to a timeline for their development?

If there are additional costs for expanded reporting, provide these fees in your response to the Financial Section of the RFP.

37. Confirm you would be willing to provide the State with its claims data during its contract period to a party the State designates.

38. Confirm you would be willing to provide its claims data with the State directly.

39. Confirm you would agree to transfer electronic claim history and eligibility data to the State at no additional cost upon termination.

Claims and Appeals

40. Do you have a formal written appeal/grievance/reconsideration process for both self-funded and fully-insured plans? (*Check only one*)

- a. Yes
- b. No
- If yes, please describe these processes, including how the appeal providers are chosen, who is retained for external appeals and what the turnaround time is from the time an appeal is submitted to when a decision on the appeal is reached.

41. Is there information regarding the option for an appeal, the timeframe, and the mailing address and all other information required by ERISA claims and appeal rules in either the body of or attached to all claim and appeal notification letters? (Check only one)
- a. Yes
 - b. No
42. Have your claims and/or UR staff been educated and trained on how to process claims and/ or pre-certification review under ERISA guidelines? (Check only one)
- a. Yes
 - b. No
43. Are you fully compliant with ERISA claims and appeals regulations? (Check only one)
- a. Yes
 - b. No
44. Will your organization run two claims and/or UR processes: one for ERISA clients and one for non-ERISA clients? (Check only one)
- a. Yes
 - b. No
 - c. Other, please explain: _____
45. Who is the fiduciary? Who is responsible for the second level of appeal?

Utilization Management Services Reporting

The State is interested in receiving reports that contain analysis of the State's dental plan performance to better understand the services our employees are seeking, how often employees are seeking preventative services and to assist in making future plan design changes that will make our plan more effective and efficient. Please answer the following questions and provide examples of any other utilization management service reports you are able to provide on a quarterly and/or annual basis.

46. Are you able to provide an annual summary of the State's utilization statistics and your overall savings?
- a. Yes
 - b. No
47. Confirm that you are able to provide quarterly and ad-hoc reports of the State's utilization statistics and your overall savings, and that you are willing to present utilization reports to the State during a meeting held quarterly.
- a. Yes
 - b. No

Network Provider Management

Provider Credentialing

48. Please complete the following table. Check off those elements that are included in the dentist selection process and provide the percentage of dentists who satisfy the following selection criteria elements.

Criteria	Standard Selection Criterion (check if yes)	Percentage of Providers that Satisfy Criterion	Comments
Require unrestricted State licensure			
Review malpractice coverage and history			
Require full disclosure of current litigation & other disciplinary activity			
Require signed application/agreement			
Require Hepatitis B (3) series of shots			
Require dated examination of radiograph equipment			
Require current DEA registration			
Review adherence to state and community practice standards			
On-site review of office location and appearance			
Review hours of operation and capacity			
Review practice patterns & utilization results			

49. Please provide the latest statistics regarding quality audits of your contracted dentists, including the number as a percentage of total dentists contracted.

50. What items do you audit electronically? (*Check all that apply*)

- a. Claims payment accuracy
- b. Claims coding accuracy
- c. Provider credentials
- d. Abusive provider practice patterns
- e. Provider sanctions
- f. None of the above or unknown
- g. Other

51. Is the “right to audit” included in your standard provider contracts? (*Check only one*)

- a. Yes
- b. No

52. Percent of your provider contracts terminated in the last 12 months, as a result of unfavorable audit results. (*Check only one*)

- a. _____%.
- b. Unknown

Provider Profiling

53. What does your claim system capture and track from your network providers? (Check all that apply)

- a. Patient SSN
- b. Patient Name
- c. Provider TIN
- d. Provider Name
- e. Provider Address
- f. Date of Service
- g. Place of Service
- h. CDT Code
- i. Procedure Description
- j. Charge Amount
- k. Other: _____

54. Do you have a mechanism for routinely investigating if a contracted provider has any disciplinary actions imposed by their State licensure dental board? (*Check only one*)

- a. Yes
- b. No

55. Other than provider directories and access to providers via your website, what quality or practice pattern data about your contracted providers do you make available to plan enrollees?

- a. We provide _____
- b. Nothing at this time

HIPAA Compliance

56. Confirm that your organization will comply with all HIPAA regulations and that you provide, upon request, supporting documentation outlining your organizations HIPAA policies and procedures as they relate to management of the dental benefit plan for the State.

57. Confirm that your organization is compliant with the Electronic Data Interchange (“EDI”) Privacy and Security rules of the Health Insurance Portability and Accountability Act (“HIPAA”), and will execute the appropriate Business Associate Agreement (“BAA”) as provided by the State.

COBRA & Self-Pay Administration

Currently, the State’s medical benefits administrator provides its COBRA administrative services for medical and dental benefits and provides an election file to the incumbent dental administrator for eligibility maintenance and claim payment.

58. Confirm you will support the State’s current COBRA procedures as described above.

59. The State has a small population of direct pay participants who pay 100% of the State's premium rate for dental coverage as though they were active State employees. Historically this population has been billed by the incumbent dental administrator. Confirm that you will continue to administer this program as indicated.

B. Experience, Stability, and Contractual

Network Ownership & Background

60. Complete the following information, for the benefits that are being proposed:

Parent Company, if any: _____

61. Please indicate whether your dental networks are leased. If leased, please indicate the % of the contracts that are leased and the name of the sub-contractor(s).

62. Is your firm anticipating restructuring or reorganization in the next year? (Include any major staff relocations or office closings.) (*Check only one*)

- a. Yes, please explain _____
- b. No

63. In the past 12 months, has your organization: (*Check all that apply*).

- a. Closed any network services areas. If yes, please list the areas: _____
- b. Combined/consolidated member service or claims service centers.
If yes, please list the centers: _____
- c. Closed/consolidated or relocated any claims offices. If yes, please list the offices: _____
- d. Does not apply

64. Has your organization acquired, been acquired by, or merged with another organization in the past 24 months?

- a. Yes, please explain _____
- b. No

Financial Condition of Organization

65. Complete the following for your entire book of business.

CAUTION: Responses not provided in the proper format will not be scored.	Most Current 12-Month Period	Previous Year
a. Admitted Reserves as a Percent of Premium	%	%
b. Current Ratio (Cash to Current Liability) <i>(For example, if 100%, indicate 1.0)</i>		
c. Days in Unpaid Claims	Days	Days
d. Claims Loss Ratio		
e. Present Net Worth (Assets less Liabilities) as a percentage of total annual premium revenue	%	%

66. Indicate your **most current** claims-paying abilities as rated by:

Independent Rating Agency	Rating	Date
AM Best		
Standard & Poors		
Moody's		
Fitch		
Other/Not Rated (circle one and explain)		

67. Has there been any downgrade in your ratings in the last 2 years?

- a. Yes, please explain the nature and reason(s) for the change
- b. No

68. Indicate **any reinsurance policies currently in place OR special cash reserves set aside**, to continue paying claims on existing policies in the event your organization ceases to operate due to bankruptcy, liquidation or other factors. (*Check only one*)

- a. None
- b. Reinsurance is in effect or separate reserves are held to cover contractual services for the following number of days: _____ (*Response valid only if # of days provided*)
- c. Reserves as a percent of premium are _____% (*Response valid only if % provided*)
- d. Other: _____

The Vendor shall submit an audited financial statement for the most recent fiscal year in a separate sealed envelope; label the envelope "Confidential - Audited Financial Statement." The financial information submitted shall remain confidential and shall not be public record. The financial information will be reviewed by the Bureau of Audits on a Pass/Fail basis. If the financial statement receives a "Pass" determination, the Vendor's proposal will move to the Technical Review committee for further evaluation. If the financial statement receives a "Fail" determination, the Vendor's proposal will be dropped from further consideration.

Liability Insurance/Pending Legal Action

69. Are there any outstanding legal actions pending against your organization?

- a. Yes, please explain the nature and current status of the action(s) to the extent possible.

- b. No

70. Can you assure the State these actions will not disrupt business operation?

- a. Yes
- b. No

71. What fidelity and surety insurance or bond coverage do you carry to protect your clients? Specifically describe the type and amount of the fidelity bond insuring your employees that would protect the State in the event of a loss. [Please provide copies of such policies].

- a. Indicate your firm's liability INSURANCE LIMIT with regard to errors, omission, negligence, and malpractice.
- b. Annual dollar limit per occurrence: _____
- c. Provide name of insurer:

Technology Issues (Information System, Phone System,)

72. Complete the following table:

	Years Current Systems in Place	Do you plan to implement major changes (e.g., new system) in next 12 months?
Computer System		<input type="checkbox"/> Yes, please describe _____ <input type="checkbox"/> No
Telephone System		<input type="checkbox"/> Yes, please describe _____ <input type="checkbox"/> No

73. How many times has each system been non-operational over the past twelve months?

(Complete the table):

	20 minutes or less	More than 20 minutes but less than 2 hours	2 - 24 hours	Over 24 hours	Don't track
Computer System					
Telephone System					

74. Do you have a disaster recovery program and system back up in place? *(Check only one)*

- a. Yes
- b. No

General Contract Provisions

The State's current contract (including three amendments) with Delta Dental of Rhode Island is included in Appendix F. Should the State elect to maintain the fully-insured model as a result of this RFP process, the State expects to execute substantially similar contract provisions as reflected in its current dental contract. To expedite a process of finalizing the contract once a vendor and funding arrangement are elected, please include your firm's sample contract with your proposal for both fully-insured and self-funded arrangements.

75. Confirm you agree to include in your contract a hold harmless provision that indemnifies the State against liability that arises as the result of negligent acts, errors, omissions, fraud and other criminal acts committed by your officers, employees, and agents of the organization? *(Check only one)*

- a. Yes
- b. No

76. Confirm you agree to be bound by the terms of your proposal until a final contract is executed.
77. Confirm the contract will provide the State or its designee the right to audit the performance of the plan and services provided.
78. Indicate what services, records and access will be made available to the State or its designee to audit at no additional charge.
79. Indicate frequency and notice requirements that are part of the right to audit provision.
80. Do you agree that all books, records, lists or names, plates, seals, passbooks, journals and ledgers and all data specific to this Program shall be the property of and shall be used exclusively for this plan at the direction of the State? (*Check only one*)
- a. Yes
 - b. No
81. Are there any special contract provisions that you believe will need to be added to address liability or other issues specifically related to your performance of duties as the dental (ASO or fully-insured) benefits administrator for the State of Rhode Island?

Termination Clauses

82. Confirm the State shall have the right to terminate the contract at any time by giving the vendor thirty (30) days advance written notice.
83. At the outset of the contract with the State, how will coverage for treatment in progress be handled for the self-funded plan (if applicable)? (*Check only one*)
- a. Will offer network discounts only if patient's provider is in-network.
 - b. No network benefits apply if treatment is in progress on first day of eligibility.
84. At the end of a client's contract, treatment in progress for the self-funded plan (if applicable) is covered as follows: (*Check only one*)
- a. Network discounts apply until completion of treatment.
 - b. Network discounts cease to apply.

C. Implementation

85. Confirm you agree to guarantee complete implementation within 60 days.
86. Provide a proposed implementation plan and timetable, beginning with the award of the business to effective date of coverage, include:
- Describe the steps required to successfully implement the program including: dates, tasks, critical events, tasks and task dependencies
 - Identify the entity responsible (vendor or State) for each step.

- Contacts and personnel assigned to each step of the implementation process.
- Establishment of bank accounts, check stock, on-line plan information.

87. Describe the qualifications and experience of the proposed implementation Project Manager.
88. Confirm you will you produce and distribute ID cards, enrollment materials, and benefit booklets\summary plan descriptions by July 1, 2016 as part of your implementation at no additional cost to the State.
89. Confirm that you will have final benefit summaries available to the State by October 15th each year for the purposes of open enrollment, or by a date mutually agreed upon.
90. Confirm that there will be no additional fees charged for any start-up costs including, but not limited to, the following:
- Initial set-up charges
 - Development of communications materials
 - Participation at employee education meetings
 - Review of transition cases
 - Total first year start-up fees
91. Confirm that you will be able to accept claims history (including the orthodontics lifetime maximum data).
92. Confirm that you will be able to accept the plan eligibility data from the State’s current dental benefits administrator.
93. Confirm you will you promptly transfer enrollment cards, claim information, and other administrative records to any carrier/TPA that would replace you in the event of termination of this contract at no charge.

D. References

Please provide three references. These clients should use the same claim office that your organization proposed for the State. References listed for terminated account should not reflect an account that terminated due to a merger or acquisition.

Employer Group (Current Account)	
Number of Employees/Group Size	
Contact Name and Title	
Contract Telephone Number	
Program Implementation Date	
Product	
Employer Group (January 1, 2016 Implementation)	
Number of Employees/Group Size	
Contact Name and Title	
Contract Telephone Number	
Program Implementation Date	
Product	

Employer Group (December 31, 2015 Termination)	
Number of Employees/Group Size	
Contact Name and Title	
Contract Telephone Number	
Program Implementation Date	
Product	

SECTION 4.4: Geographic Network Match

Introduction:

One of the State's key objectives is to determine if your organization can provide accessible dental services to its employees. In order to assess your network's ability to meet the State's needs, please prepare a network match (GeoAccess® analysis) using residential zip codes and your network of providers.

Results are to be prepared in the following formats:

- GeoNetworks Report (Adobe Acrobat .pdf file)

In order for your organization's responses to be evaluated, it is critical that you comply with all instructions.

Upon request, your organization will receive a summary database in Microsoft Excel format. The database summarizes unique zip codes and total employees. The database will be made available on a password protected, encrypted USB Drive available for pick up at the Division of Purchases, One Capitol Hill, 2nd Floor, Providence, RI 02908 and the Division is open Monday - Friday 8:30 AM – 4:00 PM EST. The USB Drive will be provided upon receipt of a signed "Limited Use, Confidentiality and Nondisclosure Agreement" and "Data Request Form". Please contact Meredith Skelly at DOA.PurQuestions8@purchasing.ri.gov or 401-574-8156 for scheduling a time window to pick up the USB Drive. Once the USB Drive is picked up, the password to open the file will be provided via e-mail to the Vendor point of contact as designated by the Vendor. This USB Drive and related files are to remain the property of the State and the Vendor shall return the USB Drive and related files (with encryption and password protect intact) by the submission deadline, whether a response is submitted or not. All State files shall be removed from the Vendor's system(s) by the submission deadline.

Summary of Census Information

The following fields are included in the file named Appendix A - Census.xlsx and defined as:

Relationship (subscriber, spouse, dependent child)

Zip Code – residential zip codes

Date of Birth

Coverage Tier (individual, family)

As an offeror in this process you agree to keep the information contained within this file confidential. You agree not to share this information with anyone outside of your organization as well as members of your own organization who do not require access to the data in order to complete the request.

Using the census data provided, complete the attached network access spreadsheet included in Appendix C using driving distance as the measurement of distance, not as the crow flies. The parameters of the report must include access to two (2) dentists within a five (5) mile radius.

SECTION 4.5: Provider Disruption

Offerors are to complete the provider disruption file accompanying this proposal. Detailed information on this file is referenced in Appendix C - Utilized Providers.

Upon request, your organization will receive a Microsoft Excel file needed to complete the provider disruption analysis. The file will be made available on a password protected, encrypted USB Drive available for pick up at the Division of Purchases, One Capitol Hill, 2nd Floor, Providence, RI 02908 and the Division is open Monday - Friday 8:30 AM – 4:00 PM EST. The USB Drive will be provided upon receipt of a signed “Limited Use, Confidentiality and Nondisclosure Agreement” and “Data Request Form”. Please contact Meredith Skelly at DOA.PurQuestions8@purchasing.ri.gov or 401-574-8156 for scheduling a time window to pick up the USB Drive. Once the USB Drive is picked up, the password to open the file will be provided via e-mail to the Vendor point of contact as designated by the Vendor. This USB Drive and related files are to remain the property of the State and the Vendor shall return the USB Drive and related files (with encryption and password protect intact) by the submission deadline, whether a response is submitted or not. All State files shall be removed from the Vendor’s system(s) by the submission deadline.

Summary of Provider Utilization Information

The following fields are included in the file named Appendix C - Utilized Providers.xlsx:

Provider Name
Provider Tax Identification Number (if available)
National Provider Identification Number (if available)
Provider Specialty
Provider Address (if available)
 Street Address
 City
 State
 Zip Code

Offerors must indicate whether each provider is in your dental network by placing a “Y” or “N” in the designated columns. Please complete the dental provider disruption request using your dental PPO network. If submitting a proposal for more than one dental network, please complete separately for each network.

Do not change the file format, re-sort the list provided, or delete any columns from the file. In addition, do not rename any of the worksheets.

As an offeror in this process you agree to keep the information contained within this file confidential. You agree not to share this information with anyone outside of your organization as well as members of your own organization who do not require access to the data in order to complete the request.

SECTION 5: COST PROPOSAL

General

This section must be completed in full. Offeror's are cautioned that failure to respond in full, or in part, to all questions may negatively affect the evaluation of the offeror's proposal, up to and including disqualification.

Proposal Requirements

Potential offerors are cautioned that proposals must conform to the specification of this RFP. Each offeror must submit proposals for the current dental PPO plan for the entire eligible population based on both fully-insured and self-funded financial arrangements. Offerors are required to submit proposals for each of the first three (3) plan years of the initial 30-month contract. At the end of the 30-month contract, the State may seek to extend the Contract with two one-year renewal extensions.

SECTION 5.1: Fully-Insured Rates

In the event that State or Federal legislation requires an increase to the current premium tax or other events make the fully-insured arrangement less advantageous, the State reserves the right to modify its funding arrangement, and move from fully-insured to self-insured.

Assumptions

Outlined below are the assumptions and requirements to be used in preparing your responses:

1. The new Contract will cover all claims incurred on and after July 1, 2016. The prior claims run-off will be paid under the existing contract.
2. Employees and their dependents are eligible for dental coverage on their date of hire.
3. Assume that all employees and dependents currently enrolled will continue to be enrolled.
4. Assume that the current enrollment remains constant for the plan years beginning 2016.
5. No rate revision may occur if enrollment varies by less than +/-15 percent at any time after the effective date.
6. Commissions are not to be included in your proposal.
7. During the pre-installation period and the post-installation period (three (3) months after the implementation date), your organization will provide on-site Customer Service Representatives as needed. These individuals will assist employees with questions regarding enrollment, the network and its administrative procedures, etc. In addition, the vendor shall work with the State's Office of Employee Benefits staff to achieve the most appropriate level of periodic on-site support.

Any deviations from these assumptions must be clearly noted below.

Fully-Insured Rates

Please provide your thirty-month cost proposal for three plan years: July 1 - December 31, 2016 (short plan year), January 1 – December 31, 2017, and January 1 - December 31, 2018. At the end of the thirty-month contract the State may seek to extend the Contract with two one-year renewal extensions, at the sole option of the State.

- Your monthly premium rates should include ALL of the following components. Please confirm your organization’s agreement below for each component.

Service	Included? (Yes/No)
Claims Administration	
Network Access	
Utilization Review	
Student Certification	
A dedicated toll-free telephone line to claim and member services group	
Distribution of Provider Directories upon request	
Standard communication materials	
Customization and delivery of ID cards, claim forms, and EOBs	
Customized printing of enrollment kits and open enrollment materials	
Development, distribution (initial and ongoing), and printing of compliant SPDs	

If you respond ‘No’ to any of the above fee components, please explain why.

- The State expects that the following reports be included in the proposed premium rates. All reports should be State-specific and automatically sent to the State at the frequency noted below. Through the implementation process with the selected offeror, the State will identify the desired group structure. The State will have approximately 12 distinct groups of employees.

Report	Frequency	Agree (Yes/No)
Monthly paid claims by population and group number	Monthly	
Monthly enrollment by population and group number	Monthly	
Paid/Incurred claims triangle	Quarterly	
Claims by provider type	Quarterly	
Utilization reports (broken out by service class) by population and group number	Quarterly	
Network utilization	Quarterly	
Full detailed claim file	Semi-Annually	
NAJC and Department of Business Regulation Filings	Quarterly	
Enrollee complaints and grievances including resolutions	Quarterly	
Enrollee satisfaction survey results	Annually	

If you responded “No” to any of the above reports, please explain why.

3. Please provide your thirty-month cost proposal for three plan years: July 1-December 31, 2016 (short plan year), January 1 – December 31, 2017, and January 1, - December 31, 2018 for the Dental PPO. If submitting a proposal for more than one dental network, please complete separately for each network.

Proposed rates must be on a mature basis where you are responsible for all claims incurred during the policy year.

Guaranteed premium rates are requested for July 1-December 31, 2016 (short plan year). If you are not proposing guaranteed premium rates for CY 2017 or CY 2018, propose guaranteed rate increase caps.

Plan Year	Employee Only	Family
7/1/2016 – 12/31/2016		
1/1/2017 – 12/31/2017		
1/1/2018 – 12/31/2018		

Please confirm that these rates do not include commissions.

Confirmed

The signed Fully-Insured Rates form should be included as attachment to the transmittal letter in order to be considered in the carrier evaluation process.

Accepted this _____ day of _____, 2016

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

SECTION 5.2: Administrative Fees

Self-Funded Rates

Please populate the table below with the required information.

Current Plan	Year 1 7/1/16–12/31/16	Year 2 CY 2017	Year 3 CY 2018
<u>Guaranteed</u> Administration Fee - PEPM*	\$	\$	\$
Estimated Working Rates (<u>incurred</u> claims plus administration)			
Individual	\$	\$	\$
Family	\$	\$	\$
Advance deposit requirement **	\$	\$	\$

* Administrative fees are requested on a mature basis. The fees should include a 12-month run-out period for claims incurred during the contract period and paid after termination (i.e., there should not be an additional charge for run-out administration).

* Please indicate whether you are proposing administrative fee guarantees in Year 4 (CY 2019) and Year 5 (CY 2020).

** Please indicate whether an advance deposit is required, the amount, and the basis for determining the amount. In addition, please indicate the amount of interest paid on the deposit.

If submitting a proposal for more than one dental network, please complete separately for each network.

The signed Self-Funded Rates form should be included as attachment to the transmittal letter in order to be considered in the carrier evaluation process.

Accepted this ____ day of _____, 2016

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

SECTION 5.3: Network Discounts

1. Please complete the attached dental network provider discount and non-network R&C maximum allowance spreadsheet. **If submitting a proposal for more than one dental network, please complete separately for each network.** [See Appendix B.]

2. **Claims Re-Pricing Analysis** – Please re-price the claims provided in the Detailed Claims Data in Appendix B.

The re-pricing should be based on the submitted charges, shown in the column “Billed Eligible Charge” on the claims file, and your current network provider contractual fee arrangements as of the date of your RFP response. **The claims re-pricing amounts shall be based on actual data and shall not include any assumptions regarding projected discounts or assumed increases in billed charges.**

- *Provide the sums of all re-priced claims by in-network and out-of-network based on the submitted charges in the column “Billed Eligible Charge”. [See Appendix B.]. **If submitting a proposal for more than one dental network, please separate “in-network” claims by network.***
 - Responses are due in the electronic Excel format provided.
 - Provide an explanation detailing how you re-priced the claims, noting any and all adjustments and methodologies.
 - Provide a reconciliation that ties your claims re-pricing back to the total billed charges provided.
1. **Confirm your re-pricing is based on your current network provider contractual fee arrangements. “Current” is defined as the discounts the State would achieve through your network as of your proposal submission date. The re-priced amounts should reflect what you would have paid a provider if the claim was incurred in February 2016.**
 2. **Confirm your re-pricing is based on actual data and does not include any assumptions regarding projected discounts or assumed increases in billed charges.**
 3. **Confirm that you have provided an explanation summarizing how you re-priced claims, noting any and all adjustments and methodologies.**
 4. **Confirm you have not omitted any adjustments or methodologies from your explanation on how you re-priced the claims.**
 5. **Confirm that you have provided the claims reconciliation for all charges provided in the claims file.**

SECTION 5.4: Financial Questions

General

1. For in-network dentists, please describe in detail, for each network (if applicable):
 - a. How you determine the cost to the State (i.e., the amount you pay the provider for the service).
 - b. How you determine the out-of-pocket cost (if any) to the member.
 - c. Do your EOBs indicate these amounts and how they are determined?
2. For out-of-network dentists, please describe in detail:
 - a. How you determine the cost to the State (i.e., the amount you pay the provider for the service).
 - b. How you determine the out-of-pocket cost (if any) to the member.
 - c. Do your EOBs indicate these amounts and how they are determined?
3. The State current out-of-network allowance is set at the in-network negotiated rate. Are you able to administer this out-of-network schedule?
4. Describe in detail how you contract with and pay orthodontic dentists. Do you negotiate rates based on CDT code, discount from billed services, treatment plan, etc.?
5. Describe any incentive-based bonuses, withholds, retroactive capitations, etc. you have with network dentists.
6. How often are network fees and out-of-network allowances updated?
7. When were the last two times that the network fee schedule and out-of-network allowances increased, and how much did the fee schedule increase each time?
8. Are there financial incentives to network dentists that are tied to utilization goals, specialty referrals, quality of care outcomes, or other performance results? If so, please explain.
9. Will R&C fee schedule be made available by CDT code and zip code?
10. What steps are taken if the maximum allowable charge is exceeded? How is the State and its plan participants supported in their resistance to charges in excess of allowances?
11. Can a claimant be privy to the payment schedule in advance of treatment? If so, how?
12. Does your claim processing system have any protection against unbundling and/or upcoding claims? If so, please describe in detail.
13. When you are the secondary payor in a COB situation, do you use your UCR profiles, reduced network fees, or those of the primary carrier in determining your level of reimbursement?
14. How do you determine and define maximum allowable charges or “reasonable & customary” charges (e.g. own data, a percentile of purchased data, relative value scale) for out-of-network claims? If a percentile, what percentile do you use and what database do you use?
15. Can the State select and define its own schedule for out-of-network R&C purposes?
16. When participant coinsurance exists for discounted plans are providers obligated to limit their charge to participants to the coinsurance percentage of the discounted charge?

17. Are any arrangements made with dental suppliers and labs? Do you limit reimbursement for supplies [i.e., crowns, bridges] and equipment, or help network providers to purchase supplies at wholesale prices?
18. Do network discounts apply after an individual has met the annual maximum?

Fully-Insured Proposal

1. Confirm you guarantee that all insureds, who would have continued to be covered on the plan effective date if there had been no change in carriers, will be covered by your policy on the plan effective date.
2. At the outset of the contract with the State, how will coverage for treatment in progress be handled? (Check only one)
 - a. Coverage begins on the first day of eligibility, patient can keep current provider until treatment ends and in-network benefits apply.
 - b. Coverage begins on first day of eligibility and patient must use network provider or receive out-of-network benefits.
 - c. No coverage until completion of current treatment.
3. At the end of a client's contract, treatment in progress is covered as follows: (Check only one)
 - a. Coverage continues until completion of current treatment.
 - b. Coverage ends on the day the contract is terminated.

SECTION 6: EVALUATION AND SELECTION

Evaluation Committee

Audited Financial Statements shall be reviewed by the Bureau of Audits for a Pass or Fail determination.

Technical and Cost Proposals will be reviewed by a Technical Review Committee comprised of State employees who will review proposals and make recommendations for award of the contract.

Evaluation Process

The State has retained the services of a benefits consultant to assist in the evaluation process of the proposals. The Technical Review Committee described above shall be responsible for conducting a comprehensive and impartial evaluation of all proposals. The consultant shall also review the technical and cost proposals utilizing its dental industry expertise and deliver a consultative analysis of each to the Technical Review Committee. The consultant shall not be involved in the Technical Review Committee’s deliberations or recommendations. The Department of Administration shall be solely responsible for the contract award.

The evaluation process will consist of two (2) components – specifically:

1. Technical Proposal Evaluation (50%)
2. Cost Proposal Evaluation (50%)

To advance to the Cost Evaluation phase, the Technical Proposal must receive a minimum of 40 (80%) out of a maximum of 50 technical points. Any technical proposals scoring less than 40 points will not have the cost component opened and evaluated. The proposal will be dropped from further consideration.

Proposals scoring 40 technical points or higher will be evaluated for cost and assigned up to a maximum of 50 points in cost category, bringing the potential maximum score to 100 points.

Each evaluation component is described below.

Proposals will be reviewed and scored based upon the following criteria:

Criteria	Possible Points
Technical Component:	
Vendor Accountability and Performance Guarantees	5 Points
Questionnaire	12.5 Points
Geographic Network Match	12.5 Points
Provider Disruption	20 Points
Total Possible Technical Points	50 Points
Cost calculated as lowest responsive cost proposal divided by (this cost proposal) times 50 points *	50 Points
Total Possible Points	100 Points

*The lowest bidder will receive one hundred percent (100%) of the available points for cost. All other bidders will be awarded cost points based upon the following formula:

$$(\text{lowest bid} \div \text{vendor's bid}) \times \text{available points}$$

For example: If the lowest bidder (Vendor A) bids \$65,000 and Vendor B bids \$100,000 for monthly cost and service fee and the total points available are Fifty (50), vendor B's cost points are calculated as follows:

$$\mathbf{\$65,000 \div \$100,000 \times 50 = 32.5}$$

Points shall be assigned based on the offeror's clear demonstration of his/her abilities to complete the work, apply appropriate methods to complete the work, create innovative solutions and quality of past performance in similar projects.

Applicants may be required to submit additional written information or may be asked to make an oral presentation before the technical review committee to clarify statements made in their proposal.

SECTION 7: PROPOSAL SUBMISSION

Questions concerning this solicitation may be e-mailed to the Division of Purchases at DOA.PurQuestions8@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. Please reference **RFP #7550291** on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information. If technical assistance is required to download, call the Help Desk at (401) 574-9709.

Offerors are encouraged to submit written questions to the Division of Purchases. **No other contact with State parties will be permitted.** Interested offerors may submit proposals to provide the services covered by this Request on or before the date and time listed on the cover page of this solicitation. Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases will not be considered.

Responses should be **hand-delivered** in a sealed envelope marked “**RFP# 7550291**” to:

RI Dept. of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time will not be considered. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time will be determined to be late and will not be considered. Proposals faxed, or emailed, to the Division of Purchases will not be considered. The official time clock is in the reception area of the Division of Purchases.

RESPONSE CONTENTS

Responses shall include the following:

1. One (1) completed and signed three-page R.I.V.I.P generated bidder certification cover sheet (included in the original copy only) downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.
2. One (1) completed and signed W-9 (included in the original copy only) downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.
3. **A separate Technical Proposal** should be in the order as presented within this RFP. Responses to Sections 4.1, 4.2, and 4.3 shall be submitted in Word using the attachment provided in the solicitation posting (do not PDF your response). Responses to Sections 4.4 and 4.5 should be provided on a separate electronic file in Microsoft Excel format (do not PDF your response). Responses are required for all questions; failure to respond to any question may result in rejection of the proposal. Please include the following:
 - One (1) printed Paper Copy, marked “Technical Proposal – Original” and signed.
 - Six (6) printed Paper copies.
 - One (1) Electronic copy on a CD-R, marked “Technical Proposal - Original”.
4. **A separate, signed and sealed Cost Proposal** should be provided in accordance with the requirements of this RFP. Responses to Sections 5.1, 5.2, and 5.4 may be included within the RFP Word document (do not PDF your response). Responses to Section 5.3 must be provided on a

separate electronic file in Microsoft Excel format (do not PDF your response). Responses are required for all questions; failure to respond to any question may result in rejection of the proposal.

- One (1) printed Paper Copy, marked “Cost Proposal – Original” and signed.
 - Six (6) printed Paper copies.
 - One (1) Electronic copy on a CD-R, marked “Cost Proposal - Original”.
5. **A separate, signed and sealed Audited Financial Statement** – An Audited Financial Statement, as outlined in Section 4.3 (page 26) is to be included in the response package and in .pdf file format. Copies to be included are as follows:
- One (1) Electronic copy on a CD-R, marked “Confidential – Audited Financial Statement”.
 - One (1) printed Paper copy, marked “Confidential – Audited Financial Statement”, signed and enclosed in a separate sealed envelope.
6. The original USB Drive provided with related files to assist the Vendor in developing their technical and/or cost Proposal shall be returned as outlined in Sections 4.4 and 4.5. The purpose of the USB Drive is for the State to provide information/data for Vendor to build a response, in turn the Vendor shall not include any Responsive files or data on the returned USB Drive.
7. CD-R Requirements:
- Separate CD-Rs are required for the Technical Proposal, Cost Proposal and Audited Financial Statement as outlined above in 7.3, 7.4 and 7.5 and included in the applicable sealed proposal package.
 - All CD-Rs submitted must be labeled with the Vendor’s name, RFP #, RFP Title and which of the three (3) files it contains (e.g. Technical Proposal, Cost Proposal, Audited Financial Statement).
 - Vendors are responsible for testing their CD-Rs before submission as the State’s inability to read your CD-Rs will be grounds for rejection of a Vendor’s proposal. All files should be readable and readily accessible on the CD-Rs submitted with no instructions to download files from any external resource(s). If a file is partial, corrupt or unreadable, the State shall consider it “non-responsive”. Please note that the CD-Rs submitted, shall not be returned.
8. Formatting of written documents and printed copies requirements:
- For clarity, the Technical Proposal shall be typed. The document shall be single-spaced with 1” margins on white 8.5”x 11” paper using a font of 12 point Times New Roman.
 - All pages on the Technical Proposal are to be sequentially numbered in the footer, starting with number 1 on the first page of the narrative (this does not include the cover page or table of contents) through to the end, including all forms and attachments. The Bidder’s name should appear on every page, including attachments. Each attachment should be referenced appropriately within the proposal section and the attachment title should reference the proposal section it is applicable to.
 - The Cost Proposal shall be typed using the formatting provided on the provided template.
 - Printed copies are to be only bound with removable binder clips.
 - All electronic responses to both the Technical and Cost Proposals shall be in the format provided.
 - Sections 4.1-4.3 have been provided in a Word version document and are posted as an

attachment to the solicitation. This document is for Vendors to provide responses as indicated in 7.3. Vendors shall not alter any of the language provided other than to update the fields/questions with their responses.

CONCLUDING STATEMENTS

Notwithstanding the above, the State reserves the right not to award this contract or to award on the basis of cost alone, to accept or reject any or all proposals, and to award in its best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

The State may, at its sole option, elect to require presentation(s) by offerors clearly in consideration for award.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded to the RFP. The State's General Conditions of Purchases/General Terms and Conditions can be found at the following URL: <https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf>

LIMITED USE, CONFIDENTIALITY AND NONDISCLOSURE AGREEMENT

This Confidentiality and Nondisclosure Agreement (“Agreement”) is entered into for the benefit of the State of Rhode Island (“State”), by and through Division of Purchases, and the _____ (“Vendor”) (collectively hereinafter “Parties”).

The Parties acknowledge that certain confidential and/or sensitive information and/or material may be disclosed to the Vendor during the request for proposal process for Dental Plan for the State of Rhode Island, in order to assist the Vendor in formulating a proposal. The State will release this “Confidential Information,” as defined below, to the Vendor for the limited purpose of assisting the Vendor in formulating a proposal and pursuant to the terms and conditions contained in this Agreement.

NOW THEREFORE, in consideration of the above premises and the promises contained herein, the Contracting Parties agree as follows:

1. Whenever used in this Agreement, the term “Confidential Information” shall mean (i) information exempt from disclosure to the public or other unauthorized persons under either the Rhode Island General Laws or federal statutes; or (ii) information in any medium related **RFP# 7550291**; or (iii) any other information which the State has identified to the Vendor in writing as confidential at the time Confidential Information is released to the Vendor or within thirty (30) days after such release; or (iv) information that would ordinarily be reasonably considered confidential or proprietary in the light of the circumstances surrounding its release to the Vendor. Confidential Information may take the form of, but is not limited to, plans, calculations, charts, concepts, know-how, inventions, licensed technology, design sheets, design data, diagrams, system design, materials, hardware, manuals, drawings, processes, schematics, specifications, instructions, explanations, research, test procedures and results, equipment, identity and descriptions of components or materials used, any and all personal and/or confidential information pertaining to personnel. Confidential Information may be in tangible or intangible form. The State’s failure to expressly identify Confidential Information as such shall not in any way lessen or negate the Parties’ obligation to keep such information confidential in accordance with this Agreement.
2. Notwithstanding the foregoing, the term Confidential Information shall not be construed to include information that (i) is or becomes readily available in public records or documents, other than as a result of an inappropriate disclosure by the Parties or other entity or persons acting on behalf of the Parties, or (ii) can be documented to have been known by the Parties prior to its release to the Parties by the State, or (iii) is disclosed pursuant to applicable Rhode Island law and/or federal law, judicial action or government regulations.
3. The Parties acknowledge that the Confidential Information is confidential and proprietary information and that its protection is essential. The purpose of this Agreement is to enable State to make disclosure of the Confidential Information to the Vendor for the limited purpose of formulating a proposal in response to **RFP# 7550291**, while still maintaining rights in and control over the Confidential Information in conformance with such mandate. The purpose is also to preserve confidentiality of the Confidential Information and to prevent its unauthorized disclosure during the **RFP# 7550291** process. The vendor shall not use the Confidential Information for any other purpose as stated herein. It is understood that this Agreement does not grant the Parties an express or implied license or an option on a license, or any other rights to or interests in the Confidential Information.
4. The Parties shall require its employees, officers, independent contractors, and subcontractors, agents and any other entities acting on its behalf (collectively “Affiliates”) to:

- a. Copy, reproduce or use Confidential Information only for the purpose described herein and not for any other purpose unless specifically authorized to do so in writing by the State; and
 - b. Not permit any other person to use or disclose the Confidential Information for any purpose other than those expressly authorized by this Agreement; and
 - c. Disclose such Confidential Information only to those of its Affiliates who require knowledge of the same for the purpose described herein; provided such Affiliates are obligated to maintain the confidentiality of the Confidential Information and otherwise comply with the terms of this Agreement; and
 - d. Implement physical, electronic and managerial safeguards to prevent unauthorized access to or use of Confidential Information, including without limitation, providing Affiliates a copy of the terms of this Agreement and any other non-disclosure agreement the State may provide for said Affiliates' signature. Such restrictions will be at least as stringent as those applied by the Parties to its own most valuable confidential and proprietary information.
5. The acts or omissions of the Parties' Affiliates with respect to the Confidential Information shall be deemed to be acts or omissions of the Party.
 6. The Parties will not remove, obscure or alter any confidentiality or trade secret notation from the Confidential Information without the State's prior written authorization.
 7. Confidential Information will remain the exclusive property of the State unless as otherwise provided for in any agreement and/or the contract between the State and the Vendor; upon completion of the review of the Confidential Information, or whenever requested by the State, the Parties will promptly destroy or return to the State all Confidential Information and all copies thereof, including summaries, reports or notes based thereon, unless otherwise expressly authorized otherwise by the State in writing.
 8. The Parties agree that the breach of the terms of this Agreement would cause irreparable damage to the State. Therefore, the Parties agree that the State has the right to seek an order to restrain the Vendor from breaching this Agreement. If the State does seek such an order, the Parties agree at this time to waive any claim or defense that the State has an adequate remedy at law or in damages. The State shall have the right to commence any and all legal action, whether in law and/or in equity, the State determines is necessary and required pursuant to this Agreement, to include but is not necessarily limited to, any alleged violation of this Agreement by the any of the Parties and/or Affiliates.
 9. This Agreement sets forth the entire agreement of the Parties with respect to the use and disclosure of the Confidential Information and may be modified only by a writing signed by the Parties. This Agreement will be construed and enforced in all respects in accordance with the laws of the State of Rhode Island. The Parties consent to the exclusive jurisdiction of the Superior Court of the State of Rhode Island and exclusive venue in Providence County, Providence, Rhode Island.
 10. The term of this Agreement shall be concurrent with award of a contract by the State under **RFP# 7550291**.

Signed and agreed by an authorized agent of the Vendor,

By: _____

Vendor Name: _____

DATE: _____

DATA REQUEST FORM

1. We have signed and are returning the Confidentiality and Nondisclosure Agreement (included above) with this completed Data Request Form.
2. We confirm that we are requesting this information for the sole purpose of responding to the State of Rhode Island's Dental RFP. As a recipient of this information, we will not use or disclose it for any other purpose than to respond to the State's RFP. We will destroy this information upon the completion of the RFP process.
3. We confirm that we are able to provide the benefits and services requested in the RFP and our proposal will meet the requirements identified in this RFP document.

We confirm:

- We are able to provide the requested benefits and all the required administrative services;
- We are requesting this information for the sole purpose of responding to the State's RFP;
- We will not use or disclose this information for any other purpose than to respond to the State's RFP;
- We will destroy this information upon the completion of the RFP process;
- Our proposal will not include commissions; and
- Our proposal will include complete response to all sections of this RFP, including both the technical and cost sections.

Accepted this _____ day of _____, 2016

Officer: _____

Signature: _____

Title: _____

Firm: _____

Phone: _____

Email: _____

SUBMISSION CHECKLIST

The items listed below are required in order for your proposal to be considered.

- ___ Signed Plan Design Form (Section 3)
- ___ Transmittal Letter (Section 4.1)
- ___ Total Amount Per Contract Year At Risk for Performance Guarantees (Section 4.2, Page 10)
- ___ Vendor Accountability and Performance Guarantees (Section 4.2)
- ___ Questionnaire (Including References) (Section 4.3)
- ___ Audited Financial Statement (Section 4.3, Page 26)
- ___ Sample Contract for Both Fully-Insured and Self-Funded Arrangements (Section 4.3, Page 27)
- ___ Geographic Network Match (Section 4.4)
- ___ Provider Disruption (Section 4.5)
- ___ Fully-Insured Rates (Section 5.1, Pages 32-34)
- ___ Self-Funded Rates (Section 5.2, Page 35)
- ___ Network Discounts (Section 5.3)
- ___ Financial Questions (Section 5.4)
- ___ All Submissions Compliant with Formatting Requirements (Section 7)
- ___ R.I.V.I.P Generated Bidder Certification Cover Sheet (Section 7.1)
- ___ Completed and Signed W-9 (Section 7.2)