

# EXHIBIT A

## DENTAL QUESTIONNAIRE

### A.1 Mandatory Requirements

- Complete the questions in Section A.1 indicating “yes” or “no” as to your organization’s ability to meet the mandatory requirements.
- If you cannot answer “yes” to all of these mandatory requirements, your proposal may be disqualified by the City.

**A.1.1** It is a requirement of the City that no employee suffers a loss of coverage by virtue of a change in carriers other than by plan design. Indicate your agreement to this stipulation. If you will not agree, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.1.2** The premium rates or fees quoted in your proposal can only be recalculated if enrollment changes more than 20% from the census. If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.1.3** Quoted rates are guaranteed for a minimum of 36 months. If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.1.4** No actively at work requirements apply to participants covered by the prior carrier on the day before the effective date of this contract. If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.1.5** For contract years 4 and 5, agree to at least **210 days** advance written notice of any change in fees/premium. If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.1.6** Agree to have available a toll-free customer-service number for City employees at no cost to the City. If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.1.7** For the Indemnity Dental Plan and the Prepaid Dental Plan (DHMO), agree to waive all pre-existing condition provisions for employees and dependents presently covered by the prior carrier on the day before the effective date of this contract. If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.1.8** Your proposal should be **net of commissions**. Is your quotation consistent with this request? If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.1.9** Your rates may not be contingent on being the exclusive provider for both the DPPO and DHMO benefits. If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.1.10** Acknowledge that DHMO copays may not be changed during the term of the contract without express written consent of the City of Houston. If no, explain.

<i>Single, Pull-down list.</i>	<i>Limited to 200 words.</i>
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1: Yes	
2: No	

## A.2 General Information (All Proposers)

**A.2.1** Describe your organization’s experience administering and providing Dental Insurance benefits.

*Limited to 250 words.*

**A.2.2** Identify those individuals who would be responsible for the day-to-day service contact with this Client. At a minimum, include the positions below:

**1. Account Manager** - Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, overseeing contractual services under the contract with the City, and managing all other Proposer staff working on this account. Has overall responsibility for waste, fraud and abuse oversight and control. The Account Manager will have a minimum five (5) years of experience as an Account Manager for your firm.

Name	<i>Unlimited</i>
Address	<i>Unlimited</i>
Phone Number	<i>Unlimited</i>
Email Address	<i>Unlimited</i>
Years of Experience in Present Position	<i>Unlimited</i>
Resume	<i>Attach Resume</i>

**2. Customer Service Manager** – Responsible for all customer service functions and reporting. The Customer Services Manager shall have at least three (3) years of experience as a Customer Service Manager for your firm.

Name	<i>Unlimited</i>
Address	<i>Unlimited</i>
Phone Number	<i>Unlimited</i>
Email Address	<i>Unlimited</i>
Years of Experience in Present Position	<i>Unlimited</i>
Resume	<i>Attach Resume</i>

**3. Operations/HRIS Manager** – Responsible for all claims operations and reporting, including overseeing the file transfer process of eligibility data, interfaces and data sharing. Operations Manager shall have three (3) years of experience as an Operations Manager for your firm.

Name	<i>Unlimited</i>
Address	<i>Unlimited</i>
Phone Number	<i>Unlimited</i>
Email Address	<i>Unlimited</i>
Years of Experience in Present Position	<i>Unlimited</i>
Resume	<i>Attach Resume</i>

**4. Network Manager** – Responsible for monitoring and assisting in resolving provider contract disputes and monitors and reports to the City on network access. Monitors the City’s utilization and is proactive in expanding networks as needed to adjust to changes in member demand and access needs.

Name	<i>Unlimited</i>
Address	<i>Unlimited</i>
Phone Number	<i>Unlimited</i>
Email Address	<i>Unlimited</i>
Years of Experience in Present Position	<i>Unlimited</i>
Resume	<i>Attach Resume</i>

**5. Reporting Manager** – Responsible for the oversight of report generation and ad hoc report generation. The Reporting Manager shall have at least three (3) years of experience as a Reporting Manager.

Name	<i>Unlimited</i>
Address	<i>Unlimited</i>
Phone Number	<i>Unlimited</i>
Email Address	<i>Unlimited</i>
Years of Experience in Present Position	<i>Unlimited</i>
Resume	<i>Attach Resume</i>

**6. Implementation Manager** – Responsible for development and execution of implementation plan. Coordinates with the City, internal and other external resources.

The Implementation Manager shall have three (3) years of experience as an Implementation Manager for your firm.

Name	<i>Unlimited</i>
Address	<i>Unlimited</i>
Phone Number	<i>Unlimited</i>
Email Address	<i>Unlimited</i>
Years of Experience in Present Position	<i>Unlimited</i>
Resume	<i>Attach Resume</i>

**A.2.3** If your company is awarded this business, how soon after notification of the award would you be able to have a draft of the:

	<b># Of Business Days</b>
A. Master Policy	<i>Unlimited</i>
B. Certificate of Coverage	<i>Unlimited</i>

**A.2.4** All sample forms and communication materials should be provided for approval to the Client in advance of distribution (ID cards, claim forms, enrollment forms, booklets, brochures, flyers, mailers, etc.). Do you agree to this requirement? If no, explain why not.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.2.5** Does your firm have the capability to provide customer service in other languages? Please specify.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.2.6** What are the most recent ratings for your company by the following:

	<b>Rating</b>	<b>Date</b>
Standard and Poors	<i>Unlimited.</i>	<i>Unlimited.</i>
A.M. Best	<i>Unlimited.</i>	<i>Unlimited.</i>

Moody's	Unlimited.	Unlimited.
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**A.2.7** Confirm that you will provide the most recent two (2) years of your audited financial statements. Provide the requested statements as an attachment to your proposal.

Yes/No

**A.2.8** Is your company "affiliated" with another company? If yes, describe the "affiliate relationship." "Affiliated" means owned by another company, owned by a common controlling shareholder or interest, or inter-tied by contract so as to be under the dominion or influence of another.

Single, Pull-down list. 1: Yes 2: No	Limited to 200 words.
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**A.2.9** Is your firm involved in any current litigation against or from the City? If yes, describe.

Single, Pull-down list. 1: Yes 2: No	Limited to 200 words.
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**A.2.10** Have you been involved in litigation within the last five years arising out of your performance in the administration of a Group Dental plan? Exclude routine matters involving participants that do not reflect on your performance under the contract with your City. If the answer is yes, explain fully.

Single, Pull-down list. 1: Yes 2: No	Limited to 200 words.
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**A.2.11** Do you anticipate any mergers, transfers of company ownership, sales management reorganizations, or departures of key personnel within the next three years that might affect your ability to carry out your proposal if it results in a contract with the City? If yes, explain.

Single, Pull-down list. 1: Yes 2: No	Limited to 200 words.
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**A.2.12** Provide three current customer references. For at least one of these references, proposers must cover at least one group plan of 10,000 or more employees. The City is interested in working with carriers that have experience with and a history of providing dental Insurance benefits to public sector plans of similar size.

The City may contact any customer of the vendor, whether or not included in the vendor’s reference list, and use such information in the evaluation process. Provide the following for each reference:

	<b>Reference 1</b>	<b>Reference 2</b>	<b>Reference 3</b>
1. Customer Name	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
2. Length of time serviced	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
3. Number of covered members	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
4. Description of services	<i>Limited to 200 words</i>	<i>Limited to 200 words</i>	<i>Limited to 200 words</i>
5. Name of contact	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
6. Contact title	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
7. Contact phone number	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
8. Contact email	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
9. Contact address	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>

**A.2.13** Provide the names of any clients who have terminated contracts within the last five years for cause or under dispute for any services that you propose to provide. Provide the names, location, size of client, date lost, reason lost, and telephone numbers of the former clients' benefit managers or contact persons.

	<b>Reference 1</b>	<b>Reference 2</b>
1. Customer Name	<i>Unlimited.</i>	<i>Unlimited.</i>
2. Length of time serviced	<i>Unlimited.</i>	<i>Unlimited.</i>
3. Number of covered members	<i>Unlimited.</i>	<i>Unlimited.</i>
4. Description of services	<i>Limited to 250 words.</i>	<i>Limited to 250 words.</i>
5. Reason for termination of services	<i>Limited to 250 words.</i>	<i>Limited to 250 words.</i>
6. Name of contact	<i>Unlimited.</i>	<i>Unlimited.</i>
7. Contact title	<i>Unlimited.</i>	<i>Unlimited.</i>
8. Contact phone number	<i>Unlimited.</i>	<i>Unlimited.</i>
9. Contact email	<i>Unlimited.</i>	<i>Unlimited.</i>

**A.2.14** Will your organization be willing to include contractual language in the service agreement that will warrant that your firm and its related organizations will not outsource work to foreign workers during the life of the contract? If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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### **A.3 HIPAA**

**A.3.1** Do you agree to maintain compliance with HIPAA EDI, Privacy and Security for the duration of the contract period? If no, explain

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.3.2** Are you willing to sign a HIPAA Business Associate Agreement with the City that indicates your firm will pay fines the City may be assessed as a result of your firm's noncompliance with HIPAA EDI, Privacy and Security regulations and pay costs associated with remedy of any breach your firm initiates? If no, explain

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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### **A.4 General Dental**

**A.4.1** Are you willing to provide a dedicated representative to reside in the City offices? If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.4.2** What hours and days are live customer service representatives available (CST)?  
*Limited to 100 words.*

**A.4.3** What alternative services do you provide?

	Yes	No
1. Assistance for hearing impaired		
2. 24-hour toll-free customer service automated benefits/eligibility		
3. Translation Services		
4. Customer service accessibility via the internet		
5. Other (itemize)		

**A.4.4** Do you provide ID cards for each covered member at no cost to the City? If no, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.4.5** Confirm that the cost of ID card printing and mailing to the employee is included in your fees. If no, explain

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.4.6** Please outline all limitations and exceptions for each option, separately for enrollment/eligibility, and benefits.

*Limited to 200 words.*

**A.4.7** Can eligibility and reporting be accessed online through a secured website by the City and their designated Consultant? If no, explain

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.4.8** Provide a description of those circumstances under which benefits continue being paid upon:

	Explanation
1. Termination of an insured's coverage	<i>Limited to 200 words</i>
2. Termination of the policy	<i>Limited to 200 words</i>

**A.4.9** What additional dental health screenings and/or wellness benefits (i.e. screenings for oral cancer, cavity risk assessment tool, additional benefits for diabetics, expectant mothers, CAD patients, etc.) do you offer at no additional cost?

	<b>Yes</b>	<b>No</b>
1. Dental health screenings and/or wellness screenings	<i>Limited to 200 words</i>	<i>Limited to 200 words</i>
2. Screenings for oral cancer	<i>Limited to 200 words</i>	<i>Limited to 200 words</i>
3. Cavity risk assessment tool	<i>Limited to 200 words</i>	<i>Limited to 200 words</i>
4. Additional benefits for diabetics	<i>Limited to 200 words</i>	<i>Limited to 200 words</i>
5. Additional benefits for expectant mothers	<i>Limited to 200 words</i>	<i>Limited to 200 words</i>
6. Additional benefits for CAD patients	<i>Limited to 200 words</i>	<i>Limited to 200 words</i>
7. Other (itemize)	<i>Limited to 200 words</i>	<i>Limited to 200 words</i>

**A.4.10** What pre-existing conditions are imposed?

*Limited to 250 words.*

## **A.5 Quality of Care & Continuity of Care**

**A.5.1** Describe how treatment in progress will be covered at initial takeover.

*Limited to 250 words.*

**A.5.2** Describe how orthodontic claims in process will be adjudicated at initial takeover.

*Limited to 250 words.*

**A.5.3** Describe how treatment in progress will be covered if your plan is terminated during an episode of treatment.

*Limited to 250 words.*

## **A.6 Network**

**A.6.1** Do you wholly own and operate the network you are proposing for the City (if subcontracting with an external vendor please identify your subcontractor)?

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.6.2** Please provide separate Geo Access reports for the entire census, for the Indemnity/ DPPO population and for the DHMO population based on the following requirements (include open practices only).

1. General Dentists:

BASE ON UNIQUE TIN NUMBERS

Report should reflect city, state, zip code, and number of unique providers by zip, number of employees with access (criteria 2 providers within 10 miles of home zip code) and locations (zip code and County) where no access exists.

Please include the total number of contracted providers within the service area for this Client totaled by City.

2. Pediatric Dental Specialists:

BASE ON UNIQUE TIN NUMBERS

Report should reflect city, state, zip code, and number of unique providers by zip, number of employees with access (criteria 2 providers within 10 miles of home zip code) and locations (zip code and County) where no access exists.

Please include the total number of contracted providers within the service area for this Client totaled by City.

3. Other Specialists:

BASE ON UNIQUE TIN NUMBERS

Report should reflect city, state, zip code, and number of unique providers by zip, number of employees with access (criteria 2 providers within 10 miles of home zip code) and locations (zip code and County) where no access exists.

Please include the total number of contracted providers within the service area for this Client totaled by City.

4. Orthodontists:

BASE ON UNIQUE TIN NUMBERS

Report should reflect city, state, zip code, and number of unique providers by zip, number of employees with access (criteria 2 providers within 20 miles of home zip code) and locations (zip code and County) where no access exists.

*Unlimited.*

**A.7 Financial**

**A.7.1** Indicate any minimum requirement for employee and dependent participation in the dental plan.

*Limited to 100 words.*

**A.7.2** If this minimum is not achieved, what affect will it have on the policy (*i.e.*, can it still be issued, but at different rates)?

*Limited to 100 words.*

**A.7.3** Please confirm that all costs are included in the rate provided. No additional costs will be paid unless they are specified in the contract.

*Limited to 100 words.*

**A.7.4** Do you agree to the Performance Standards as outlined in this Request for Proposal?

*Limited to 250 words.*

## **A.8 Indemnity Dental**

**A.8.1** From what location would this policyholder's claims be processed (include full address)?

*Limited to 100 words.*

**A.8.2** Describe how your pretreatment review process operates.

*Limited to 250 words.*

**A.8.3** What is the turnaround time for a pretreatment review?

*Limited to 100 words.*

**A.8.4** Will you agree to furnish the following quarterly reports?

<b>Reports</b>	<b>Response</b>	<b>If No, Explain</b>
1. Monthly premium and paid claims, by employee, dependent and plan (DHMO/DPPO).	Yes/No.	<i>Limited to 200 words</i>
2. Monthly utilization by in and out of network and by major class (i.e., preventive, basic, major, orthodontia).	Yes/No.	<i>Limited to 200 words</i>
3. Monthly subscriber and member counts	Yes/No.	<i>Limited to 200 words</i>
4. Claim Loss Ratio and how it is calculated	Yes/No.	<i>Limited to 200 words</i>
5. Total number of complaints by reason and resolution	Yes/No.	<i>Limited to 200 words</i>
6. Total number of appeals by reason and resolution	Yes/No.	<i>Limited to 200 words</i>
7. Network composition	Yes/No.	<i>Limited to 200 words</i>
8. Performance guarantee and MWBE compliance reports	Yes/No.	<i>Limited to 200 words</i>
9. Annual savings generated from discounts	Yes/No.	<i>Limited to 200 words</i>

**A.8.5** Provide a complete description of the benefit limitations and exclusions. (Save as Indemnity\_Dental\_Limitations, and attach.)

*Limited to 250 words.*

**A.8.6** Does your proposed plan include:

	Response	If you answered “Yes” on any of the questions, please provide an explanation. Do not refer the reader to your underwriting back-up (unless additional detail is needed).
1. Any deductibles or coinsurance levels that differ from the current plan?	Yes/No.	<i>Limited to 250 words.</i>
2. Any plan maximums that differ from the current benefit level?	Yes/No.	<i>Limited to 250 words.</i>
3. Any change in current service classification (i.e. moving services from one classification [preventive, basic, major] to another)?	Yes/No.	<i>Limited to 250 words.</i>
4. Any frequency limits that differ from what currently exists?	Yes/No.	<i>Limited to 250 words.</i>
5. Any exclusions where coverage exists today?	Yes/No.	<i>Limited to 250 words.</i>
6. A missing tooth limitation?	Yes/No.	<i>Limited to 250 words.</i>
7. Any late entrant restrictions?	Yes/No.	<i>Limited to 250 words.</i>
8. Any waiting period limitations?	Yes/No.	<i>Limited to 250 words.</i>
9. Please list all coverage differences from the current coverage (including those above) on the Exhibit C – Deviation Sheet.	Yes/No.	<i>Limited to 250 words.</i>

**A.8.7** Please identify any benefit improvements you think the City should consider. (Please complete the Rate Exhibits for each benefit option proposed.)

*Limited to 250 words.*

**A.8.8** Please identify any reduction to your rates, expressed as a percentage, if you are awarded both the DPPO and DHMO programs.

*Limited to 250 words.*

## **A.9 Indemnity Dental Claims**

**A.9.1** How are “reasonable and customary” charges determined by your company in the administration of your proposed plan?

*Limited to 250 words.*

**A.9.2** The 85<sup>th</sup> and 90<sup>th</sup> percentiles are requested to be used in determining “reasonable and customary for out-of-network claims.” Please confirm your agreement.

Yes / No

**A.9.3** Explain how in-network maximum allowable charges are determined geographically:

1. By the location of the provider of dental services? Other? Please explain.

*Limited to 250 words.*

2. How are specific areas delineated (e.g., 5 digit zip, 3 digit zip, county)?

*Limited to 100 words.*

3. How often and approximately when is data updated?

*Limited to 250 words.*

**A.9.4** Can a claimant find out what the in-network maximum allowable charge is for a particular procedure in advance of having the procedure performed? If yes, explain how?

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.9.5** Will you provide client specific R&C data to City members? If no, explain

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.9.6** Will you agree to allow an annual third party dental claim audit at no charge for internal claims audit support? If no, explain why not.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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## **A.10 DHMO Dental**

**A.10.1** Provide a copy of your patient charge schedule of benefits and copayments. (Save as DHMO\_Dental\_Benefits, and attach.)

*Unlimited.*

**A.10.2** Discuss how your plan handles re-treatment of Previous Root Canal therapy - anterior, bicuspid, and molar.

*Limited to 250 words.*

**A.10.3** For the DHMO plan, what is the average waiting time for the following:

	<b>Wait Time</b>
a. Routine cleanings	<i>Limited to 100 words.</i>
b. Non-routine appointments	<i>Limited to 100 words.</i>
c. First appointments	<i>Limited to 100 words.</i>
d. Emergency appointments	<i>Limited to 100 words.</i>

**A.10.4** For the City of Houston’s service area, what percent of dentists have evening or weekend office hours?

*Percent.*

**A.10.5**

1. Are members required to select a primary care dentist?

*Yes/no*

2. If yes, can family members choose a different primary care dentist?

*Yes/no*

**A.10.6** How are specialist services charged?

	<b>Yes/No</b>
A. Same copayment as primary care dentist?	
B. Separate structure	
C. Discount to normal charges	
D. Other (explain)	Limited to 100 words.

**A.10.7**

1. Does your plan require a referral from a general dentist to use a specialist?

*Limited to 100 words.*

2. Are there any specialist categories not covered by your plan?

*Limited to 100 words.*

**A.10.8** How is emergency care handled for individuals traveling **outside** the service areas?

*Limited to 250 words.*

**A.10.9** Does your plan require members to pay additional lab fees in excess of the member copay? If yes, explain.

Single, Pull-down list. 1: Yes 2: No	Limited to 200 words.
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**A.10.10** If lab fees are additional, provide your estimate of an average lab fee based on your book of business statistics) for the City of Houston’s service area for the following:

	Response
a. D2750 – Crown	<i>Unlimited.</i>
b. D5110 – Dentures	<i>Unlimited.</i>
c. D5211 Partial Denture	<i>Unlimited.</i>
d. D5610 Denture repair	<i>Unlimited.</i>
e. D7866 Biopsy of Oral Tissue	<i>Unlimited.</i>

**A.10.11** Provide a complete description of the benefit limitations and exclusions (Save as DHMO\_ Dental\_Limitations and attach.)

*Unlimited.*

**A.10.12** Does your proposed plan include:

	Response	If you answered “Yes” on any of the questions, please provide an explanation. Do not refer the reader to your underwriting back-up (unless additional detail is needed).
1. Any frequency limits that differ from what currently exists?	Yes/No.	<i>Limited to 250 words.</i>
2. Any exclusions where coverage exists today?	Yes/No.	<i>Limited to 250 words.</i>
3. Any late entrant restrictions?	Yes/No.	<i>Limited to 250 words.</i>
4. Any waiting period limitations?	Yes/No.	<i>Limited to 250 words.</i>
5. Least expensive professionally acceptable treatment clause?	Yes/No.	<i>Limited to 250 words.</i>
6. Please list all coverage differences from the current coverage (including those above). Exhibit C – Deviation Sheet.	Yes/No.	<i>Limited to 250 words.</i>

**A.10.13** Please identify any benefit improvements you think the City should consider. (Please complete the Rate Exhibits for each benefit option proposed)

*Limited to 250 words.*

**A.10.14** Please identify any reduction to your rates, expressed as a percentage, if you are awarded both the DPPO and DHMO programs.

*Limited to 250 words.*

**A.10.15** Will you agree to furnish the following quarterly reports?

<b>Reports</b>	<b>Response</b>	<b>If No, Explain</b>
1. Monthly premium and paid claims by tier	Yes/No.	Limited to 200 words
2. Monthly utilization by major class (i.e., preventive, basic, major, orthodontia).	Yes/No.	Limited to 200 words
3. Monthly subscriber and member counts	Yes/No.	Limited to 200 words
4. Claim Loss Ratio and how it is calculated	Yes/No.	Limited to 200 words
5. Total number of complaints by reason and resolution	Yes/No.	Limited to 200 words
6. Total number of appeals by reason and resolution	Yes/No.	Limited to 200 words
7. Network composition	Yes/No.	Limited to 200 words
8. Performance guarantee and MWBE compliance reports	Yes/No.	Limited to 200 words
9. Annual savings generated from discounts	Yes/No.	Limited to 200 words

**A.11 Miscellaneous**

**A.11.1** Selected vendors shall assist in plan communication and enrollment to approximately 20,000 active employees, some of whom work around the clock, in multiple work locations/shifts throughout Houston. Separate meetings may be required for the City's approximately 9,800 retirees as well. Indicate your agreement to this stipulation.

Yes/No

**A.11.2** Do you agree to attend quarterly compliance review meetings at the City's desired location in Houston, Texas?

Yes/No

**A.11.3** If awarded the contract, the vendor must agree to maintain City files for 7 years from the date of the service and allow the City the option to take over the records in a magnetic format.

Yes/No

**A.11.4** All vendors awarded a contract must agree to the following:

1. Transmit test data to a new vendor no less than 30 days prior to the termination of a contract.

Yes/No

2. To provide a final verified transition data file to the new vendor within 30 days after the termination date.

Yes/No

**A.11.5**

1. Are your quoted rates guaranteed for a minimum of 3 years?

Yes/No

2. If your quoted rates are guaranteed for a minimum of 3 years, are you willing to

a. Guarantee rates for more than 3 years?

Yes/No

b. Provide maximum rate increases for years 4 and 5, or

Yes/No

c. Provide a formula to calculate rates for years 4 and 5?

Yes/No

**A.11.6** A knowledgeable IT service representative must be available to work with the City of Houston's IT department to prepare eligibility data for initial and continuing transmission. Indicate your agreement to this stipulation.

Yes/No

**A.11.7** All vendors that are awarded a contract must provide customized Certificates of Coverage to all subscribers annually. Indicate your agreement to this stipulation.

Yes/No

**A.11.8** Do you agree to provide a Client specific annual member satisfaction survey provided electronically and/or via mail to all members for the DPPO and DHMO at no cost to the City? The survey questions, survey vehicle, terms, rewards and penalties will be mutually agreed to by the selected proposer and the City during negotiations. If you do not agree, explain

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.11.9** Do you agree with the Indemnification and Release language which will be included as part of the Agreement between the City and Proposer? If no explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.11.10** Do you agree with the insurance requirements as outlined in the Insurance Section, including naming the City as an additional insured. If you do not agree, explain.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.11.11** Do you have a program for assuring equality of contracting opportunity for Minority, Women, and Disadvantaged Business Enterprises? Should you be successful in obtaining this contract, identify all anticipated opportunities (in dollars annually) to contract for supplies and services with Minority, Women, Disadvantaged Business Enterprises certified by the City. Complete and attach Exhibit II

*Attachment.*

**A.11.12** Does your company or any individual who owns 10% or more of this firm owe any delinquent taxes, fees, etc., to the City? Provide response to question, complete and attach the Affidavit in Exhibit IV.

*Attachment.*

**A.11.13** Do any former City employees (management/executive level) work for your firm? If yes, indicate for how long and in what capacity?

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 100 words.</i>
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**A.11.14** Have you been cited or been threatened with citation within the last five years by federal or state regulators for violations of state or federal laws and failure to implement regulations? If the answer is yes, explain fully.

<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Limited to 200 words.</i>
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**A.11.15** Do you agree the City will have the right to review and approve all forms and communication materials (ID cards, claim forms, enrollment forms, booklets, brochures, flyers, mailers, etc.)?

| Yes/No.

|

## **A.12 Implementation**

Describe your implementation process and provide a proposed implementation plan and timetable, beginning with the award of business to the completion of the work, assuming a plan effective date of May 1, 2016. Your response should include:

1. Steps required to implement the program;  
*Limited to 200 words.*
2. Roles played by the City and vendor;  
*Limited to 200 words.*
3. A timeline outlining the scope of implementation;  
*Limited to 200 words.*
4. Eligibility feeds;  
*Limited to 200 words.*
5. Contact information (title, phone, fax, address, email) and personnel assigned to each step of the implementation process;  
*Limited to 200 words.*
6. Dedicated toll-free phone line for member services should be operational by March 15;  
*Limited to 200 words.*
7. Banking arrangements established; and  
*Limited to 200 words.*
8. An Explanation of your firm's approach to dispute management, control of the scope of responsibilities, and quality assurance.  
*Limited to 200 words.*

## **A.13 Web Tools**

**A.13.1** Briefly describe your member website capabilities including whether your member website includes the following:

1. Accurate provider directory and provider search.  
*Limited to 100 words.*
2. Directions to provider's office provided by Map Quest or other mapping/direction applications.

*Limited to 100 words.*

3. Ability to make appointments online.

*Limited to 100 words.*

4. Ability to review claims payment status online.

*Limited to 100 words.*

5. Ability to review a history of claims payments deductible status, out-of-pocket maximum status online.

*Limited to 100 words.*

6. Ability to review or print a statement with a history of claims payments.

*Limited to 100 words.*

7. Ability to see a summary of the City's plan design and review the City's EOC.

*Limited to 100 words.*

8. Ability to print ID cards and request replacement cards.

*Limited to 100 words.*

9. Ability to contact member/customer service online.

*Limited to 100 words.*

10. Ability to review the City's appeals process and file an appeal online.

*Limited to 100 words.*

11. Ability to view pricing data by procedure by provider online (Indemnity/DPPO).

*Limited to 100 words.*

12. Ability to view Usual and Customary pricing by procedure online (Indemnity/DPPO.

*Limited to 100 words.)*

13. Ability to view copayments by procedure online (DHMO).

*Limited to 100 words.*

14. Treatment cost estimator.

*Limited to 100 words.*

15. Contact information for the City, its other vendors, and links to their websites

*Limited to 100 words.*

16. List of covered dependents.

*Limited to 100 words.*

17. On-line access to forms.

*Limited to 100 words.*

**A.13.2.** Confirm that you will include the City's logo throughout your portal and that the website can be customized, as requested by the City.

*Limited to 100 words.*

**A.13.3.** Do you utilize applications for mobile devices for messaging, provider lookup, general health information or other services? Please describe.

*Limited to 100 words.*

#### **A.14.1. Exhibits to be Completed by Proposing Organizations**

Exhibit 5A – DHMO Provider Disruption Analysis

Exhibit 5B – DPPO Provider Disruption Analysis

Exhibit 6A – DHMO Rate Quotation Sheet

Exhibit 6B – Indemnity/DPPO Rate Quotation Sheet

Exhibit 7A – DHMO Plan Procedures

Exhibit 7B – Indemnity/DPPO Plan Procedures (In-Network)

Exhibit 7C – Indemnity/DPPO Plan Procedures (Out-of-Network)

Exhibit 8 – Indemnity/DPPO Plan Design

Exhibit 9A – DHMO Provider Counts

Exhibit 9B – Indemnity/DPPO Provider Counts

Exhibit 10A – DHMO Deviations

Exhibit 10B – Indemnity/DPPO Deviations