Missouri Consolidated Health Care Plan
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PO Box 104355
Jefferson City, MO 65110
Phone: 800-701-8881
www.mchcp.org

Judith Muck, *Executive Director*

February 15, 2023

TO: Invited Vendors

FROM: Judith Muck, Executive Director

RE: Request for Proposal for Dental Services

Missouri Consolidated Health Care Plan (MCHCP) will be working with Optavise (DirectPath is becoming Optavise), an online request for proposal (RFP) system, in the marketing of the 2024 MCHCP Dental RFP for a January 1, 2024, effective date. You are invited to submit a proposal for these services. We believe that you will find this RFP a great potential opportunity for your organization.

MCHCP is the employee health benefit program for most State of Missouri employees, retirees and their families. This contract provides for a voluntary, fully-insured dental program on a national basis to state members of MCHCP. Missouri Department of Transportation (MoDOT), Missouri State Highway Patrol (MSHP), and Missouri Department of Conservation (MDC) are included in MCHCP's procurement for this dental program. Current State dental plan enrollment is over 44,000 subscribers (over 80,000 lives).

In addition, MCHCP offers a dental plan to those public entities that have elected to join MCHCP for their medical coverage. These members are also included in this RFP under separate pricing. Current public entity dental enrollment is over 500 subscribers (over 700 lives).

MCHCP's total health plan enrollment is over 49,000 subscribers (over 85,000 lives). MoDOT covers approximately 4,200 employees (over 10,600 lives), MSHP covers approximately 2,000 employees (5,500 lives), and MDC has approximately 1,300 employees (3,600 lives). Total public entity health plan enrollment is over 900 subscribers (over 1,200 total lives).

The term of the contract will be one year with an additional four (4) one-year renewal options available at the sole option of the MCHCP Board of Trustees. Bidders are required to provide guaranteed pricing for the plan year beginning January 1, 2024, with not-to-exceed pricing for plan years beginning January 1 of 2025 and 2026. Pricing for plan years beginning January 1 of 2027 and 2028 will be negotiated.

Current Contract

MCHCP's current contracts with MetLife will expire on December 31, 2023. MCHCP reserves the right to award multiple contracts from this RFP.

Minimum Bidder Requirements

To be considered for contract award, bidders must meet the following minimum requirements:

- Licensing – The bidder must hold a certificate of authority to do business in the State of Missouri and be in good standing with the office of the Missouri Secretary of State and the Missouri Department of Commerce and Insurance. MCHCP requires the contractor to comply with all state and federal laws, rules and regulations affecting their conduct of business on their own behalf and on behalf of a covered entity such as MCHCP.
- Data Transfer – Bidder shall agree to provide claim-level data electronically to MCHCP or designated data vendor (currently Merative) monthly. Bidders may be required to demonstrate the ability to provide such data before a contract award is made.
- Size and Experience – The bidder or its partner must currently provide dental coverage to employers that have at least 250,000 covered lives combined and have at least one (1) client with 50,000 covered lives. The bidder must be willing to disclose the name of the large employer client if requested. The bidder or its partner must have been in operation and performing the services requested in this RFP for a minimum of five (5) years.
- Network – Bidders must offer a contracted dental provider network capable of delivering benefits as described in the stated plan design. MCHCP requires a broad network that provides national coverage.
- Contract – Bidders shall not link nor attempt to link (unless permitted by this RFP), the award of this contract to any other bids, products, or contracts. Any bid proposal containing any contingency based upon MCHCP's actual or potential awards of contracts, whether or not related specifically to this RFP, or containing pricing contingencies, shall result in such bid proposal being rejected for non-responsiveness and non-compliance with this RFP.
- Rates – Bidders shall not be permitted to alter their rate or fees after submission except with agreement by MCHCP.
- Timely Submission – All deadlines outlined are necessary to meet the timeline for this contract award. MCHCP may reject any submissions after respective deadlines have passed. All bidder documents and complete proposals must be received by the proposal deadline of March 29, 2023, as outlined in the timeline of events for this RFP. Late proposals will not be accepted. MCHCP reserves the right to modify a deadline or extend a deadline for all bidders at its discretion.
- Plan Designs – Bidders must provide pricing for the plan design as described in the RFP. Additional services and/or options may be offered as part of the entire plan design.

Intent to Bid

Once the RFP is released, bidders who are interested in submitting a proposal should complete the Intent to Bid (available as a response document within the Optavise system). The Intent to Bid is due at 5 p.m. CT, Monday, March 13, 2023.

Use of DirectPath

During this RFP process you will find Optavise's internet-based application offers an opportunity to streamline information exchange. We are confident your organization will find the process straightforward and user-friendly. Optavise will be contacting you within the next two to three days to establish a contact person from your organization and to set up a training session, if necessary. To assist you in preparing for the online proposal process, we have outlined below some important information about this event.

General Instructions

Your proposal will be submitted over the Internet, through an anonymous online bidding process. Optavise will assign a unique username, which will allow you to view the information pertinent to the bidding process, submit response documents, communicate directly with MCHCP through the application's messaging component, and respond to our online questionnaires. In addition, Optavise will provide a user guide with instructions for setting up your account.

You may wish to have other people in your organization access this online event to assist in the completion of the RFP. Each member of your response team must secure a unique username and password from Optavise by way of a provider contact spreadsheet, e-mailed directly to you by Optavise. There is no cost to use the Optavise system.

System Training

Optavise offers all participants of a Optavise-hosted event access to their downloadable *User Guides* and *Pre-Recorded Training Sessions*. These guides are located on the homepage of the *vendor-user* view and provide an overview of the application's functionality. We recommend that you and your response team take advantage of this unique opportunity to realize the full benefit of the application. In addition to this self-help option, Optavise's experienced support personnel will offer an application overview via a web-cast session.

DirectPath Support is also available Monday through Friday from 8:30 a.m. to 5:00 p.m. ET to help with any technical or navigation issues that may arise. The toll-free number for DirectPath Support is 800-979-9351. Support can also be reached by e-mail at Support@DirectPathHealth.com.

Key Event Information

Online RFP Released	Monday, March 6, 2023 8 a.m. CT (9 a.m. ET)
Intent to Bid Due	Monday, March 13, 2023 5 p.m. CT (6 p.m. ET)
Bidder Question Submission Deadline	Monday, March 13, 2023 5 p.m. CT (6 p.m. ET)
MCHCP Responses to Submitted Questions	Friday, March 17, 2023 5 p.m. CT (6 p.m. ET)
All Questionnaires and Pricing due	Wednesday, March 29, 2023 5 p.m. CT (6 p.m. ET)

If this notice should have been sent to a different individual within your organization, please contact Tammy Flaugher at 573-526-4922 or by email at tammy.flaugher@mchcp.org.

We look forward to working with you throughout this process.

Introduction

Missouri Consolidated Health Care Plan (MCHCP) is the employee health benefit program for most State of Missouri employees, retirees, and their dependents covering over 85,000 members (lives). An additional 1,200 non-state local government members are covered through their public entity employer.

This contract provides for a voluntary, fully-insured dental program on a national basis to state members of MCHCP. Missouri Department of Transportation (MoDOT), Missouri State Highway Patrol (MSHP), and Missouri Department of Conservation (MDC) are eligible for this dental program.

In addition, MCHCP offers a dental plan to those public entities that have elected to join MCHCP for their medical coverage. These members are also included in this Request for Proposals (RFP).

This document constitutes a request for sealed proposals, to provide a voluntary dental plan on a fully-insured basis to State of Missouri active employees, retirees, and their covered dependents, as well as those local governments (public entities) that have joined MCHCP and elect to offer dental coverage. The contractor assumes the risk for dental care for plan participants and must have a network or series of networks providing quality dental care and discounted service fees. This network must include general dentists and specialists, and the contractor must conduct a quality assurance review of providers and services that stresses quality and efficiency.

Approximately 44,000 State employees and retirees (over 80,000 lives) and 500 public entity employees (700 lives) are covered by the dental program for the 2023 plan year.

MCHCP's Contracting Intentions:

- Any contract awarded from this RFP will be effective January 1, 2024.
- MCHCP intends to award two contracts to facilitate robust member choice but reserves the right to award a sole contract. Bidders are required to provide pricing based on a single contract award and pricing on two contract awards.
- MCHCP intends to offer members a choice between two plan designs: 1) a Basic Plan and 2) a Classic Plan or a Classic Plan with Orthodontia.
- Bidders must provide national coverage to all eligible members.
- MCHCP intends to award a one-year contract with up to four possible one-year renewals. Bidders are required to submit firm, fixed prices for 2024 and not-to-exceed prices for 2025 and 2026. Rates for 2027 and 2028 will be negotiated.
- Pricing and benefits are subject to negotiation prior to contract award and renewal each year.
- Bidders should understand that MCHCP views its foremost obligation as providing efficient and effective services to its membership. MCHCP will aggressively pursue and implement measures

toward meeting this goal. Bidders are strongly encouraged to demonstrate in their response to this RFP that they share a common vision and commitment.

Minimum Bidder Requirements

To be considered for contract award, bidders must meet the following minimum requirements:

- Licensing – The bidder must hold a certificate of authority to do business in the State of Missouri and be in good standing with the office of the Missouri Secretary of State and the Missouri Department of Commerce and Insurance. MCHCP requires the contractor to comply with all state and federal laws, rules and regulations affecting their conduct of business on their own behalf and on behalf of a covered entity such as MCHCP.

- Data Transfer – Bidder shall agree to provide claim-level data electronically to MCHCP or designated data vendor (currently Merative) monthly. Bidders may be required to demonstrate the ability to provide such data before a contract award is made.

- Size and Experience – The bidder or its partner must currently provide dental coverage to employers that have at least 250,000 covered lives combined and have at least one (1) client with 50,000 covered lives. The bidder must be willing to disclose the name of the large employer client if requested. The bidder or its partner must have been in operation and performing the services requested in this RFP for a minimum of five (5) years.

- Network – Bidders must offer a contracted dental provider network capable of delivering benefits as described in the stated plan design. MCHCP requires a broad network that provides national coverage.

- Contract – Bidders shall not link nor attempt to link (unless permitted by this RFP), the award of this contract to any other bids, products, or contracts. Any bid proposal containing any contingency based upon MCHCP's actual or potential awards of contracts, whether or not related specifically to this RFP, or containing pricing contingencies, shall result in such bid proposal being rejected for non-responsiveness and non-compliance with this RFP.

- Rates – Bidders shall not be permitted to alter their rate or fees after submission except with agreement by MCHCP. The bidder shall

- Timely Submission – All deadlines outlined are necessary to meet the timeline for this contract award. MCHCP may reject any submissions after respective deadlines have passed. All bidder documents and complete proposals must be received by the proposal deadline of March 29, 2023, as outlined in the timeline of events for this RFP. Late proposals will not be accepted. MCHCP reserves the right to modify a deadline or extend a deadline for all bidders at its discretion.

- Plan Designs – Bidders must provide pricing for the plan design as described in the RFP. Additional services and/or options may be offered as part of the entire plan design.

Background Information

- Missouri Consolidated Health Care Plan is governed by the provisions of Chapter 103 of the Revised Statutes of Missouri. Under the law, MCHCP is directed to procure health care benefits for most state employees. The law also authorizes non-state public entities and participating higher education entities to participate in the plan. Rules and regulations governing the plan can be found by following this link http://www.sos.mo.gov/adrules/csr/current/22csr/22csr.asp.

- MCHCP's current contract with MetLife will expire on December 31, 2023. Monthly premiums are listed below:

Rate Category	2019	2020	2021	2022	2023
Subscriber Only	$22.96	$23.56	$23.44	$24.07	$24.31
Subscriber and Spouse	$45.72	$46.91	$46.68	$47.94	$48.42
Subscriber and Child(ren)	$47.45	$48.68	$48.44	$49.75	$50.25
Subscriber and Family	$79.55	$81.62	$81.21	$83.40	$84.23

- Current membership in the dental plan is as follows:

Enrollment	State	Public Entity
Subscribers	44,081	539
Dependents	36,660	253
Total Lives	80,741	792

Complete demographic files are available after completion of Exhibit A-2 Limited Data Use Agreement, available as a Response Document in Optavise (DirectPath is becoming Optavise).

- For state members, MCHCP, MoDOT, MSHP and MDC do not contribute to the monthly premium cost. The entire premium is paid by the subscriber. Members must enroll for the entire plan year except as noted in Exhibit B-Scope of Work.

- MCHCP offers the optional dental plan to public entity employers who participate with MCHCP's medical coverage. Public entities participating with MCHCP may opt to add or drop the dental plan at each annual enrollment period.

Assumptions and Considerations

Please submit your proposal using the DirectPath/Optavise online submission tool no later than **Wednesday, March 29, 2023, 5 p.m. CT (6 p.m. ET)**. Due to the limited timeframe for proposal analysis and program implementation, **no individual deadline extensions will be granted**.

The board of trustees has final responsibility for all MCHCP contracts. Responses to the RFP and all proposals will remain confidential until awarded by the MCHCP Board of Trustees or its designee or until all proposals are rejected.

Do not contact MCHCP directly regarding this RFP. Questions about the technical procedures for participating in this on-line RFP process should be addressed to DirectPath/Optavise. Any questions concerning the content of the RFP should be submitted via the messaging tool of the DirectPath/Optavise website.

Proposal Instructions

NOTE: READ THESE INSTRUCTIONS COMPLETELY PRIOR TO RESPONDING TO THE RFP

To be considered you must respond to all sections of this RFP. Bidders are strongly encouraged to read the entire RFP prior to the submission of a proposal. The bidder must comply with all stated requirements. Bidders are expected to provide complete and concise answers to all questions. Your responses to all questions must be based on your current proven capabilities. You should describe your future capabilities only as a supplement to your current capabilities.

If any information contained in the proposal is found to be falsified, the proposal will immediately be disqualified.

Proposals must be valid until October 1, 2023. If a contract(s) is awarded, prices shall remain firm for the specified contract period.

A proposal may only be modified or withdrawn by signed, written notice which has been received by MCHCP prior to the official filing date and time specified.

Contract Term

The initial agreement is for the period of January 1, 2024 through December 31, 2024, with up to four additional one year contracts renewable at the sole option of the MCHCP Board of Trustees and the state departments electing to contract under this proposal.

Clarification of Requirements

It is assumed that bidders have read the entire RFP prior to the submission of a proposal and, unless otherwise noted by the bidder, a submission of a proposal and any applicable amendment(s) indicates that the bidder will meet all requirements stated herein.

The bidder is advised that the only official position of MCHCP is that position which is stated in writing and issued by MCHCP as a RFP and any amendments and/or clarifications thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.

Schedule of Events

The timeline for the procurement is provided below. No pre-bid conference has been scheduled.

Activity	Timing
Online RFP Released	**Monday, March 6, 2023** **8 a.m. CT (9 a.m. ET)**
Intent to Bid Document Due	**Monday, March 13, 2023** **5 p.m. CT (6 p.m. ET)**

Bidder Question Submission Deadline	**Monday, March 13, 2023** **5 p.m. CT (6 p.m. ET)**
MCHCP Responses to Submitted Questions	**Friday, March 17, 2023** **5 p.m. CT (6 p.m. ET)**
Online RFP Closes (all proposals due)	**Wednesday, March 29, 2023** **5 p.m. CT (6 p.m. ET)**
Finalist Interviews/Site Visits (if necessary)	**May, 2023**
Final Vendor Selection	**Late May, 2023**
Program Effective Date	**January 1, 2024**

Questions

During this bidding opportunity, MCHCP will be using the online messaging module of the DirectPath/Optavise application for all official answers to questions from bidders, amendments to the RFP, exchange of information and notification of awards. It is the bidder's responsibility to notify MCHCP of any change in contact information of the bidder. During the bidding process you will be notified via the messaging module of the posting of any new bid-related information.

Any and all questions regarding specifications, requirements, competitive procurement process, etc., must be in writing and submitted through the online messaging module of the DirectPath/Optavise application by **Monday, March 13, 2023, 5 p.m. CT (6 p.m. ET)**. Questions received after March 13 will be answered and posted through the messaging module as time permits, but there is no guarantee of a response to these questions. For step-by-step instructions, please refer to the *Downloads* section of the DirectPath/Optavise application and click on *User Guides*.

Questions deemed universally applicable will be answered in writing and shared with all vendors who have indicated they are quoting. The team will respond to your questions via the messaging module, with a summary of all questions and answers provided by **Friday, March 17, 2023.**

Bidders or their representatives may not contact other MCHCP employees or any member of the MCHCP Board of Trustees or the other mentioned state departments' employees regarding this bidding opportunity or the contents of this RFP. If any such contact is discovered to have occurred, it may result in the immediate disqualification of the bidder from further consideration.

Proposal Deadline

ALL questionnaires and pricing proposals must be submitted no later than 5 p.m. CT (6 p.m. ET), Wednesday, March 29, 2023.

Disclaimers

MCHCP will not be liable under any circumstances for any expenses incurred by any respondent in connection with the selection process.

The description of coverage and plan design contained in this RFP is solely intended to allow for the preparation and submission of proposals by respondents and does not constitute a promise or guarantee of benefits to any individual.

Confidentiality and Proprietary Materials

Pursuant to Section 610.021 RSMo, proposals and related documents shall not be available for public review until a contract has been awarded or all proposals are rejected. MCHCP maintains copies of all proposals and related documents.

MCHCP is a governmental body under Missouri Sunshine Law (Chapter 610 RSMo). Section 610.011 requires that all provisions be "liberally construed and their exceptions strictly construed to promote" the public policy that records are open unless otherwise provided by law. Regardless of any claim by a bidder as to material being proprietary and not subject to copying or distribution, or how a bidder characterizes any information provided in its proposal, all material submitted by the bidder in conjunction with the RFP is subject to release after the award of a contract in relation to a request for public records under the Missouri Sunshine Law (see Chapter 610 of the Missouri Revised Statutes). Only information expressly permitted by the provisions of Missouri's Sunshine Law to be closed – strictly construed – will be redacted by MCHCP from any public request submitted to MCHCP after an award is made. Bidders should presume information provided to MCHCP in a proposal will be public following the award of the bid and made available upon request in accordance with the provisions of state law.

Evaluation Process

Any apparent clerical error may be corrected by the bidder before contract award. Upon discovering an apparent clerical error, MCHCP shall contact the bidder and request written clarification of the intended proposal. The correction shall be made in the notice of award. Examples of apparent clerical errors are: 1) misplacement of a decimal point; and 2) obvious mistake in designation of unit.

Any pricing information submitted by a bidder must be disclosed on the pricing pages as designated in this RFP. Any pricing information which appears elsewhere in the bidder's proposal shall not be considered by MCHCP.

Awards shall only be made to the bidder(s) whose proposal(s) complies with all mandatory specifications and requirements of the RFP. MCHCP reserves the right to evaluate all offers and based upon that evaluation to limit the number of contract awards or reject any and all offers.

MCHCP reserves the right to request written clarification of any portion of the bidder's response to verify the intent of the bidder. The bidder is cautioned, however, that its response shall be subject to acceptance or rejection without further clarification.

MCHCP reserves the right to consider historic information and fact, whether gained from the bidder's proposal, question and answer conferences, references, or any other source, in the evaluation process. The bidder is cautioned that it is the bidder's sole responsibility to submit information related to the evaluation categories and that MCHCP is under no obligation to solicit such information if it is not included with the bidder's proposal. Failure of the bidder to submit such information may cause an adverse impact on the evaluation of the bidder's proposal.

After determining that a proposal satisfies the mandatory requirements stated in the RFP, the comparative assessment of the relative benefits and deficiencies of the proposal in relationship to the published evaluation criteria shall be made by using subjective judgment. The award of a contract resulting from this RFP shall be based on the lowest and best proposal received in accordance with the evaluation criteria stated below:

Evaluation Criteria

Non-financial:

Provider Network	150 points
Vendor Profile	50 points
Customer Service	50 points
Account Management and Implementation	50 points
Performance Guarantees	50 points
Technology and Security	50 points
Access to Services and Benefits	50 points
Claims Administration	35 points
Reporting	15 points
Sub-total – Non-financial points	500 points
Bonus Points – MBE/WBE Participation Commitment	10 points

Financial:

Price	500 points

Finalist Evaluation:

References	40 points
Finalist Interview	60 points

MCHCP will limit the number of finalists to the bidders receiving 80 percent (400 points) of the possible 500 non-financial points available or the top two bidders if less than two bidders receive 80 percent of the possible 500 non-financial points.

The bidder's proposed participation of MBE/WBE firms in meeting the targets of the RFP will be considered in the evaluation process. A maximum of MBE/WBE participation points of 10 points will be awarded based on the participation amount proposed by the bidder. Awarded MBE/WBE participation points will be added to the non-financial points earned by the bidder and will be included to determine if a bidder meets the 80 percent threshold to obtain finalist status.

Minority Business Enterprise (MBE)/Women Business Enterprise (WBE) Participation

The bidder should secure participation of certified MBEs and WBEs in provider products/services required in this RFP. The targets of participation recommended by the State of Missouri are 10% MBE and 5% WBE of the total dollar value of the contract.

a) These targets can be met by a qualified MBE/WBE vendor themselves and/or through the use of qualified subcontractors, suppliers, joint ventures, or other arrangements that afford meaningful opportunities for MBE/WBE participation.

b) The services performed or the products provided by MBE/WBEs must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract. Therefore, if the services performed or the products provided by MBE/WBEs is utilized, to any extent, in the bidder's obligations outside of the contract, it shall not be considered a valid added value to the contract and shall not qualify as participation in accordance with this clause.

c) In order to be considered as meeting these targets, the MBE/WBEs must be "qualified" by the proposal opening date (date the proposal is due). See below for a definition of a qualified MBE/WBE.

d) If the bidder is proposing MBE/WBE participation, in order to receive evaluation consideration for MBE/WBE participation, the bidder must provide the following information with the proposal.

   a. Participation Commitment - If the bidder is proposing MBE/WBE participation, the vendor must complete Section 11 of the Dental Questionnaire (MBE-WBE Participation Commitment), by listing each proposed MBE and WBE, the committed percentage of participation for each MBE and WBE, and the commercially useful products/services to be provided by the listed MBE and WBE. If the vendor submitting the proposal is a qualified MBE and/or WBE, the vendor must include the vendor in the appropriate table on the Participation Commitment Form.

   b. Documentation of Intent to Participate – The bidder must either provide a properly completed Exhibit A-6, Documentation of Intent to Participate Form, signed and dated no earlier than the RFP issuance date by each MBE and WBE proposed or must provide a letter of intent signed and dated no earlier than the RFP issuance date by each MBE and WBE proposed which: (1) must describe the products/services the MBE/WBE will provide and (2) should include evidence that the MBE/WBE is qualified, as defined herein (i.e., the MBE/WBE Certification Number or a copy of MBE/WBE certificate issued by the Missouri OEO). If the bidder submitting the proposal is a qualified MBE and/or WBE, the bidder is not required to complete Exhibit A-6, Documentation of Intent to Participate Form or provide a recently dated letter of intent.

e) Commitment – If the bidder's proposal is awarded, the percentage level of MBE/WBE participation committed to by the bidder on Exhibit A-6, Participation Commitment, shall be interpreted as a contractual requirement.

Definition -- Qualified MBE/WBE:

In order to be considered a qualified MBE or WBE for purposes of this RFP, the MBE/WBE must be certified by the State of Missouri, Office of Administration, Office of Equal Opportunity (OEO) by the proposal opening date.

MBE or WBE means a business that is a sole proprietorship, partnership, joint venture, or corporation in which at least fifty-one percent (51%) of the ownership interest is held by minorities or women and the management and daily business operations of which are controlled by one or more minorities or women who own it.

Minority is defined as belonging to one of the following racial minority groups: African Americans, Native Americans, Hispanic Americans, Asian Americans, American Indians, Eskimos, Aleuts, and other groups that may be recognized by the Office of Advocacy, United States Small Business Administration, Washington D.C.

A listing of several resources that are available to assist bidders in their efforts to identify and secure the participation of qualified MBEs and WBEs is available at the website shown below or by contacting the Office of Equal Opportunity (OEO) at:

Office of Administration, Office of Equal Opportunity (OEO)
Harry S Truman Bldg., Room 630, P.O. Box 809, Jefferson City, MO 65102-0809
Phone: (877) 259-2963 or (573) 751-8130
Fax: (573) 522-8078
Web site: http://oeo.mo.gov

Pricing

The bidder must provide firm, fixed monthly premiums for all rate tiers. Bidders are required to bid on the benefits as described in the Dental Plan Design included in Exhibit A-8. The bidder must submit firm, fixed premiums if MCHCP awards a single contract and firm, fixed premiums if MCHCP awards multiple contracts.

Any cost and/or pricing data submitted or related to the bidder's proposal including any cost and/or pricing data related to contractual extension options shall be subject to evaluation if deemed by MCHCP to be in the best interests of members of the Plan.

In determining pricing points, MCHCP will consider the potential three-year cost of the program including the full not-to-exceed price for the second and third years of the contract.

The contractor shall understand that annual renewal rates for CY2025 and CY2026 will be negotiated, but must be within the not-to-exceed prices submitted within this bid. Pricing for CY2027 and CY2028 will be negotiated.

Finalist Interview

After an initial screening process, a technical question and answer conference or interview may be conducted, if deemed necessary by MCHCP, to clarify or verify the bidder's proposal and to develop a comprehensive assessment of the proposal. MCHCP reserves the right to interview the proposed account management team. MCHCP may ask additional questions and/or conduct a site visit of the bidder's service center or other appropriate location.

Negotiation and Contract Award

The bidder is advised that under the provisions of this RFP, MCHCP reserves the right to conduct negotiations of the proposals received or to award a contract without negotiations. If such negotiations are conducted, the following conditions shall apply:

- Negotiations may be conducted in person, in writing, or by telephone.
- Negotiations will only be conducted with bidders who provide potentially acceptable proposals. MCHCP reserves the right to limit negotiations to those bidders which received the highest rankings during the initial evaluation phase. All bidders involved in the negotiation process will be invited to submit a best and final offer.
- Terms, conditions, prices, methodology, or other features of the bidder's proposal may be subject to negotiation and subsequent revision. As part of the negotiations, the bidder may be required to submit supporting financial, pricing, and other data in order to allow a detailed evaluation of the feasibility, reasonableness, and acceptability of the proposal.
- The mandatory requirements of the RFP shall not be negotiable and shall remain unchanged unless MCHCP determines that a change in such requirements is in the best interest of MCHCP and its members.
- Bidder understands that the terms of any negotiation are confidential until an award is made or all proposals are rejected.

Any award of a contract resulting from this RFP will be made only by written authorization from MCHCP.

Renewal of Contract

The initial agreement is for the period of January 1, 2024, through December 31, 2024, with up to four additional one-year contracts renewable at the sole option of the MCHCP Board of Trustees.

Proposed pricing for Years 2-3 (CY2025 and CY2026) of this contract, not to exceed the allowed maximum, shall be submitted prior to May 15 of the next plan year. Pricing for Years 4-5 (CY2027 and

CY2028) will be negotiated and is due prior to May 15 of the next plan year. The contractor must also provide supporting documentation that provides the rationale for any requested rate increase each year.

Using DirectPath/Optavise

The 2024 MCHCP Dental RFP contains 2 broad categories of items that you will need to work on via the DirectPath/Optavise application:

1) Items Requiring a Response:

   a) Questionnaires (e.g., Dental Questionnaire, etc.) are online forms to collect your responses to our questions about your capabilities.

   b) Response Documents (e.g., Exhibit A-1 Intent to Bid, etc.) are attachment files (e.g., MS Word or Excel) that are posted to the DirectPath/Optavise website. They should be downloaded, completed and/or signed by your organization, and then posted/uploaded back to the DirectPath/Optavise application. When you upload your response, from the drop-down menu, identify each uploaded document as a *Response* document and associate it to the appropriate document by name. For step-by-step instructions, please refer to the *How to Download and Attach Files* User Guide located in the *Downloads* section on the application homepage.

2) Reference Files from Event Administrator:

   a) Documents (e.g. Exhibit B-Scope of Work) that you should download and read completely before submitting your RFP response.

These components can be found in the DirectPath/Optavise application under the 2024 MCHCP Dental RFP on the Event Details page of the application.

Note that as you use the DirectPath/Optavise application to respond to this RFP, User Guides are accessible throughout the application by clicking on the help icon or from the *Downloads* area of the DirectPath/Optavise application homepage. For help with data entry and navigation throughout the application, you can contact the DirectPath/Optavise staff:

- Phone: 800-979-9351
- E-mail: support@directpathhealth.com

Responding to Questionnaires

We have posted two forms for your response:

- Dental Questionnaire
- Mandatory Contract Provisions Questionnaire

The questionnaires need to be completed and submitted to DirectPath/Optavise by**, Wednesday, March 29, 2023, 5 p.m. CT (6 p.m. ET).**

The questionnaires are located within the *Items Requiring a Response* tab. This tab contains the items you and your team are required to access and respond to. For step-by-step instructions, please refer to the *How to Submit a Questionnaire* User Guide located in the *Downloads* section of the DirectPath/Optavise application homepage. You have the option to “respond online” or through two different off-line (or desktop) tools.

Completing Response Documents

The following exhibits must be completed, signed (if applicable), and uploaded to DirectPath/Optavise:

- Exhibit A-1 – Intent to Bid (due 5 p.m. CT, March 13, 2023)
- Exhibit A-2 – Limited Data Use Agreement (due 5 p.m. CT, March 13, 2023)
- Exhibit A-3 – Proposed Bidder Modifications (due 5 p.m. CT, March 29, 2023)
- Exhibit A-4 – Confirmation Document (due 5 p.m. CT, March 29, 2023)
- Exhibit A-5 – Contractor Certification (due 5 p.m. CT, March 29, 2023)
- Exhibit A-6 – MBE-WBE Intent to Participate Document (due 5 p.m. CT, March 29, 2023)
- Exhibit A-7 – Provider Match (due 5 p.m. CT March 29, 2023)
- Exhibit A-8 – Dental Plan Design and Pricing (due 5 p.m. CT March 29, 2023)

The follow exhibits must be reviewed and the bidder provide any suggested red-lined changes to the documents using Microsoft Word Track Changes functionality. Changes proposed may or may not be accepted by MCHCP.

- Exhibit A-9 – Sample MCHCP Contract (due 5 p.m. CT, March 29, 2023)
- Exhibit A-10 – Sample MCHCP Business Associate Agreement (due 5 p.m. CT, March 29, 2023)

Completing Exhibit A-8 Dental Plan Design and Pricing

The financial worksheet (Exhibit A-8 Dental Plan Design and Pricing.xlsx) may be accessed in *Items Requiring a Response*. The spreadsheet contains worksheets to collect fee quotations based on the stated benefit plan designs. Please be certain to complete all worksheets. **The final bid deadline is Wednesday, March 29, 2023, 5 p.m. CT (6 p.m. ET)**.

Notes Regarding Pricing

Quotes should assume:

- Plan effective date: January 1, 2024

- Submitted prices for CY2024 shall be firm, while prices for CY2025 and CY2026 shall be submitted as “not to exceed” amounts. Proposed prices and plan designs are subject to negotiation prior to the award of a contract by MCHCP.

- Rates for CY2027 and CY2028 will be negotiated.
- Annual renewals are solely at the option of MCHCP. Renewal prices are due by May 15 of each year and are subject to negotiation.

RFP Checklist

Prior to the March 29, 2023, close date, please be sure you have completed and/or reviewed each of the documents listed below:

Type	Document Name
Questionnaire	Dental Questionnaire
Questionnaire	Mandatory Contract Provisions Questionnaire
Response	Exhibit A-1 Intent to Bid.docx DUE: Monday, March 13, 2023
Response	Exhibit A-2 Limited Data Use Agreement.docx DUE: Monday, March 13, 2023
Response	Exhibit A-3 Proposed Bidder Modifications.docx
Response	Exhibit A-4 Confirmation Document.docx
Response	Exhibit A-5 Contractor Certification.docx
Response	Exhibit A-6 MBE-WBE Intent to Participate Document.docx
Response	Exhibit A-7 Provider Match.xlsx
Response	Exhibit A-8 Dental Plan Design and Pricing.xlsx
Response	Exhibit A-9 Sample MCHCP Contract.docx
Response	Exhibit A-10 Sample MCHCP Business Associate Agreement.docx
Reference	Introduction and Instructions – 2024 MCHCP Dental RFP.pdf
Reference	Attachment 1 – Enrollee file layouts.docx
Reference	Attachment 2 – Eligible member file.xlsx (access to this file is granted after receipt of the signed Limited Data Use Agreement)
Reference	Attachment 3 – Dental enrollee file.xlsx (access to this file is granted after receipt of the signed Limited Data Use Agreement)
Reference	Attachment 4 – Example provider file layout.xlsx
Reference	Attachment 5 – Dental claim file layout.docx
Reference	Attachment 6 – Dental experience.xlsx
Reference	Exhibit B – Scope of Work (Dental RFP).docx
Reference	Exhibit C – General Provisions.docx

Contact Information

We understand that content and technical questions may arise. All questions regarding this document and the selection process must be submitted through the online messaging module of the DirectPath/Optavise application by **Monday, March 13, 2023, 5 p.m. CT (6 p.m. ET)**.

For technical questions related to the use of DirectPath/Optavise, please contact the DirectPath/Optavise customer support team at support@directpathhealth.com, or by calling the Customer Support Line at 1-800-979-9351.

SECTION B
SCOPE OF WORK

B1. GENERAL REQUIREMENTS

B1.1 The contractor shall provide a fully-insured dental plan(s) for State and Public Entity eligible and enrolled members in accordance with the provisions and requirements of this document on behalf of Missouri Consolidated Health Care Plan (hereinafter referred to as MCHCP). The contractor understands that in carrying out its mandate under the law, MCHCP is bound by various statutory, regulatory and fiduciary duties and responsibilities and contractor expressly agrees that it shall accept and abide by such duties and responsibilities when acting on behalf of MCHCP pursuant to this engagement. The contractor agrees that any and all subcontracts entered into by the contractor for the purpose of meeting the requirements of this contract are the responsibility of the contractor. MCHCP will hold the contractor responsible for assuring that subcontractors meet all requirements of this contract and all amendments thereto. The contractor must provide complete information regarding each subcontractor used by the contractor to meet the requirements of this contract.

B1.2 The contractor is obligated to follow the performance standards as outlined in Section 10 of the Dental RFP Questionnaire.

B2. ELIGIBILITY REQUIREMENTS - The contractor shall comply and agree with the following regarding eligibility requirements:

B2.1 Eligible State of Missouri members are those employees (including Participating Higher Education Entities and eligible foster parents), retirees and their dependents who are eligible members of MCHCP as defined in the statutes, rules and regulations or revision(s) to such. MCHCP is the sole source in determining eligibility. The following information is provided primarily as general information to the bidder. Eligibility shall also be available to Missouri Department of Transportation and Highway Patrol, and the Missouri Department of Conservation active employees and their dependents.

B2.2 Eligibility periods:

B2.2.1 Employees and their dependents can enroll during the employee’s or dependent’s initial period of eligibility.

B2.2.2 Open enrollment shall be the period announced by MCHCP to allow eligible individuals to change coverage or add eligible dependents. It is anticipated, but not guaranteed, that open enrollment for coverage effective January 1 of the following year will be October 1 – October 31. MCHCP reserves the right to create a special emergency enrollment period as it deems necessary.

B2.2.3 Eligible individuals may be allowed to enroll throughout the year during special enrollment periods as outlined in 22 CSR 10-2.020(3) and 22 CSR 10-3.030(3).

B2.3 Termination: The contractor must agree that:

B2.3.1 A member's coverage under this agreement terminates under those conditions specified in statute and MCHCP regulations.

B2.3.2 The contractor shall not regard a member as terminated until the contractor receives an official termination notice directly from MCHCP. However, the contractor may suspend coverage on a member if payment for that member is not received, unless otherwise prohibited by law.

B2.4 Continuation of Coverage:

B2.4.1 The contractor shall comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Public Law 99-272, as amended, and provide the required maximum period of continuation coverage for eligible members. The contractor must agree that MCHCP will administer COBRA and will retain the additional 2 percent premium.

B3. LEVEL OF BENEFITS

B3.1 The contractor must administer the minimum benefits, in terms of covered services and member responsibility, as described in the stated plan design. Bidders may separately propose additional services or options to be included in the plan design at MCHCP’s discretion.

B3.2 The contractor must agree to waive the one-year waiting period for major services for those members who can provide evidence of at least one year of prior dental coverage through MCHCP’s current dental plan or any other comparable dental plan.

B3.3 Under no circumstances shall the contractor require a member to pay for any dental services except for stated premiums, deductibles, co-payments, coinsurance, balance billing resulting from non-network services and non-covered services. Members shall not be required to pay any additional enrollment fees, application fees or other charges in addition to the monthly premium.

B3.4 The contractor shall annually provide MCHCP a copy of its Certificate of Insurance by January 1 of each year.

B4. REPORTING REQUIREMENTS

B4.1 The contractor agrees that all data required by MCHCP shall be confidential and will not be public information. The contractor further agrees not to disclose this or similar information to any person or company, either directly or indirectly.

B4.2 MCHCP reserves the right to retain a third-party contractor (currently Merative) to receive claims-level data from the contractor and store the data on MCHCP’s behalf. This includes a full claim file including, but not limited to all financial, demographic and utilization fields. The contractor agrees to cooperate with MCHCP’s designated third-party contractor in the fulfillment of the contractor's duties under this contract, including the provision of data as specified without constraint on its use. The contractor shall agree to:

B4.2.1 Provide person-level claims and utilization data to MCHCP and/or MCHCP's data vendor in a format specified by MCHCP with the understanding that the data shall be owned by MCHCP;

B4.2.2 Provide data in an electronic form and within a time frame specified by MCHCP;

B4.2.3 Place no restraints on use of the data, provided MCHCP has in place procedures to protect the confidentiality of the data consistent with HIPAA requirements; and

B4.2.4 This obligation continues for a period of one year following contract termination.

B4.3 The contractor shall submit standard reports to MCHCP on a quarterly and annual basis. MCHCP and the contractor will negotiate the format and content upon award of this contract. The reports shall be submitted to MCHCP quarterly and are due within 30 days of the end of the quarter reported. Annual reports are due within 45 days of the end of the year.

B4.4 The contractor shall provide quarterly reports detailing customer service telephone answer time and abandonment. The reports shall be submitted to MCHCP quarterly and are due within 30 days of the end of the quarter reported.

B4.5 At the request of MCHCP and at the contractor's expense, the contractor agrees to conduct an annual customer satisfaction survey, and provide MCHCP with all information and responses in connection therewith.

B4.6 At the request of MCHCP, the contractor shall submit additional ad hoc reports on information and data readily available to the contractor.

B4.7 MCHCP will determine the acceptability of all reports submitted based upon timeliness, format, and content. If reports are not deemed to be acceptable or have not been submitted as requested, the contractor will receive written notice to this effect and the applicable performance guarantee penalty will be assessed.

B5. PAYMENTS

B5.1 The contractor shall agree that the monthly premium due the contractor will be self-billed and will be initiated for electronic payment via automated clearing house (ACH) on the twentieth of the month following the month of coverage. MCHCP will remit all payments and provide all associated reports electronically.

B5.2 The contractor shall have the right to audit appropriate MCHCP records to determine the accuracy of the monthly premium paid.

B5.2.1 Any discrepancies must be identified by the contractor within 90 days after receipt of the payment and such discrepancy must be submitted in writing to MCHCP. Failure to identify a discrepancy within the time frame stated shall be considered as acceptance of MCHCP's calculations, payment and records.

B6. GENERAL SERVICE REQUIREMENTS

B6.1 The contractor shall agree that any state and/or federal laws and applicable rules and regulations enacted during the terms of the contract which are deemed by MCHCP to necessitate a change in the contract shall be incorporated into the contract. MCHCP will review any request for additional fees or premium resulting from such changes and retains final authority to make any changes. A consultant may be utilized to determine the cost impact.

B6.2 The contractor must agree that during the life of the contract or any extension thereof, MCHCP and auditors designated by MCHCP shall have access to and the right to examine any pertinent books, documents, papers, or records of the contractor involving any and all transactions related to the performance of the contract. Also, the contractor must furnish all information necessary for MCHCP to comply with all state and/or federal regulations. MCHCP would be responsible for the cost of any such audit or review.

B6.3 Appeal/Grievance Procedure

B6.3.1 The contractor shall have the responsibility to perform a complete investigation of all complaints, grievances and appeals and make decisions regarding medical necessity and the provision of services or benefits.

B6.3.2 The contractor shall have a timely and organized system for resolving members' complaints and grievances in compliance with state and federal laws and regulations, as amended.

B6.3.3 If the member's grievance is not resolved to his or her satisfaction, the member has the right to a formal appeal to the contractor. The contractor's appeal process shall be in compliance with state and federal laws and regulations as amended.

B7. ACCOUNT MANAGEMENT

B7.1 The contractor shall establish and maintain throughout the term of the contract an account management team that will work directly with MCHCP staff. This team must include, but is not limited to, a dedicated account executive, a customer service manager, clinical advisor, a person responsible for preparing the reports and an information technology representative. Approval of the account management team rests with MCHCP. The account executive and service representative(s) will deal directly with MCHCP's benefit administration staff. The account management team must:

B7.1.1 Be able to devote the time needed to the account, including being available for telephone and on-site consultation with MCHCP. Bidders who are not committed to account service will not receive serious consideration.

B7.1.2 Be extremely responsive.

B7.1.3 Be comprised of individuals with specialized knowledge of the contractor's networks, claims and eligibility systems, system reporting capabilities, claims adjudication policies and procedures, administrative services, and relations with third parties.

B7.1.4 Be thoroughly familiar with virtually all of the contractor's functions that relate directly or indirectly to the MCHCP account.

B7.1.5 Act on behalf of MCHCP in cutting through the bureaucracy of the contractor's organization. The account management team must be able to effectively advance the interest of MCHCP through the contractor's corporate structure.

B7.1.6 The contractor agrees to provide MCHCP with at least 15 days advance notice of any material change to its account management and servicing methodology or to a personnel change in the contractor's account management and servicing team.

B7.2 MCHCP requires the contractor to meet with MCHCP staff and/or Board of Trustees as requested to discuss the status of the MCHCP account in terms of utilization patterns and costs, as well as propose new ideas that may benefit MCHCP and its members.

B7.2.1 The contractor is expected to present actual MCHCP claims experience and offer suggestions as to ways the benefit could be modified to reduce costs or improve the health of MCHCP members. Suggestions must be modeled against actual MCHCP membership and claims experience to determine the financial impact as well as the number of members impacted.

B7.2.2 The contractor must also present benchmark data by using the plan's entire book of business, a comparable client to MCHCP, or some other industry norm.

B8. CUSTOMER SERVICE

B8.1 The contractor must provide a high quality and experienced customer service unit. The dental plan staff members must be fully trained in the MCHCP benefit design, and the contractor must have the ability to track and report performance in terms of telephone response time, call abandonment rate, and the number of inquiries made by type.

B8.2 The contractor shall maintain a toll-free telephone line to provide prompt access for members and providers to qualified customer service personnel. At a minimum, customer service must be available between the hours of 8:00 a.m. and 5:00 p.m. Central Time (CT) Monday through Friday except for designated holidays.

B8.3 The contractor shall refer any and all questions received from members regarding eligibility or premiums to MCHCP.

B8.4 The contractor is responsible for developing, printing, and mailing any necessary identification cards directly to the member's home. The contractor is responsible for these production and mailing costs.

B8.5 The contractor shall agree that MCHCP reserves the right to review and approve all written communications and marketing materials developed and used by the contractor to communicate specifically with MCHCP members at any time during the contract period. This does not refer to items such as provider directories and plan-wide newsletters as long as they do not contain information on eligibility, enrollment, benefits, rates, etc., which MCHCP must review. Notwithstanding the foregoing, nothing herein prohibits contractor from communicating directly with members in the regular course of providing services under the contract (e.g., responding to member inquiries, etc.).

B8.6 No provider may be listed on the contractor's website or distributed to the membership through the dental plan's customer service unit unless a signed contract is in place. In the event a plan provides incorrect information and a member seeks treatment based on that information, the contractor agrees to recognize and be financially responsible for any services rendered by that provider, under the terms of this contract, as if the provider had been under contract.

B9. INFORMATION TECHNOLOGY AND ELIGIBILITY FILE

B9.1 The contractor shall be able to accept, via secure file transfer, all MCHCP eligibility information on a weekly basis utilizing the ASC X12N 834 (005010X095A1) transaction set. MCHCP will supply specific record set information in an electronic format and the contractor must process such information within 24 hours of receipt. The contractor must provide a dedicated technical contact that will provide support to MCHCP Information Technology Department for any EDI issues. MCHCP is willing to work with the contractor on these requirements after the contract is awarded.

B9.1.1 It is MCHCP's intent to send a transactional based eligibility file weekly and a periodic full eligibility reconciliation file. Contractor is expected to provide an audit report of this reconciliation for MCHCP review of accuracy.

B9.1.2 MCHCP will provide a recommended data mapping for the 834 transaction set to the contractor after the contract is awarded, and is willing to work with the contractor on any specific needs to ensure accuracy and timeliness.

B9.1.3 Within two business days after processing any eligibility related file, the contractor will provide a report that lists any errors and exceptions that occurred during processing. The report will also provide record counts, error counts and list the records that had an error, along with an error message to indicate why it failed. A list of the conditions the contractor audits will be provided to ensure the data MCHCP is sending will pass the contractor's audit tests.

B9.1.4 The contractor shall provide access to view member data on their system via a web based "Employer Portal" to ensure MCHCP provided eligibility files are correctly updating the contractor's system, and for MCHCP member support to verify individual member specific information on demand.

B9.1.5 The contractor will supply a data dictionary of the fields MCHCP is updating on their system and the allowed values for each field.

B9.1.6 The contractor shall provide MCHCP with a monthly file ("eligibility audit file") in a mutually agreed upon format of contractor's eligibility records for all MCHCP members. Such file shall be utilized by MCHCP to audit contractor's records. Such eligibility audit file shall be provided to MCHCP no later than the second Thursday of each month.

B9.1.7 The required method for all file transfers is Secure FTP. No PGP is required but can be implemented upon request. MCHCP will provide an account for the contractor transfers at ftp.mchcp.org.

B9.2 The contractor must be able to support single sign-on from MCHCP's own Member Portal to the contractor's Member Portal utilizing Security Assertion Markup Language (SAML2). MCHCP is willing to work with the contractor on the specifics of this requirement after the contract is awarded.

B9.3 The contractor must work with MCHCP to develop a schedule for testing of the eligibility test record set and error reporting responses. MCHCP requires that the contractor accept and run an initial test record set no later than October 15, 2023. Results of the test must be provided to MCHCP by October 30, 2023. Final acceptance of all eligibility file formats and responses are expected no later than November 30, 2023.

B9.4 The contractor must have a website that is updated regularly. The website must include the ability for MCHCP members to obtain current listings of active network providers and other information. The provider listing must be searchable, at a minimum, by zip code, specialty, and provider name. If MCHCP discovers that provider information contained at the contractor's website is inaccurate, MCHCP will notify the contractor immediately. The contractor must correct inaccuracies within 10 days of being notified by MCHCP.

B10. IMPLEMENTATION

B10.1 The contractor and MCHCP must agree to a final implementation schedule within 30 days of the contract award. At a minimum, the timeline must include the required dates for the following activities:

- Testing of eligibility file;
- Acceptable date for final eligibility file;
- ID card production and distribution;
- Enrollment kit printing
- Testing of claim file to data warehouse vendor

B10.2 The contractor must have a customer service unit in place to answer member inquiries. Note: Open enrollment is anticipated to be October 1-31, 2023, with coverage effective January 1, 2024. At a minimum, the customer service unit must be able to address network and benefit issues.

B11. CONTRACTED NETWORK

B11.1 The contractor must have in place a contracted provider network which will offer access to all MCHCP members nationwide to assure that all services will be accessible without unreasonable delay or unreasonable travel. The contractor shall notify MCHCP within five (5) business days if the networks' geographic access changes from what is proposed by the contractor.

B11.2 The offered network must include a full range of general dental practitioners and dental specialists. Contractors are responsible for having a network available that can provide access to all covered services under this contract and to meet member needs within reasonable geography and reasonable time.

B11.3 MCHCP requires that network providers be responsible for obtaining all necessary pre-certifications, pre-authorizations, and filing claims for members.

B11.4 At a minimum, ninety percent (90%) of MCHCP members shall have access to a network general dentist provider within twenty (20) miles of their zip code. The contractor shall report network geographic access analysis results to MCHCP by January 31 of each year or within 30 days after a material network change.

B11.5 The contractor shall pay covered services as a network benefit when provided by a non-network provider in the instance that the service is not available through a network provider within seventy-five (75) miles of the member's home or in a reasonable appointment availability time. The member must seek approval from the contractor before the date of service to have the non-network provider's claims approved as a network benefit. Such approval shall be granted for a minimum three (3) month period.

B12. MCHCP REQUIREMENTS AND SERVICE

B12.1 MCHCP will provide the following administrative services to assist the contractor:

- Certification of eligibility
- Enrollments (new, change, and terminations) in an electronic format
- Maintenance of individual eligibility and membership data
- Payment of monies due the contractor
- Coordination of open enrollment period
- Administration of COBRA regulations

EXHIBIT C
GENERAL PROVISIONS

C1. TERMINOLOGY AND DEFINITIONS

Whenever the following words and expressions appear in this Request for Proposal (RFP) document or any amendment thereto, the definition or meaning described below shall apply.

C1.1 **Amendment** means a written, official modification to an RFP or to a contract.

C1.2 **Bidder** means a person or organization who submitted an offer in response to this RFP.

C1.3 **Breach** shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exceptions set forth, in 45 C.F.R. 164.402.

C1.4 **Contract** means a legal and binding agreement between two or more competent parties, in consideration for the procurement of services as described in this RFP.

C1.5 **Contractor** means a person or organization who is a successful bidder as a result of an RFP and/or who enters into a contract or any subcontract of a successful bidder.

C1.6 **Employee** means a benefit-eligible person employed by the state and present and future retirees from state employment who meet the plan eligibility requirements.

C1.7 **May** means that a certain feature, component, or action is permissible, but not required.

C1.8 **Member** means any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

C1.9 **Must** means that a certain feature, component, or action is a mandatory condition. Failure to provide or comply may result in a proposal being considered non-responsive.

C1.10 **Off-shore** means outside of the United States.

C1.11 **Participant** has the same meaning as the word member.

C1.12 **PHI** shall mean Protected Health Information, as defined in 45 C.F.R. 160.103, as amended.

C1.13 **Pricing Pages** apply to the form(s) on which the bidder must state the price(s) applicable for the services required in the RFP. The pricing pages must be completed and uploaded by the bidder prior to the specified proposal filing date and time.

C1.14 **Privacy Regulations** shall mean the federal privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, codified at 45 C.F.R. Parts 160 and 164 (Subparts A & E).

C1.15 **Proposal Filing Date and Time** and similar expressions mean the exact deadline required by the RFP for the receipt of proposals by DirectPath/Optavise system.

C1.16 **<u>Provider</u>** means a physician, hospital, medical agency, specialist or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2010(22). Other providers include but are not limited to:

- C1.16.1 Audiologist (AUD or PhD);
- C1.16.2 Certified Addiction Counselor for Substance Abuse (CAC);
- C1.16.3 Certified Nurse Midwife (CNM) – when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;
- C1.16.4 Certified Social Worker or Masters in Social Work (MSW)
- C1.16.5 Chiropractor;
- C1.16.6 Licensed Clinical Social Worker
- C1.16.7 Licensed Professional Counselor (LPC);
- C1.16.8 Licensed Psychologist (LP);
- C1.16.9 Nurse Practitioner (NP);
- C1.16.10 Physician Assistant (PA);
- C1.16.11 Occupational Therapist;
- C1.16.12 Physical Therapist;
- C1.16.13 Speech Therapist;
- C1.16.14 Registered Nurse Anesthetist (CRNA);
- C1.16.15 Registered Nurse Practitioner (ARNP); or
- C1.16.16 Therapist with a PhD or Master's Degree in Psychology or Counseling.

C1.17 **<u>Request for Proposal (RFP)</u>** means the solicitation document issued by MCHCP to potential bidders for the purchase of services as described in the document. The definition includes these Terms and Conditions as well as all Pricing Pages, Exhibits, Attachments, and Amendments thereto.

C1.18 **<u>Respondent</u>** means any party responding in any way to this RFP.

C1.19 **<u>Retiree</u>** means a former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020(2)(B) and is currently receiving a monthly retirement benefit from a retirement system listed in such rule.

C1.20 **<u>RSMo (Revised Statutes of Missouri)</u>** refers to the body of laws enacted by the Legislature, which govern the operations of all agencies of the State of Missouri. Chapter 103 of the statutes is the primary chapter governing the operations of MCHCP.

C1.21 **<u>Shall</u>** has the same meaning as the word must.

C1.22 **<u>Should</u>** means that certain feature, component and/or action is desirable but not mandatory.

C1.23 **<u>Subscriber</u>** means the person who elects coverage under the plan.

C2. GENERAL BIDDING PROVISIONS

C2.1 It shall be the bidder's responsibility to ask questions, request changes or clarification, or otherwise advise MCHCP if any language, specifications or requirements of an RFP appear to be ambiguous, contradictory, and/or arbitrary, or appear to inadvertently restrict or limit the requirements stated in the RFP to a single source. Any and all communication from bidders regarding specifications, requirements, competitive procurement process, etc., must be directed to MCHCP via the messaging tool on the DirectPath/Optavise web site, as indicated on the last page of the *Introduction and Instructions* document of the RFP. Such communication must be received no later than Monday, March 13, 2023, 5 p.m. CT (6 p.m. ET).

Every attempt shall be made to ensure that the bidder receives an adequate and prompt response. However, to maintain a fair and equitable procurement process, all bidders will be advised, via the issuance of an amendment or other official notification to the RFP, of any relevant or pertinent information related to the procurement. Therefore, bidders are advised that unless specified elsewhere in the RFP, any questions received by MCHCP after the date noted above might not be answered.

It is the responsibility of the bidder to identify and explain any part of their response that does not conform to the requested services described in this document. Without documentation provided by the bidder, it is assumed by MCHCP that the bidder can provide all services as described in this document.

C2.2 Bidders are cautioned that the only official position of MCHCP is that position which is stated in writing and issued by MCHCP in the RFP or an amendment thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.

C2.3 MCHCP monitors all procurement activities to detect any possibility of deliberate restraint of competition, collusion among bidders, price-fixing by bidders, or any other anticompetitive conduct by bidders, which appears to violate state and federal antitrust laws. Any suspected violation shall be referred to the Missouri Attorney General's Office for appropriate action.

C2.4 No contract shall be considered to have been entered into by MCHCP until the contract has been awarded by the MCHCP Board of Trustees and all material terms have been finalized. The contract is expected to be finalized and signed by a duly authorized representative of Contractor in less than fifteen (15) days from MCHCP's initial contact to negotiate a contract. An award will not be made until all contract terms have been accepted.

C3. PREPARATION OF PROPOSALS

C3.1 Bidders must examine the entire RFP carefully. Failure to do so shall be at the bidder's risk.

C3.2 Unless otherwise specifically stated in the RFP, all specifications and requirements constitute minimum requirements. All proposals must meet or exceed the stated specifications and requirements.

C3.3 Unless otherwise specifically stated in the RFP, any manufacturer's names, trade names, brand names, and/or information listed in a specification and/or requirement are for informational purposes only and are not intended to limit competition. Proposals that do not comply with the requirements and specifications are subject to rejection without clarification.

C4. DISCLOSURE OF MATERIAL EVENTS

C4.1 The bidder agrees that from the date of the bidder's response to this RFP through the date for which a contract is awarded, the bidder shall immediately disclose to MCHCP:

C4.1.1 Any material adverse change to the financial status or condition of the bidder;

C4.1.2 Any merger, sale or other material change of ownership of the bidder;

C4.1.3 Any conflict of interest or potential conflict of interest between the bidder's engagement with MCHCP and the work, services or products that the bidder is providing or proposes to provide to any current or prospective customer; and

C4.1.4 (1) Any material investigation of the bidder by a federal or state agency or self-regulatory organization; (2) Any material complaint against the bidder filed with a federal or state agency or self-regulatory organization; (3) Any material proceeding naming the bidder before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming the bidder as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken against the bidder by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against the bidder as a result of any material criminal or civil action in which the bidder was a party; or (7) Any other matter material to the services rendered by the bidder pursuant to this RFP.

C4.1.4.1 For the purposes of this paragraph, "material" means of a nature, or of sufficient monetary value, or concerning a subject which a reasonable party in the position of and comparable to MCHCP would consider relevant and important in assessing the relationship and services contemplated by this RFP. It is further understood that in fulfilling its ongoing responsibilities under this paragraph, the bidder is obligated to make its best faith efforts to disclose only those relevant matters which come to the attention of or should have been known by the bidder's personnel involved in the engagement covered by this RFP and/or which come to the attention of or should have been known by any individual or office of the bidder designated by the bidder to monitor and report such matters.

C4.2 Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to either reject the proposal or continue evaluating the proposal.

C5. COMPLIANCE WITH APPLICABLE FEDERAL LAWS

C5.1 In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall comply with all applicable requirements and provisions of the Health Insurance Portability and Accountability Act (HIPAA) and The Patient Protection and Affordable Care Act (PPACA), as amended.

C5.2 Any bidder offering to provide services must be able to sign a Business Associate Agreement (BAA) (see Exhibit A-10) due to the provisions of HIPAA. Any requested changes shall be noted and returned with the RFP**. The changes are accepted only upon MCHCP signing a revised BAA after contract award.**

C5.3 Upon awarding of the contract by the Board, the BAA shall be signed by both parties within five (5) working days of the request to sign, or the award of the contract may be rescinded.

ATTACHMENT 1

LAYOUT FOR MCHCP ENROLLEE FILE (Attachment 2)

Field Name	**Description**
ID	Number assigned by MCHCP
Relation	Identifies if member is subscriber, spouse, or child 1 – subscriber 2 – spouse 3 – child
Cov Level	Identifies subscriber's level of coverage MI – Employee Only MS – Employee and Spouse MC – Employee and Child(ren) MF – Employee, Spouse, and Child(ren) SC – Surviving Child NC – No Coverage
Status	Identifies status of member ACT – Active Employee RTN – Retired Employee NC – No Coverage
Zip	5-Digit Zip Code
YOB	Year of Birth (YYYY)
Gender	M – Male F – Female
State or Public Entity	S – State PE – Public Entity member

Total record count = 94,699

ATTACHMENT 1

LAYOUT FOR MCHCP DENTAL ENROLLEE FILE (Attachment 3)

Field Name	**Description**
ID	Number assigned by MCHCP
Relation	Identifies if member is subscriber, spouse, or child 1 – subscriber 2 – spouse 3 – child
Coverage Level	Identifies subscriber's level of coverage MI – Employee Only MS – Employee and Spouse MC – Employee and Child(ren) MF – Employee, Spouse, and Child(ren)
Status	Identifies status of member ACT – Active Employee RTN – Retired Employee
Zip	5-Digit Zip Code
YOB	Year of Birth
Gender	M – Male F – Female
State or Public Entity	S – State PE – Public Entity member

Total record count = 81,533

Attachment 4
Sample Provider File Layout

Each dentist should have the same number of records as number of office locations. The example below is for a dentist with 2 office locations.															
License	TIN	Lname	First	MI	Title	Role 1	Role 2	Accept	Street 1	Street 2	City	State	Zip	Phone	County
R1234	555555555	Doe	John	J	DDS	General	SPEC	Y	123 West High	Suite 300	Columbia	MO	65202	5735555555	Boone
R1234	555555555	Doe	John	J	DDS	General	SPEC	Y	456 Forum		Columbia	MO	65202	5734444444	Boone

Attachment 5

Dental Claims Functional Specifications for File Layout - Detail Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type, for example void, adjustment and original.	Yes	Adjustment Type values will be identified in the Data Dictionary.
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.		Format 9(8)v99 (2 - digit, implied decimal)
3	Capitated Service Indicator	12	12	1	Character	An indicator that this service (encounter record) was capitated		Applicable field values are "Y" for Capitated services and "N" for non-cap services.
4	Charge Submitted	13	22	10	Numeric	The submitted or billed charge amount		Format 9(8)v99 (2 - digit, implied decimal)
5	Claim ID	23	37	15	Character	The client-specific identifier of the claim.		
6	Co-Insurance	38	47	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 - digit, implied decimal)
7	Copayment	48	57	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 - digit, implied decimal)
8	HRA Amount	58	67	10	Numeric	The amount paid from the HRA as a result of this claim.		Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
9	HSA Amount	68	77	10	Numeric	The amount paid from the HSA as a result of this claim.		Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
10	Date of Birth	78	87	10	Date	The birth date of the person.		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
11	Date of First Service	88	97	10	Date	The date of the first service reported on the claim or authorization record.		MM/DD/CCYY format
12	Date of Last Service	98	107	10	Date	The date of the last service reported on the claim or authorization record.		MM/DD/CCYY format
13	Date Paid	108	117	10	Date	The date the claim or data record was paid.		MM/DD/CCYY format This is the check date.
14	Deductible	118	127	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.		Format 9(8)v99 (2 - digit, implied decimal)
15	Diagnosis Code Principal	128	135	8	Character	The first or principal diagnosis code for a service, claim or lab result. Length expanded from 5 to 8 for future use.		No decimal point.
16	Diagnosis Code 2 UB	136	143	8	Character	A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use.		No decimal point.
17	Diagnosis Code 3 UB	144	151	8	Character	A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use.		No decimal point.
18	Diagnosis Code 4 UB	152	159	8	Character	A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use.		No decimal point.
19	Diagnosis Code 5 UB	160	167	8	Character	A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use.		No decimal point.
20	Diagnosis Code 6 UB	168	175	8	Character	A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use.		No decimal point.

Attachment 5

Dental Claims Functional Specifications for File Layout - Detail Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
21	Diagnosis Code 7 UB	176	183	8	Character	A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use.		No decimal point.
22	Diagnosis Code 8 UB	184	191	8	Character	A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use.		No decimal point.
23	Diagnosis Code 9 UB	192	199	8	Character	A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use.		No decimal point.
24	Diagnosis Code 10 UB	200	207	8	Character	A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use.		No decimal point.
25	Discount	208	217	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.		Format 9(8)v99 (2 - digit, implied decimal)
26	Family ID / Employee SSN	218	226	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
27	Gender Code	227	227	1	Character	The member's gender code.		"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
28	Line Number	228	229	2	Numeric	The detail line number for the service on the claim		
29	Net Payment	230	239	10	Numeric	The actual check amount for the record		Format 9(8)v99 (2 - digit, implied decimal)
30	Network Paid Indicator	240	240	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level		Y or "N"
31	Network Provider Indicator	241	241	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs		Y or "N"
32	Ordering Provider ID	242	254	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.		The ID should be the physician's Federal Tax ID (TIN).
33	Ordering Provider Name	255	284	30	Character	The Name of the provider who referred the patient or ordered the test or procedure.		
34	Ordering Provider Zip Code	285	289	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.		
35	PCP Responsibility Indicator	290	290	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.		
36	Place of Service Code	291	292	2	Character	Client-specific code for the place of service.	Yes	Place of Service values will be identified in the Data Dictionary.
37	Procedure Code	293	299	7	Character	The procedure code for the service record. Expanded from 5 to 7 for future use.		ADA codes.
38	Procedure Modifier Code	300	301	2	Character	The 2-character code of the first procedure code modifier on the professional claim.		
39	Provider ID	302	314	13	Character	The identifier for the provider of service.		This must be the federal tax ID in order to use the Standard Physician lookup.
40	Provider Type Code Claim	315	317	3	Numeric	Client-specific code for the provider type on the claim record	Yes	Provider Type codes values will be identified in the Data Dictionary.
41	Provider Zip Code	318	322	5	Character	The 5-digit zip code corresponding to the Provider ID		Provider Location zip code
42	Third Party Amount	323	332	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Format 9(8)v99 (2 – digit, implied decimal)
43	Units of Service	333	336	4	Numeric	Client-specific quantity of services or units		
44	Provider Name	337	366	30	Character	The description or name corresponding to the Provider ID.		

Attachment 5

Dental Claims Functional Specifications for File Layout - Detail Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
45	Funding Type Code	367	368	2	Character	Specifies whether the claim was paid under a fully or self-funded arrangement		“S” = Self-funded “F” = Fully-funded
46	Account Structure	369	376	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Yes	Additional fields may be added to the layout if there is more than one component of the account structure.
47	Provider NPI Number	377	386	10	Character	The National Provider ID number for the provider.		
48	Provider Address 1	387	436	50	Character	The current street address1 of the provider of service.		
49	Provider Address 2	437	486	50	Character	The current street address2 of the provider of service.		
50	Tooth Code	487	488	2	Character	The standard ADA tooth code for the dental claim record.	Yes	
51	Tooth Surface Code	489	493	5	Character	The tooth surface code for dental claims.	Yes	
52	ICD Version	494	494	1	Character	The ICD version or qualifier code that identifies either ICD-9 (9) or ICD-10 (0) diagnosis codes.	See Notes	If 0 and 9 not used, values defined in the Data Dictionary.
53	Filler	495	999	505	Character	Reserved for future use		Fill with blanks
54	Record Type	1000	1000	1	Character	Record type identifier		Hard Code to "D"

Attachment 5

Dental Claims Functional Specifications for File Layout - Trailer Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Fixed-Record Length							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	999	955	Character	Reserved for future use	Fill with Blanks
6	Record Type	1000	1000	1	Character	Record Type Identifier	Hard Code ‘T’

Attachment 6

MISSOURI CONSOLIDATED HEALTH CARE PLAN

Dental - Monthly

Coverage	Month	Employee Lives	Member Lives	Premium	Claims	EOBs
			State			
Dental	01/01/2021	43,563	63,908	$1,686,520	$1,409,861	9,510
Dental	02/01/2021	43,495	63,789	$1,683,903	$1,416,984	9,198
Dental	03/01/2021	43,425	63,684	$1,680,877	$1,844,232	12,560
Dental	04/01/2021	43,284	63,455	$1,674,959	$1,702,795	11,274
Dental	05/01/2021	43,204	63,340	$1,672,704	$1,584,895	10,132
Dental	06/01/2021	43,023	63,066	$1,665,663	$1,664,074	11,018
Dental	07/01/2021	42,861	62,838	$1,658,946	$1,644,421	11,066
Dental	08/01/2021	42,717	62,616	$1,653,096	$1,673,022	11,443
Dental	09/01/2021	42,656	62,462	$1,648,412	$1,537,512	10,463
Dental	10/01/2021	42,523	62,248	$1,641,404	$1,557,144	10,890
Dental	11/01/2021	42,416	62,065	$1,636,476	$1,576,453	10,575
Dental	12/01/2021	42,340	61,902	$1,631,582	$1,744,742	11,244
Dental	01/01/2022	42,729	62,588	$1,697,244	$1,386,947	9,458
Dental	02/01/2022	42,718	62,521	$1,694,721	$1,344,623	8,818
Dental	03/01/2022	42,630	62,361	$1,691,540	$1,913,097	12,986
Dental	04/01/2022	42,613	62,287	$1,688,138	$1,763,781	11,553
Dental	05/01/2022	42,674	62,337	$1,688,254	$1,641,781	10,813
Dental	06/01/2022	42,788	62,473	$1,691,863	$1,699,376	11,327
Dental	07/01/2022	42,854	62,493	$1,691,258	$1,534,776	10,203
Dental	08/01/2022	42,973	62,624	$1,693,867	$1,703,819	11,598
Dental	09/01/2022	43,091	62,728	$1,694,609	$1,575,028	10,752
Dental	10/01/2022	43,111	62,711	$1,694,094	$1,564,933	10,781
Dental	11/01/2022	43,152	62,793	$1,697,101	$1,603,122	11,132
Dental	12/01/2022	43,215	62,846	$1,698,600	$1,614,150	10,687
			Public Entity			
Dental	01/01/2021	391	473	$11,702	$8,031	52
Dental	02/01/2021	396	477	$11,761	$6,769	57
Dental	03/01/2021	395	475	$11,714	$11,886	73
Dental	04/01/2021	392	474	$11,725	$9,657	73
Dental	05/01/2021	383	464	$11,522	$10,929	60
Dental	06/01/2021	384	464	$11,553	$8,505	61
Dental	07/01/2021	382	461	$11,392	$7,635	56
Dental	08/01/2021	380	461	$11,421	$8,665	67
Dental	09/01/2021	384	463	$11,468	$8,417	65
Dental	10/01/2021	381	459	$11,374	$8,784	58
Dental	11/01/2021	381	457	$11,281	$10,746	64
Dental	12/01/2021	386	461	$11,340	$8,139	71
Dental	01/01/2022	438	536	$13,791	$10,414	60
Dental	02/01/2022	439	536	$13,789	$6,836	58
Dental	03/01/2022	435	531	$13,574	$10,562	94
Dental	04/01/2022	437	534	$13,707	$8,601	76
Dental	05/01/2022	437	532	$13,622	$9,469	74
Dental	06/01/2022	432	527	$13,526	$11,674	79
Dental	07/01/2022	428	521	$13,354	$9,166	67
Dental	08/01/2022	425	517	$13,257	$9,291	76
Dental	09/01/2022	424	517	$13,318	$7,905	68
Dental	10/01/2022	429	522	$13,449	$9,101	72
Dental	11/01/2022	427	522	$13,417	$8,428	67
Dental	12/01/2022	433	528	$13,595	$6,223	59

State:
2021 in-network paid claims utilization = 82.4%

2022 in-network paid claims utilization = 82.6%

Public Entity:
2021 in-network paid claims utilization = 76.3%

2022 in-network paid claims utilization = 76.6%

Exhibit A-1

Intent to Bid – 2024 MCHCP Dental RFP

(Signing this form does not mandate that a vendor must bid)

Please complete this form following the steps listed below:

1) Complete this form and sign it with your electronic signature.

2) Upload the completed document to the Response Documents area of the RFP no later than Monday, March 13, 2023, at 5 p.m. CT (6 p.m. ET).

Minimum Bidder Requirements

To be considered for contract award, bidders must meet the following minimum requirements:

- Licensing – The bidder must hold a certificate of authority to do business in the State of Missouri and be in good standing with the office of the Missouri Secretary of State and the Missouri Department of Commerce and Insurance. MCHCP requires the contractor to comply with all state and federal laws, rules and regulations affecting their conduct of business on their own behalf and on behalf of a covered entity such as MCHCP.

- Data Transfer – Bidder shall agree to provide claim-level data electronically to MCHCP or designated data vendor (currently Merative) monthly. Bidders may be required to demonstrate the ability to provide such data before a contract award is made.

- Size and Experience – The bidder or its partner must currently provide dental coverage to employers that have at least 250,000 covered lives combined and have at least one (1) client with 50,000 covered lives. The bidder must be willing to disclose the name of the large employer client if requested. The bidder or its partner must have been in operation and performing the services requested in this RFP for a minimum of five (5) years,

- Network – Bidders must offer a contracted dental provider network capable of delivering benefits as described in the stated plan design. MCHCP requires a broad network that provides national coverage.

- Contract – Bidders shall not link nor attempt to link (unless permitted by this RFP), the award of this contract to any other bids, products, or contracts. Any bid proposal containing any contingency based upon MCHCP's actual or potential awards of contracts, whether or not related specifically to this RFP, or containing pricing contingencies, shall result in such bid proposal being rejected for non-responsiveness and non-compliance with this RFP.

- Rates – Bidders shall not be permitted to alter their rate or fees after submission except with agreement by MCHCP.
- Timely Submission – All deadlines outlined are necessary to meet the timeline for this contract award. MCHCP may reject any submissions after respective deadlines have passed. All bidder documents and complete proposals must be received by the proposal deadline of March 29, 2023, as outlined in the timeline of events for this RFP. Late proposals will not be accepted. MCHCP reserves the right to modify a deadline or extend a deadline for all bidders at its discretion.
- Plan Designs – Bidders must provide pricing for the plan design as described in the RFP. Additional services and/or options may be offered as part of the entire plan design.

This form will serve as confirmation that our organization has received the 2024 MCHCP Dental RFP.

☐ We intend to submit a complete proposal.

☐ We decline to submit a proposal for the following reason(s):

____

Name of Organization

____

Signature of Plan Representative

____

Title of Plan Representative

____

Date

EXHIBIT A-2
LIMITED DATA USE AGREEMENT

In order to secure data that resides with Missouri Consolidated Health Care Plan (MCHCP) and in order to ensure the integrity, security, and confidentiality of information maintained by MCHCP, and to permit appropriate disclosure and use of such data as permitted by law, MCHCP and _____enter into this Agreement to comply with the following specific paragraphs.

1. This Agreement is by and between MCHCP, a covered entity under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and_____, hereinafter referred to as "User".

2. This Agreement addresses the conditions under which MCHCP will disclose and the User will obtain and use MCHCP's file(s) specified in this agreement. This Agreement supersedes any and all agreements between the parties with respect to the use of MCHCP's file(s), and preempts and overrides any instructions, directions, agreements, or other understanding in or pertaining to any prior communication from MCHCP with respect to the data specified herein. Further, the terms of this Agreement can be changed only by a written modification to this Agreement, or by the parties adopting a new agreement. The parties agree further that instructions or interpretations issued to the User concerning this Agreement or the data specified herein, shall not be valid unless issued in writing by MCHCP's Executive Director.

3. Unless otherwise expressly stated in this Agreement, all words, terms, specifications, and requirements used or referenced in this Agreement which are defined in the HIPAA Rules shall have the same meanings as described in the HIPAA Rules. Any reference in this Agreement to a section in the HIPAA Rules means the section as in effect or amended. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

4. The parties mutually agree that MCHCP retains all ownership rights to the demographic file referred to in this Agreement, and that the User does not obtain any right, title, or interest in any of the data furnished by MCHCP.

5. The parties mutually agree that the following named individual is designated as "Custodian" of the file on behalf of the User, and will be personally responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use. The User agrees to notify MCHCP within five (5) days of any change of custodianship. The parties mutually agree that MCHCP may disapprove the appointment of a custodian, or may require the appointment of a new custodian at any time.

   Name of Custodian:
   Name of Company:
   Street Address:
   City, State and Zip Code:
   Phone Number w/ Area Code:
   E-mail Address:

6. The User represents and warrants, and in furnishing the claims file(s), MCHCP relies upon such representation and warranty, that these files will be used solely for the purposes outlined

below. The User agrees not to use or further disclose the data covered by this Agreement other than as provided for by this Agreement. The parties agree that no provision of this Agreement permits the User to use or disclose protected health information (PHI) in a manner that would violate HIPAA if used or disclosed in like manner by MCHCP. MCHCP's claims files are used solely for the following:

- Modeling of potential claim volume for purposes of bidding on a fully insured contract with MCHCP for dental benefits; and/or
- Network analysis and evaluation of proposed network's geographic accessibility to MCHCP for dental benefits; and/or
- Underwriting and premium rating for purposes of bidding on an insured contract with MCHCP for dental benefits.

The User represents and warrants further that the User shall not disclose, release, reveal, show, sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement to any person(s) other than as allowed by this Agreement. The User agrees that, within the User organization, access to the data covered by this Agreement shall be limited to the minimum number of individuals necessary to achieve the purpose stated in this section and to those individuals on a need-to-know basis only. The User agrees to ensure that any individual(s) or agent(s) the User discloses or allows to access the data covered by this Agreement will be bound to the same restrictions and conditions that apply to the User. Disclosure of this data is made pursuant to 45 CFR §§ 164.514(e)(1) and (g).

7. MCHCP will provide the User with the files, which is a subset of MCHCP's master records. MCHCP warrants that the file is accurate to the extent possible.

8. The parties mutually agree that the aforesaid file (and/or any derivative file(s) [includes any file that maintains or continues identification of individuals]) may be retained by the User only for the period of time required for any processing related to the purposes outlined in section 5 above. After the bidding process is complete, the User agrees to promptly destroy such data. The User agrees that no data from MCHCP records, or any parts thereof, shall be retained when the aforementioned file(s) are destroyed unless authorization in writing for the retention of such file(s) has been received from MCHCP's Executive Director. The User acknowledges that stringent adherence to the aforementioned information outlined in this paragraph is required. The User further acknowledges that MCHCP's demographic file received for any previous periods, and all copies thereof, must be destroyed upon receipt of an updated version. The User agrees that for any data covered by this Agreement, in any form, that the User maintains after the bidding process is complete, the User agrees to: (i) refrain from any further use or disclosure of the PHI; (ii) continue to safeguard the PHI thereafter in accordance with the terms of this Agreement; and (iii) not attempt to de-identify the PHI.

9. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the privacy and security of the data, and to prevent any unauthorized use or disclosure. The safeguards shall provide a level and scope of security that is not less than the level and scope of security established by HIPAA. The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, including protected health information, or deducible information derived from the file(s) specified above in section 6 is strictly prohibited. Further, the User agrees that the data must not be physically moved or transmitted in any way from the site indicated above in section 4, without written approval from MCHCP.

10. The User agrees that the authorized representatives of MCHCP and the Department of Health and Human Services ("HHS") will be granted access to the premises where the aforesaid file(s) are kept for the purpose of inspecting security arrangements and confirming whether the User is in compliance with the privacy and security requirements specified in this Agreement.

11. The User agrees that no findings, listing, or information derived from the file(s) specified in section 6, with or without identifiers, may be released if such findings, listing, or information contain any combination of data elements that might allow the deduction of a MCHCP member's identification (Examples of such data elements include, but are not limited to, address, zip code, sex, age, , etc.) The User agrees further that MCHCP shall be the sole judge as to whether any finding, listing, or information, or any combination of data extracted or derived from MCHCP's files identifies or reasonably could identify an individual or to deduce the identity of an individual.

12. The User agrees that the User shall make no attempt to link records included in the file(s) specified in section 6 to any other identifiable source of information or attempt to identify the information or individual(s) contained in the data. This includes attempts to link to other MCHCP data files. In addition, the User agrees not to contact the individual(s) who are the subject of the data covered by this Agreement.

13. The User understands and agrees that it may not reuse original or derivative data file(s) without prior written approval from MCHCP's Executive Director.

14. The User agrees to immediately report to MCHCP any use or disclosure of PHI not authorized or provided for by this Agreement in accordance with the notice provisions prescribed in this Section 14.

    14.1 The notice shall be delivered to, and confirmed received by, MCHCP without unreasonable delay, but in any event no later than three (3) business days of the User's first discovery, meaning the first day on which such unauthorized use or disclosure is known to the User, or by exercising reasonable diligence, would have been known to the User, of the unauthorized use or disclosure.

    14.2 The notice shall be in writing and shall include a complete description of the unauthorized use or disclosure, and if applicable, a list of affected individuals and a copy of the template breach notification letter to be sent to affected individuals.

15. The User agrees that in the event MCHCP determines or has a reasonable belief that the User has made or may have used or disclosed the aforesaid file(s) that is not authorized by this Agreement, or other written authorization from MCHCP's Executive Director, MCHCP in its sole discretion may require the User to: (a) promptly investigate and report to MCHCP the User's determinations regarding any alleged or actual unauthorized use or disclosure, (b) promptly resolve any problems identified by the investigation; (c) if requested by MCHCP, submit a formal written response to an allegation of unauthorized use or disclosure; (d) if requested by MCHCP, submit a corrective action plan with steps designed to prevent any future unauthorized uses or disclosures; and (e) if requested by MCHCP, destroy or return data files to MCHCP immediately. The User understands that as a result of MCHCP's determination or reasonable belief that unauthorized uses or disclosures have taken place, MCHCP may refuse

to release further MCHCP data to the User for a period of time to be determined by MCHCP. Further, the User agrees that MCHCP may report the problem to the Secretary of HHS.

16. The User agrees to assume all costs and responsibilities associated with any breach, as defined in the HIPAA breach notification provisions, of any protected health information obtained from MCHCP's demographic file caused by the User organization. Such costs and responsibilities include: determining if and when a breach has occurred, however, all final decisions involving questions of a breach shall be made by MCHCP; investigating the circumstances surrounding any possible incident of breach; providing on behalf of MCHCP all notifications legally required of a covered entity in accordance with HIPAA breach notification laws and regulations; paying for the reasonable and actual costs associated with such notifications; The User further agrees to indemnify and hold MCHCP harmless from any and all penalties or damages associated with any breach caused by the User organization.

17. The User hereby acknowledges the criminal and civil penalties for violations under HIPAA. If User is a covered entity under HIPAA, its receipt of MCHCP's limited data set and violation of this data use agreement may cause the User to be in noncompliance with the standards, implementation specifications, and requirements of 45 CFR § 164.514 (e).

18. By signing this Agreement, the User agrees to abide by all provisions set out in this Agreement for protection of the data file specified in section 6, and acknowledges having received notice of potential criminal and civil penalties for violation of the terms of the Agreement.

19. On behalf of the User, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein. This Agreement shall be effective upon signature by both parties. The duration of this Agreement is one year from the effective date. The User also acknowledges that this Agreement may be terminated at any time with the consent of both parties involved. Either party may independently terminate the Agreement upon written request to the other party, in which case the termination shall be effective 60 days after the date of the notice, or at a later date specified in the notice.

_____
(Name/Title of Individual)

_____
(State Agency/Organization)

_____
(Street Address)

_____
(City/State/ZIP Code)

_____
(Phone Number Including Area Code)

_____
(E-mail Address)

Signature _____ Date

20. On behalf of MCHCP, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

____ ____________
Judith Muck, Executive Director Date
Missouri Consolidated Health Care Plan

EXHIBIT A-3
BIDDER'S PROPOSED MODIFICATIONS TO THE RFP
2024 DENTAL RFP

The bidder must utilize this document to clearly identify by subsection number any exceptions to the provisions of the Request for Proposal (RFP) and include an explanation as to why the bidder cannot comply with the specific provision. Any desired modifications should be kept as succinct and brief as possible. **Failure to confirm acceptance of the mandatory contract provisions will result in the bidder being eliminated from further consideration as its proposal will be considered non-compliant.**

Any modification proposed shall be deemed accepted as a modification of the RFP if and only if this proposed modification exhibit is countersigned by an authorized MCHCP representative on or before the effective date of the contract awarded under this RFP.

____
Name/Title of Individual

____
Organization

____
Signature

____
Date

On behalf of MCHCP, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

____
Executive Director Date
Missouri Consolidated Health Care Plan

Exhibit A-4

Confirmation Document
2024 MCHCP Dental RFP

Please complete this form following the steps listed below:

1) Confirm that you have read and understand all of MCHCP's instructions included in the DirectPath/Optavise application.

☐ Yes

☐ No

2) Bidders are required to submit a firm, fixed price for CY2024 and not-to-exceed prices for CY2025 and CY2026. Prices will be subject to best and final offer which may result from subsequent negotiation. Pricing for 2027 and 2028 will be negotiated. You are advised to review all proposal submission requirements stated in the original RFP and in any amendments, thereto. Confirm that you hereby agree to provide the services and/or items at the prices quoted, pursuant to the requirements of the RFP, including any and all RFP amendments.

☐ Yes

☐ No

3) Completion of the signature block below constitutes your company's acceptance of all terms and conditions of the original RFP plus any and all RFP amendments, and confirmation that all information included in this response is truthful and accurate to the best of your knowledge. You also hereby expressly affirm that you have the requisite authority to execute this Agreement on behalf of the Vendor and to bind such respective party to the terms and conditions set forth herein.

____

Name/Title of Individual

____

Organization

____

Signature

____

Date

EXHIBIT A-5

CONTRACTOR CERTIFICATION
OF COMPLIANCE WITH FEDERAL EMPLOYMENT LAWS
2024 MCHCP DENTAL RFP

________________________________ (hereafter referred to as “Contractor”) hereby certifies that all of Contractor’s employees and its subcontractors’ employees assigned to perform services for Missouri Consolidated Health Care Plan (“MCHCP”) and/or its members are eligible to work in the United States in accordance with federal law.

Contractor acknowledges that MCHCP is entitled to receive all requested information, records, books, forms, and any other documentation (“requested data”) in order to determine if Contractor is in compliance with federal law concerning eligibility to work in the United States and to verify the accuracy of such requested data. Contractor further agrees to fully cooperate with MCHCP in its audit of such subject matter.

Contractor also hereby acknowledges that MCHCP may declare Contractor has breached its Contract if MCHCP has reasonable cause to believe that Contractor or its subcontractors knowingly employed individuals not eligible to work in the United States. MCHCP may then lawfully and immediately terminate its Contract with Contractor without any penalty to MCHCP and may suspend or debar Contractor from doing any further business with MCHCP.

THE UNDERSIGNED PERSON REPRESENTS AND WARRANTS THAT HE/SHE IS DULY AUTHORIZED TO SIGN THIS DOCUMENT AND BIND THE CONTRACTOR TO SUCH CERTIFICATION.

____
Name/Title of Individual

____
Organization

____
Signature

____
Date

Exhibit A-6

Documentation of Intent to Participate
2024 MCHCP Dental RFP

If the bidder is proposing to include the participation of a Minority Business Enterprise/Women Business Enterprise (MBE/WBE) in the provision of the products/services required in the RFP, the bidder must either provide a recently dated letter of intent, signed and dated no earlier than the RFP issuance date, from each organization documenting the following information, or complete and provide this Exhibit with the bidder's proposal.

~ Copy This Form For Each Organization Proposed ~

Bidder Name: ______________________________

This Section To Be Completed by Participating Organization:

By completing and signing this form, the undersigned hereby confirms the intent of the named participating organization to provide the products/services identified herein for the bidder identified above.

Name of Organization: (Name of MBE, WBE)			
Contact Name:		Email:	
Address:		Phone #:	
City:		Fax #:	
State/Zip:		Certification #	
Type of Organization (MBE or WBE):		Certification Expiration Date:	(or attach copy of certification)

PRODUCTS/SERVICES PARTICIPATING ORGANIZATION AGREED TO PROVIDE

Describe the products/services you *(as the participating organization)* have agreed to provide:

____

____

____

____

Authorized Signature:

____
Authorized Signature of Participating Organization (MBE, WBE)

____
Date (Dated no earlier than the RFP issuance date)

Exhibit A-7
Provider Match
Instructions

The purpose of this exercise is to determine network overlap with MCHCP's current dental network. The providers listed on the second tab of this workbook represent the providers used by MCHCP members in a recent 12-month period.

1. Bidders should complete the second tab, indicating in Column J whether the provider is currently participating in your proposed network. Complete the Participating Provider column based upon contracts that are in place as of March 1, 2023. Do not enter the status based upon future contracts.

2. Upload the completed document to DirectPath/Optavise no later than Wednesday, March 29,

Exhibit A-8
2024 MCHCP Dental RFP Pricing

Instructions

1. Bidders must propose a firm fixed monthly premium for CY2024 and not-to-exceed monthly premiums for CY2025 and CY2026. Bidders must also submit pricing for all plan designs. MCHCP will offer only 2 plan designs to members - the basic plan and either the Classic Plan or the Classic Plan with Orthodontia.
2. Bidders must use the worksheets labeled "Multiple Contractor" to indicate premiums if two contracts are awarded, and the worksheet labeled "Sole Contractor" to indicate premiums if only one contract is awarded.
3. Renewal pricing for future contract years is due no later than May 15 of the prior year.
4. For each COBRA participant, the additional 2 percent of total monthly premium will be permanently retained by MCHCP.
5. Bidders may use Enhanced Benefit Pricing for any benefits that are not included in the benefit design and premium. Enhanced benefits could be things such as moving benefits from a specific group to another group (i.e., from Major to Basic and Restorative); adding an additional benefit not mentioned in the plan design, or another enhancement proposed by the bidder. Bidders should list the incremental cost for adding the proposed benefit. If there are multiple enhancements, then duplicate the tab for Enhanced benefits for each proposed.
6. Bidders may use Supplemental Pricing for any optional services that are not included in the premium. Optional services that could be listed include an on-line reporting utility, ID card customization costs, etc. Include the basis for payment (PEPM, one-time fee, etc) in the Basis for Payment column. Any increases in supplemental pricing for future years should be included in the Basis for Payment column.

Exhibit A-8
Dental Plan Design

Basic Plan

Plan Provisions	
Annual Deductible	$50 per person; does not apply to diagnostic and preventive services
Annual Maximum	$1,000 per person per calendar year benefit period
Waiting Period	N/A
Non- Network	R&C percentage used in Bid : _______ th% (minimum 90th%) Balanced Billing may occur.
Diagnostic and Preventive Services 100% coverage. Services do not apply to the individual plan maximum	
Examinations	Coverage limited to two exams per calendar year (one every six months)
Prophylaxes (teeth cleaning)	Teeth cleaning, scaling and polishing, including periodontal maintenace visits; coverage limited to two per calendar year (one every six months). Two additional cleanings per calendar year for members who are pregnant, diabetic, have a suppressed immune system or have a history of periodontal therapy (one every three months).
Fluoride	Topical fluoride application once per calendar year (all ages)
Bitewing Radiographs (x-rays)	Coverage limited to one set per calendar year
Sealants	Limited to caries-free occlusal surfaces of the first and second permanent molars once in five calendar years
Emergency Palliative Treatment	Minor procedures to temporarily reduce or eliminate pain
Brush Biopsy	Brush biopsy to detect oral cancer
Basic and Restorative 20% Coinsurance after Deductible	
Space Maintainers	Space maintainers that replace prematurely lost teeth of eligible dependent children up to age 14 once in five calendar years, except for accidental injuries
Simple Extractions	Routine removal (through use of forceps) of tooth structure, minor smoothing of socket bone, and closure
Minor Restorative Services (fillings)	Fillings (once per two calendar years unless accidental injury). Fillings include amalgam restorations and composite restorations on anterior and posterior teeth.

Exhibit A-8
Dental Plan Design

Basic Plan

Periapical X-Ray	Periapical X-rays as required
Full Mouth X-rays	Includes panoramic film with or without other films, as well as multiple x-rays on the same date of service once every five calendar years
Major Services	
Oral Surgery	Not Covered.
Periodontics	Not Covered.
Endodontics	Not Covered.
Prosthetics	Not Covered.
Major Restorative Services	Not Covered.
General Anesthesia	Not Covered.
Bridges and Dentures	Not Covered.
Implants	Not Covered.

Exhibit A-8
Dental Plan Design

Classic Plan

Plan Provisions	
Annual Deductible	$50 per person; does not apply to diagnostic and preventive services
Annual Maximum	$2,000 per person per calendar year benefit period
Waiting Period	12-month waiting period for Major Services. Waiting period is waived with proof of 12 month continuous dental coverage for major services immediately prior to effective date of coverage in MCHCP's dental plan
Non-Network	R&C percentage used in Bid : _______ th% (minimum 90th%) Balanced Billing may occur.
Diagnostic and Preventive Services 100% coverage. Services do not apply to the individual plan maximum	
Examinations	Coverage limited to two exams per calendar year (one every six months)
Prophylaxes (teeth cleaning)	Teeth cleaning, scaling and polishing, including periodontal maintenace visits; coverage limited to two per calendar year (one every six months). Two additional cleanings per calendar year for members who are pregnant, diabetic, have a suppressed immune system or have a history of periodontal therapy (one every three months).
Fluoride	Topical fluoride application once per calendar year (all ages)
Bitewing Radiographs (x-rays)	Coverage limited to one set per calendar year
Sealants	Limited to caries-free occlusal surfaces of the first and second permanent molars once in five calendar years
Emergency Palliative Treatment	Minor procedures to temporarily reduce or eliminate pain
Brush Biopsy	Brush biopsy to detect oral cancer
Basic and Restorative 20% Coinsurance after Deductible	
Space Maintainers	Space maintainers that replace prematurely lost teeth of eligible dependent children up to age 14 once in five calendar years, except for accidental injuries
Simple Extractions	Routine removal (through use of forceps) of tooth structure, minor smoothing of socket bone, and closure
Minor Restorative Services (fillings)	Fillings (once per two calendar years unless accidental injury). Fillings include amalgam restorations and composite restorations on anterior and posterior teeth.

Exhibit A-8
Dental Plan Design

Classic Plan

Periapical X-Ray	Periapical X-rays as required
Full Mouth X-rays	Includes panoramic film with or without other films, as well as multiple x-rays on the same date of service once every five calendar years
Major Services 50% Coinsurance after Deductible	
Oral Surgery	Includes surgical extractions, such as the cutting of gingiva and bone when removing tooth
Periodontics	Treatment for gum disease and bone supporting the teeth. Periodontal surgery covered only once in a three year period for the same site. Therapy covered once per two calendar years.
Endodontics	Root canal filling and pulpal therapy; covered once per two calendar years per tooth; re-treatment of the same tooth is allowed when performed by a different dental office
Prosthetics	Bridges, dentures and partials once per seven calendar years; an alternate benefit allowance (based on cost) will be provided for a fixed bridge
Major Restorative Services	New or replacement crown, jacket, labial veneer, inlay or onlay on or for a particular tooth will only be provided once in seven calendar years, unless the damage to that tooth was caused by an accidental injury not related to the normal function of a tooth or teeth
General Anesthesia	General anesthesia in conjunction with covered surgical procedures
Bridges and Dentures	Initial placement to replace one or more natural teeth, which are lost while covered by the plan. Dentures and bridgework replacement; one every 10 years
Implants	Once per seven calendar years per tooth; includes related bone grafts

Exhibit A-8
Dental Plan Design

Classic Plan w/ Orthodontia

Plan Provisions	
Annual Deductible	$50 per person; does not apply to diagnostic and preventive services
Annual Maximum	$2,000 per person per calendar year benefit period
Waiting Period	12-month waiting period for Major Services and Orthodontia. Waiting period is waived with proof of 12 month continuous dental coverage for major services and orthodontia immediately prior to effective date of coverage in MCHCP's dental plan
Non-Network	R&C percentage used in Bid : _______ th% (minimum 90th%) Balanced Billing may occur.
Diagnostic and Preventive Services 100% coverage. Services do not apply to the individual plan maximum	
Examinations	Coverage limited to two exams per calendar year (one every six months)
Prophylaxes (teeth cleaning)	Teeth cleaning, scaling and polishing, including periodontal maintenace visits; coverage limited to two per calendar year (one every six months). Two additional cleanings per calendar year for members who are pregnant, diabetic, have a suppressed immune system or have a history of periodontal therapy (one every three months).
Fluoride	Topical fluoride application once per calendar year (all ages)
Bitewing Radiographs (x-rays)	Coverage limited to one set per calendar year
Sealants	Limited to caries-free occlusal surfaces of the first and second permanent molars once in five calendar years
Emergency Palliative Treatment	Minor procedures to temporarily reduce or eliminate pain
Brush Biopsy	Brush biopsy to detect oral cancer
Basic and Restorative 20% Coinsurance after Deductible	
Space Maintainers	Space maintainers that replace prematurely lost teeth of eligible dependent children up to age 14 once in five calendar years, except for accidental injuries
Simple Extractions	Routine removal (through use of forceps) of tooth structure, minor smoothing of socket bone, and closure
Minor Restorative Services (fillings)	Fillings (once per two calendar years unless accidental injury). Fillings include amalgam restorations and composite restorations on anterior and posterior teeth.

Exhibit A-8
Dental Plan Design

Classic Plan w/ Orthodontia

Periapical X-Ray	Periapical X-rays as required
Full Mouth X-rays	Includes panoramic film with or without other films, as well as multiple x-rays on the same date of service once every five calendar years
Major Services 50% Coinsurance after Deductible	
Oral Surgery	Includes surgical extractions, such as the cutting of gingiva and bone when removing tooth
Periodontics	Treatment for gum disease and bone supporting the teeth. Periodontal surgery covered only once in a three year period for the same site. Therapy covered once per two calendar years.
Endodontics	Root canal filling and pulpal therapy; covered once per two calendar years per tooth; re-treatment of the same tooth is allowed when performed by a different dental office
Prosthetics	Bridges, dentures and partials once per seven calendar years; an alternate benefit allowance (based on cost) will be provided for a fixed bridge
Major Restorative Services	New or replacement crown, jacket, labial veneer, inlay or onlay on or for a particular tooth will only be provided once in seven calendar years, unless the damage to that tooth was caused by an accidental injury not related to the normal function of a tooth or teeth
General Anesthesia	General anesthesia in conjunction with covered surgical procedures
Bridges and Dentures	Initial placement to replace one or more natural teeth, which are lost while covered by the plan. Dentures and bridgework replacement; one every 10 years
Implants	Once per seven calendar years per tooth; includes related bone grafts
Orthodontia 50% Coinsurance after Deductible	
Orthodontia	Covered for those aged 18 and under.

Exhibit A-8
2024 MCHCP Dental RFP Pricing

Multiple Contractor Rates

	2024 Monthly Rate			2025 Monthly Rate			2026 Monthly Rate		
	Basic Plan	Classic Plan	Classic Plan with Ortho	Basic Plan	Classic Plan	Classic Plan with Ortho	Basic Plan	Classic Plan	Classic Plan with Ortho
Active Employees									
Employee Only									
Employee and Spouse									
Employee and Child(ren)									
Employee, Spouse and Child(ren)									
Retirees									
Retiree Only									
Retire and Spouse									
Retiree and Child(ren)									
Retiree, Spouse and Child(ren)									

Exhibit A-8
2024 MCHCP Dental RFP Pricing

Sole Contractor Rates

	2024 Monthly Rate			2025 Monthly Rate			2026 Monthly Rate		
	Basic Plan	Classic Plan	Classic Plan with Ortho	Basic Plan	Classic Plan	Classic Plan with Ortho	Basic Plan	Classic Plan	Classic Plan with Ortho
Active Employees									
Employee Only									
Employee and Spouse									
Employee and Child(ren)									
Employee, Spouse and Child(ren)									
Retirees									
Retiree Only									
Retire and Spouse									
Retiree and Child(ren)									
Retiree, Spouse and Child(ren)									

Exhibit A-8
2024 MCHCP Dental RFP Pricing

Description of Proposed Enhanced Benefit ______________________________

Multiple Contractor Rates

	2024 Monthly Incremental Increase			2025 Monthly Incremental Increase			2026 Monthly Incremental Increase		
	Basic Plan	Classic Plan	Classic Plan with Ortho	Basic Plan	Classic Plan	Classic Plan with Ortho	Basic Plan	Classic Plan	Classic Plan with Ortho
Active Employees									
Employee Only									
Employee and Spouse									
Employee and Child(ren)									
Employee, Spouse and Child(ren)									
Retirees									
Retiree Only									
Retire and Spouse									
Retiree and Child(ren)									
Retiree, Spouse and Child(ren)									

Sole Contractor Rates

	2024 Monthly Incremental Increase			2025 Monthly Incremental Increase			2026 Monthly Incremental Increase		
	Basic Plan	Classic Plan	Classic Plan with Ortho	Basic Plan	Classic Plan	Classic Plan with Ortho	Basic Plan	Classic Plan	Classic Plan with Ortho
Active Employees									
Employee Only									
Employee and Spouse									
Employee and Child(ren)									
Employee, Spouse and Child(ren)									
Retirees									
Retiree Only									
Retire and Spouse									
Retiree and Child(ren)									
Retiree, Spouse and Child(ren)									

Exhibit A-8
2024 MCHCP Dental RFP Pricing

Supplemental Pricing

	Describe Service	Cost of Service	Basis for Payment (PEPM, one-time fee, etc.)
Service 1			
Service 2			
Service 3			
Service 4			
Service 5			
Service 6			
Service 7			
Service 8			
Service 9			
Service 10			

Exhibit A-9

This contract is a sample contract for review during the RFP process only. Additional clauses and obligations may be added that are consistent with the RFP and bidder's submission which is awarded by the Board of Trustees. If there is a conflict with this sample contract and the RFP materials, the RFP materials will take precedence during the bidding process.

CONTRACT # XXXX BETWEEN
MISSOURI CONSOLIDATED HEALTH CARE PLAN
AND DENTAL CONTRACTOR

This Contract is entered into by and between Missouri Consolidated Health Care Plan ("MCHCP") and ________________ (hereinafter "CONTRACTOR" or "Contractor") for the express purpose of providing fully insured dental plan(s) for State and Public Entity members pursuant to MCHCP's 2024 Dental RFP released March X, 2023 (hereinafter "RFP").

1. GENERAL TERMS AND CONDITIONS

1.1 Term of Contract and Costs of Services: The term of this Contract is for a period of one (1) year from January 1, 2024 through December 31, 2024. This Contract may be renewed for four (4) additional one-year periods at the sole option of the MCHCP Board of Trustees. The submitted pricing arrangement for the first year (January 1 - December 31, 2024) is a firm, fixed price. The submitted prices for the subsequent (2nd – 3rd) years of the contract period (January 1 - December 31, 2025, January 1 - December 31, 2026, are guaranteed not-to-exceed maximum prices and are subject to negotiation. Pricing for the one-year renewal periods are due to MCHCP by May 15 for the following year's renewal. All prices are subject to best and final offer which may result from subsequent negotiation.

1.2 Contract Documents: This Contract and following documents, attached hereto and herby incorporated herein by reference as if fully set forth herein, constitute the full and complete Contract and, in the event of conflict in terms of language among the documents, shall be given precedence in the following order:

a. Any future written and duly executed renewal proposals or amendments to this Contract;

b. This written Contract signed by the parties;

c. The following Exhibits listed in this subsection below and attached hereto, the substance of which are based on final completed exhibits or attachments required and submitted by CONTRACTOR in response to the RFP, finalist negotiations, and implementation meetings:

   i. Pricing Pages
   ii. Business Associate Agreement
   iii. Confirmation Document
   iv. Performance Guarantees
   v. Certification of Compliance with State and Federal Employment Laws

d. The original RFP, including any amendments, the mandatory terms of which are deemed accepted and confirmed by CONTRACTOR as evidenced by CONTRACTOR affirmative confirmations and representations required by and in accordance with the bidder response requirements described throughout the RFP.

Any exhibits or attachments voluntarily offered, proposed, or produced as evidence of CONTRACTOR's ability and willingness to provide more or different services not required by the RFP that are not specifically described in this Section or otherwise not included elsewhere in the Contract documents are excluded from the terms of this Contract unless subsequently added by the parties in the form of a written and executed amendment to this Contract.

1.3 Integration: This Contract, in its final composite form, shall represent the entire agreement between the parties and shall supersede all prior negotiations, representations or agreements, either written or oral, between the parties relating to the subject matter hereof. This Contract between the parties shall be independent of and have no effect on any other contracts of either party.

1.4 Amendments to this Contract: This Contract shall be modified only by the written agreement of the parties. No alteration or variation in terms and conditions of the Contract shall be valid unless made in writing and signed by the parties. Every amendment shall specify the date on which its provisions shall be effective.

No agent, representative, employee or officer of either MCHCP or Contractor has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with this Contract, which in any way can be deemed to modify, add to or detract from, or otherwise change or alter its terms and conditions. No negotiations between the parties, nor any custom or usage, shall be permitted to modify or contradict any of the terms and conditions of this Contract.

1.5 Drafting Conventions and Definitions: Whenever the following words and expressions appear in this Contract, any amendment thereto, or the RFP document, the definition or meaning described below shall apply:

- *(Definitions that are used in the RFP will be added as needed for the contract.)*
- **"Amendment"** means a written, official modification to the RFP or to this Contract.
- **"May"** means permissible but not required.
- **"Must"** means that a certain feature, component, or action is a mandatory condition. Failure to provide or comply may result in a breach.
- **"Request for Proposal" or "RFP"** means the solicitation document issued by MCHCP to potential bidders for the purchase of services as described in the document. The definition includes Exhibits, Attachments, and Amendments thereto.
- **"Shall"** has the same meaning as the word must.
- **"Should"** means desirable but not mandatory.

- The terms **“include,” “includes,”** and **“including”** are terms of inclusion, and where used in this Contract, are deemed to be followed by the words “without limitation”.

1.6 Notices: Unless otherwise expressly provided otherwise, all notices, demands, requests, approvals, instructions, consents or other communications (collectively "notices") which may be required or desired to be given by either party to the other during the course of this contract shall be in writing and shall be made by personal delivery, by prepaid overnight delivery, by United States mail postage prepaid, or transmitted by email to an authorized employee of the other party or to any other persons as may be designated by written notice from one party to the other. Notices to MCHCP shall be addressed as follows: Missouri Consolidated Health Care Plan, ATTN: Executive Director, P.O. Box 104355, Jefferson City, MO 65110-4355. Notices to CONTRACTOR shall be addressed as follows: CONTRACTOR ATTN: ____________, ____.

1.7 Headings: The article, section, paragraph, or exhibit headings or captions in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract. Such headings or captions do not define, describe, extend, or limit the scope or intent of this Contract.

1.8 Severability: If any provision of this Contract is determined by a court of competent jurisdiction to be invalid, unenforceable, or contrary to law, such determination shall not affect the legality or validity of any other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if it were never incorporated into this Contract, but all other provisions will remain in full force and effect.

1.9 Inducements: In making the award of this Contract, MCHCP relies on CONTRACTOR’s assurances of the following:

- Contractor, including its subcontractors, has the skills, qualifications, expertise, financial resources and experience necessary to perform the services described in the RFP, Contractor’s proposal, and this Contract, in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities.
- Contractor has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand MCHCP’s current offerings and operating environment for the activities that are the subject of this Contract and the needs and requirements of MCHCP during the contract term.
- Contractor has had the opportunity to review and fully understand MCHCP’s stated objectives in entering into this Contract and, based upon such review and understanding, Contractor currently has the capability to perform in accordance with the terms and conditions of this Contract.
- Contractor has also reviewed and understands the risks associated with administering services as described in the RFP.

Accordingly, on the basis of the terms and conditions of this Contract, MCHCP desires to engage Contractor to perform the services described in this Contract under the terms and conditions set forth in this Contract.

1.10 Industry Standards: If not otherwise provided, materials or work called for in this Contract shall be furnished and performed in accordance with best established practice and standards recognized by the contracted industry and comply with all codes and regulations which shall apply.

1.11 Force Majeure: Neither party will incur any liability to the other if its performance of any obligation under this Contract is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but aren't limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, and strikes other than by Contractor’s or its subcontractors’ employees.

1.12 Breach and Waiver: Waiver or any breach of any Contract term or condition shall not be deemed a waiver of any prior or subsequent breach. No Contract term or condition shall be held to be waived, modified, or deleted except by a written instrument signed by the parties. If any Contract term or condition or application thereof to any person(s) or circumstances is held invalid, such invalidity shall not affect other terms, condition or application. To this end, the Contract terms and conditions are severable.

1.13 Independent Contractor: Contractor represents itself to be an independent contractor offering such services to the general public and shall not represent itself or its employees to be an employee of MCHCP. Therefore, Contractor hereby assumes all legal and financial responsibility for taxes, FICA, employee fringe benefits, worker's compensation, employee insurance, minimum wage requirements, overtime, etc. and agrees to indemnify, save, and hold MCHCP, its officers, agents, and employees, harmless from and against, any and all loss; cost (including attorney fees); and damage of any kind related to such matters. Contractor assumes sole and full responsibility for its acts and the acts of its personnel.

1.14 Relationship of the Parties: This Contract does not create a partnership, franchise, joint venture, agency, or employment relationship between the parties.

1.15 No Implied Authority: The authority delegated to CONTRACTOR by MCHCP is limited to the terms of this Contract. MCHCP is a statutorily created body corporate multi-employer group health plan and trust fund designated by the Missouri Legislature to administer health care services to eligible State of Missouri and public entity employees, and no other agency or entity may grant CONTRACTOR any authority related to this Contract except as authorized in writing by MCHCP. CONTRACTOR may not rely upon implied authority, and specifically is not delegated authority under this Contract to:

- Make public policy;
- Promulgate, amend, or disregard administrative regulations or program policy decisions made by MCHCP; and/or
- Unilaterally communicate or negotiate with any federal or state agency, the Missouri Legislature, or any MCHCP Contractor on behalf of MCHCP regarding the services included within this Contract.

1.16 Third Party Beneficiaries: This Contract shall not be construed as providing an enforceable right to any third party.

1.17 Injunction: Should MCHCP be prevented or enjoined from proceeding with this Contract before or after contract execution by reason of any litigation or other reason beyond the control of MCHCP, Contractor shall not be entitled to make or assess claim for damage by reason of said delay.

1.18 Statutes: Each and every provision of law and clause required by law to be inserted or applicable to the services provided in this Contract shall be deemed to be inserted herein and this Contract shall be read and enforced as though it were included herein. If through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then on the application of either party the Contract shall be amended to make such insertion or correction.

1.19 Governing Law: This Contract shall be governed by the laws of the State of Missouri and shall be deemed executed at Jefferson City, Cole County, Missouri. All contractual agreements shall be subject to, governed by, and construed according to the laws of the State of Missouri.

1.20 Jurisdiction: All legal proceedings arising hereunder shall be brought in the Circuit Court of Cole County in the State of Missouri.

1.21 Acceptance: No contract provision or use of items by MCHCP shall constitute acceptance or relieve Contractor of liability in respect to any expressed or implied warranties.

1.22 Survival of Terms: Termination or expiration of this Contract for any reason will not release either party from any liabilities or obligations set forth in this Contract that: (i) the parties expressly agree will survive any such termination or expiration; or (ii) remain to be performed or by their nature would be intended to apply following any such termination or expiration.

2 Contractor's Obligations

2.1 Eligible Members: CONTRACTOR shall agree that eligible members are those employees, retirees and their dependents who are eligible as defined by applicable state and federal laws, rules and regulations, including revision(s) to such. MCHCP is the sole source in determining eligibility. CONTRACTOR shall not regard a member as terminated until CONTRACTOR receives an official termination notice from MCHCP.

2.2 Confidentiality: Contractor will have access to private and/or confidential data maintained by MCHCP to the extent necessary to carry out its responsibilities under this Contract. No private or confidential data received, collected, maintained, transmitted, or used in the course of performance of this Contract shall be disseminated by Contractor except as authorized by MCHCP, either during the period of this Contract or thereafter. Contractor must agree to return any or all data furnished by MCHCP promptly at the request of MCHCP in whatever form it is maintained by Contractor. On the termination or expiration of this Contract, Contractor will not use any of such data or any material derived from the data for any purpose and, where so instructed by MCHCP, will destroy or render it unreadable.

2.3 Subcontracting: Subject to the terms and conditions of this section, this Contract shall be binding upon the parties and their respective successors and assigns. Contractor shall not subcontract with any person or entity to perform all or any part of the work to be performed under this Contract without the prior written consent of MCHCP. Contractor may not assign, in whole or in part, this Contract or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of MCHCP. Contractor agrees that any and all subcontracts entered into by Contractor for the purpose of meeting the requirements of this Contract are the responsibility of Contractor. MCHCP will hold Contractor responsible for assuring that subcontractors meet all the requirements of this Contract and all amendments thereto. Contractor must provide complete information regarding each subcontractor used by Contractor to meet the requirements of this Contract.

2.4 Disclosure of Material Events: Contractor agrees to immediately disclose any of the following to MCHCP to the extent allowed by law for publicly traded companies:

- Any material adverse change to the financial status or condition of Contractor;
- Any merger, sale or other material change of ownership of Contractor;
- Any conflict of interest or potential conflict of interest between Contractor's engagement with MCHCP and the work, services or products that Contractor is providing or proposes to provide to any current or prospective customer; and
- (1) Any material investigation of Contractor by a federal or state agency or self-regulatory organization; (2) Any material complaint against Contractor filed with a federal or state agency or self-regulatory organization; (3) Any material proceeding naming Contractor before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming Contractor as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken against Contractor by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against Contractor as a result of any material criminal or civil action in which Contractor was a party; or (7) Any other matter material to the services rendered by Contractor pursuant to this Contract.

For the purposes of this paragraph, "material" means of a nature or of sufficient monetary value, or concerning a subject which a reasonable party in the position of and comparable to MCHCP would consider relevant and important in assessing the relationship and services contemplated by this Contract. It is further understood in that in fulfilling its ongoing responsibilities under this paragraph, Contractor is obligated to make its best faith efforts to disclose only those relevant matters which to the attention of or should have been known by Contractor's personnel involved in the engagement covered by this Contract and/or which come to the attention of or should have been known by any individual or office of Contractor designated by Contractor to monitor and report such matters.

Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to terminate this Contract.

2.5 Off-shore Services: All services under this Contract shall be performed within the United States. Contractor shall not perform, or permit subcontracting of services under this Contract, to any off-shore companies or locations outside of the United States. Any such actions shall result in Contractor being in breach of this Contract.

2.6 Change in Laws: Contractor agrees that any state and/or federal laws and applicable rules and regulations enacted during the terms of the contract which are deemed by MCHCP to necessitate a change in the contract shall be incorporated into the contract automatically. MCHCP will review any request for additional fees resulting from such changes and retains final authority to make any changes. A consultant may be utilized to determine the cost impact.

2.7 Compliance with Laws: Contractor shall comply with all applicable federal and state laws and regulations and local ordinances in the performance of this Contract, including but not limited to the provisions listed below.

2.7.1 Non-discrimination, Sexual Harassment and Workplace Safety: Contractor agrees to abide by all applicable federal, state and local laws, rules and regulations prohibiting discrimination in employment and controlling workplace safety. Contractor shall establish and maintain a written sexual harassment policy and shall inform its employees of the policy. Contractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subcontract so that such provisions will be binding upon each subcontractor. Any violations of applicable laws, rules and regulations may result in termination of the Contract.

2.7.2 Americans with Disabilities Act (ADA) and Americans with Disabilities Act Amendments Act of 2008 (ADAAA): Pursuant to federal regulations promulgated under the authority of The Americans with Disabilities Act (ADA) and **Americans with Disabilities Act Amendments Act of 2008 (ADAAA)**, Contractor understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Contract or from activities provided for under this Contract on the basis of such disability. As a condition of accepting this Contract, Contractor agrees to comply with all regulations promulgated under ADA or ADAAA which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

2.7.3 Patient Protection and Affordable Care Act (PPACA): If applicable, Contractor shall comply with the Patient Protection and Affordable Care Act (PPACA) and all regulations promulgated under the authority of PPACA, including any future regulations promulgated under PPACA, which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

2.7.4 Health Insurance Portability and Accountability Act of 1996 (HIPAA): Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations, as amended, including compliance with the Privacy, Security and Breach Notification regulations and the execution of a Business Associate Agreement with MCHCP.

2.7.5 Genetic Information Nondiscrimination Act of 2008: Contractor shall comply with the Genetic Information Nondiscrimination Act of 2008 (GINA) and implementing regulations, as amended.

2.8 Indemnification: Contractor shall be responsible for and agrees to indemnify and hold harmless MCHCP from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against MCHCP as a result of Contractor's, Contractor's employees, or Contractor's associate or any associate's or subcontractor's failure to comply with section 2.7 of this contract.

2.9 Prohibition of Gratuities: Neither Contractor nor any person, firm or corporation employed by Contractor in the performance of this Contract shall offer or give any gift, money or anything of value or any promise for future reward or compensation to any employee of MCHCP at any time.

2.10 Solicitation of Members: Contractor shall not use the names, home addresses or any other information contained about members of MCHCP for the purpose of offering for sale any property or services which are not directly related to services negotiated in this RFP without the express written consent of MCHCP's Executive Director.

2.11 Insurance and Liability: Contractor must maintain sufficient liability insurance, including but not limited to general liability, professional liability, and errors and omissions coverage, to protect MCHCP against any reasonably foreseeable recoverable loss, damage or expense under this engagement. Contractor shall provide proof of such insurance coverage upon request from MCHCP. MCHCP shall not be required to purchase any insurance against loss or damage to any personal property to which this Contract relates. Contractor shall bear the risk of any loss or damage to any personal property in which Contractor holds title.

2.12 Hold Harmless: Contractor shall hold MCHCP harmless from an indemnify against any and all claims for injury to or death of any persons; for loss or damage to any property; and for infringement of any copyright or patent to the extent caused by Contractor or Contractor's employees or its subcontractors. MCHCP shall not be precluded from receiving the benefits of any insurance Contractor may carry which provides for indemnification for any loss or damage of property in Contractor's custody and control, where such loss or destruction is to MCHCP's property. Contractor shall do nothing to prejudice MCHCP's right to recover against third parties for any loss, destruction, or damage to MCHCP's property.

2.13 Assignment: Contractor shall not assign, convey, encumber, or otherwise transfer its rights or duties under this Contract without prior written consent of MCHCP. This Contract may terminate in the event of any assignment, conveyance, encumbrance or other transfer by Contractor made without prior written consent of MCHCP. Notwithstanding the foregoing, CONTRACTOR may, without the consent of MCHCP, assign its rights to payment to be received under this Contract, provided that Contractor provides written notice of such assignment to MCHCP together with a written acknowledgment from the assignee that any such payments are subject to all of the terms and conditions of this Contract. For the purposes of this Contract, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in Contractor provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company. Any assignment consented to by MCHCP shall be evidenced by a written assignment agreement executed by Contractor and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of this Contract and to assume the duties, obligations, and responsibilities being assigned. A change of name by Contractor, following which Contractor's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. Contractor shall give MCHCP written notice of any such change of name.

2.14 Patent, Copyright, and Trademark Indemnity: Contractor warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of this Contract which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to MCHCP under this Contract. Contractor shall defend any suit or proceeding brought against MCHCP on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of this Contract. This is upon condition that MCHCP shall provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, MCHCP may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by MCHCP at Contractor's written request, it shall be at Contractor's expense, but the responsibility for such expense shall be only that within Contractor's written authorization. Contractor shall indemnify and hold MCHCP harmless from all damages, costs, and expenses, including attorney's fees that Contractor or MCHCP may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of this Contract. If any of the products provided by Contractor in such suit or proceeding are held to constitute infringement and the use is enjoined, Contractor shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal performance products or modify them so that they are no longer infringing. If Contractor is unable to do any of the preceding, Contractor agrees to remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of MCHCP, only those items of equipment or software which are held to be infringing, and to pay MCHCP: 1) any amounts paid by MCHCP towards the purchase of the product, less straight line depreciation; 2) any license fee paid by MCHCP for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee presenting the time remaining in any period of maintenance paid for. The obligations of Contractor under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of Contractor without its written consent.

2.15 Compensation/Expenses: Contractor shall be required to perform the specified services at the price(s) quoted in this Contract. All services shall be performed within the time period(s) specified in this Contract. Contractor shall be compensated only for work performed to the satisfaction of MCHCP. Contractor shall not be allowed or paid travel or per diem expenses except as specifically set forth in this Contract.

2.16 Contractor Expenses: Contractor will pay and will be solely responsible for Contractor's travel expenses and out-of-pocket expenses incurred in connection with providing the services. Contractor will be responsible for payment of all expenses related to salaries, benefits, employment taxes, and insurance for its staff.

2.17 Tax Payments: Contractor shall pay all taxes lawfully imposed on it with respect to any product or service delivered in accordance with this Contract. MCHCP is exempt from Missouri state sales or use taxes and federal excise taxes for direct purchases. MCHCP makes no representation as to the exemption from liability of any tax imposed by any governmental entity on Contractor.

2.18 Conflicts of Interest: Contractor shall not knowingly employ, during the period of this Contract or any extensions to it, any professional personnel who are also in the employ of the State of Missouri or MCHCP and who are providing services involving this Contract or services similar in nature to the scope of this Contract to the State of Missouri. Furthermore, Contractor shall not knowingly employ, during the period of this Contract or any extensions to it, any employee of MCHCP who has participated in the making of this Contract until at least two years after his/her termination of employment with MCHCP.

3 MCHCP'S OBLIGATIONS

3.1 Administrative Services: MCHCP shall provide the following administrative services to assist CONTRACTOR

- Certification of eligibility;
- Enrollments (new, change and terminations) in an electronic format;
- Maintenance of individual eligibility and membership data;
- Payment of monies due Contractor;
- Coordination of open enrollment period; and
- Administration of COBRA regulations.

3.2 Eligibility: All determinations for coverage eligibility will be made by MCHCP. Effective and termination dates of plan participants will be determined by MCHCP. Contractor will be notified of enrollment changes through the carrier enrollment eligibility file, by telephone or by written notification from MCHCP. Eligibility and Enrollment periods will be determined by state regulations, 22 CSR 10-2.020 and 22 CSR 10-3.030. Contractor shall refer any and all questions received from members regarding eligibility or premiums to MCHCP.

3.3 Payment: Contractor shall agree that the monthly premium due the contractor will be self-billed and will be initiated for electronic payment via automated clearing house (ACH) on the twentieth of the month following the month of coverage. MCHCP will remit all payments and provide all associated reports electronically. Contractor shall have the right to audit appropriate MCHCP records to determine the accuracy of the monthly premium paid. Any discrepancies must be identified by Contractor within 90 days after receipt of the payment and such discrepancy must be submitted in writing to MCHCP. Failure to identify a discrepancy within the time frame stated shall be considered as acceptance of MCHCP's calculations, payment and records.

4 RECORDS RETENTION, ACCESS, AUDIT, AND FINANCIAL COMPLIANCE

4.1 Retention of Records: Unless MCHCP specifies in writing a shorter period of time, Contractor agrees to preserve and make available all of its books, documents, papers, records and other evidence involving transactions related to this contract for a period of seven (7) years from the date of the expiration or termination of this contract. Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds seven (7) years. Contractor agrees that authorized federal representatives, MCHCP personnel, and independent auditors acting on behalf of MCHCP and/or federal agencies shall have access to and the right to examine records during the contract period and during the ten (7) year post contract period. Delivery of and access to the records shall be at no cost to MCHCP.

4.2 Audit Rights: Audit Rights: MCHCP and its designated auditors shall have access to and the right to examine any and all pertinent books, documents, papers, files, or records of Contractor involving any and all transactions related to the performance of this Contract. Contractor shall furnish all information necessary for MCHCP to comply with all Missouri and/or federal laws and regulations. MCHCP shall bear the cost of any such audit or review. MCHCP and Contractor shall agree to reasonable times for Contractor to make such records available for audit.

4.3 Ownership: All data developed or accumulated by Contractor under this Contract shall be owned by MCHCP. Contractor may not release any data without the written approval of MCHCP. MCHCP shall be entitled at no cost and in a timely manner to all data and written or recorded material pertaining to this Contract in a format acceptable to MCHCP. MCHCP shall have unrestricted authority to reproduce, distribute, and use any submitted report or data and any associated documentation that is designed or developed and delivered to MCHCP as part of the performance of this Contract.

4.4 Access to Records: Upon reasonable notice, Contractor must provide, and cause its subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are directly pertinent to the performance of the services. Such access must be provided to MCHCP and, upon execution of a confidentiality agreement, to any independent auditor or consultant acting on behalf of MCHCP; and any other entity designated by MCHCP. Contractor agrees to provide the access described wherever Contractor maintains such books, records, and supporting documentation. Further, Contractor agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, or other conveniences deemed reasonably necessary to fulfill the purposes described in this section. Contractor shall require its subcontractors to provide comparable access and accommodations. MCHCP shall have the right, at reasonable times and at a site designated by MCHCP, to audit the books, documents and records of Contractor to the extent that the books, documents and records relate to costs or pricing data for this Contract. Contractor agrees to maintain records which will support the prices charged and costs incurred for performance of services performed under this Contract. Also, Contractor must furnish all information necessary for MCHCP to comply with all state and/or federal regulations. To the extent described herein, Contractor shall give full and free access to all records to MCHCP and/or their authorized representatives.

4.5 Financial Record Audit and Retention: Contractor agrees to maintain, and require its subcontractors to maintain, supporting financial information and documents that are adequate to ensure the accuracy and validity of Contractor's invoices. Such documents will be maintained and retained by Contractor or its subcontractors for a period of ten (10) years after the date of submission of the final billing or until the resolution of all audit questions, whichever is longer. Contractor agrees to timely repay any undisputed audit exceptions taken by MCHCP in any audit of this Contract.

4.6 Response/Compliance with Audit or Inspection Findings: Contractor must take action to ensure its or its subcontractors' compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to the services or any other deficiency contained in any audit, review, or inspection. This action will include Contractor's delivery to MCHCP, for MCHCP's approval, a corrective action plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s).

4.7 Inspections: Upon notice from MCHCP, Contractor will provide, and will cause its subcontractors to provide, such auditors and/or inspectors as MCHCP may from time to time designate, with access to Contractor service locations, facilities, or installations. The access described in this section shall be for the purpose of performing audits or inspections of the Services and the business of MCHCP. Contractor must provide as part of the services any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

5 Scope of Work

5.1 Fully Insured Plan: The contractor shall provide a fully-insured dental plan(s) for eligible and enrolled State and Public Entity members in accordance with the provisions and requirements of this contract on behalf of MCHCP.

5.2 Level of Benefits: Contractor must administer the plan design presented in the RFP and attached as Exhibit X of this contract. <<details of plan(s) selected will be added after award>>. Under no circumstances shall the contractor require a member to pay for any dental services except for stated premiums, deductibles, co-payments, coinsurance, balance billing resulting from non-network services and non-covered services. Members shall not be required to pay any additional enrollment fees, application fees or other charges in addition to the monthly premium.

5.3 COBRA Coverage: Contractor shall comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Public Law 99-272, as amended, and provide the required maximum period of continuation coverage for eligible members. The contractor agrees that MCHCP will administer COBRA and will retain the additional 2 percent premium.

5.4 Certificate of Insurance: Contractor shall annually provide MCHCP a copy of its Certificate of Insurance by January 1 of each year.

5.5 Website: Contractor must have an active, current website that is updated regularly. MCHCP members must be able to access this site to obtain current listings of active network providers and other information. The provider listing must be searchable, at a minimum, by zip code, specialty and provider name. If MCHCP discovers that provider information contained at the contractor's website is inaccurate, MCHCP will notify Contractor immediately. Contractor must correct inaccuracies within 10 days of being notified by MCHCP.

5.6 Single Sign On: Contractor must be able to support single sign-on from MCHCP's own Member Portal to the contractor's Member Portal utilizing Security Assertion Markup Language (SAML2).

5.7 Appeals and Grievance Procedure: Contractor shall have the responsibility to perform a complete investigation of all complaints, grievances and appeals and make decisions regarding dental necessity and the provision of services or benefits. Contractor shall have a timely and organized system for resolving members' complaints and grievances in compliance with state and federal laws and regulations, as amended. If the member's grievance is not resolved to his or her satisfaction, the member has the right to a formal appeal to Contractor. Contractor's appeal process shall be in compliance with state and federal laws and regulations as amended.

5.8 Account Management: Contractor shall establish and maintain throughout the term of the contract an account management team that will work directly with MCHCP staff. This team must include, but is not limited to, a dedicated account executive, a customer service manager, clinical advisor, a person responsible for preparing the reports and an information technology representative. Approval of the account management team rests with MCHCP. The account executive and service representative(s) will deal directly with MCHCP's benefit administration staff. The account management team must:

5.8.1 Be able to devote the time needed to the account, including being available for telephone and on-site consultation with MCHCP.

5.8.2 Be extremely responsive.

5.8.3 Be comprised of individuals with specialized knowledge of the contractor's networks, claims and eligibility systems, system reporting capabilities, claims adjudication policies and procedures, administrative services, and relations with third parties.

5.8.4 Be thoroughly familiar with virtually all of the contractor's functions that relate directly or indirectly to the MCHCP account.

5.8.5 Act on behalf of MCHCP in cutting through the bureaucracy of the Contractor's organization. The account management team must be able to effectively advance the interest of MCHCP through CONTRACTOR's corporate structure.

5.8.6 Contractor agrees to provide MCHCP with at least 15 days advance notice of any material change to its account management and servicing methodology or to a personnel change in the contractor's account management and servicing team.

5.9 Meetings: MCHCP requires Contractor to meet with MCHCP staff and/or Board of Trustees as requested to discuss the status of the MCHCP account in terms of utilization patterns and costs, as well as propose new ideas that may benefit MCHCP and its members. Contractor is expected to present actual MCHCP claims experience and offer suggestions as to ways the benefit could be modified in order to reduce costs or improve the health of MCHCP members. Suggestions must be modeled against actual MCHCP membership and claims experience to determine the financial impact as well as the number of members impacted. Contractor must also present benchmark data by using the plan's entire book of business, a comparable client to MCHCP, or some other industry norm.

5.10 Customer Service: Contractor must provide a high quality and experienced customer service unit. Contractor's staff members must be fully trained in the MCHCP benefit design, and the contractor must have the ability to track and report performance in terms of telephone response time, call abandonment rate, and the number of inquiries made by type.

5.10.1 Contractor shall maintain a toll-free telephone line to provide prompt access for members and providers to qualified customer service personnel. At a minimum, customer service must be available between the hours of 8:00 a.m. and 5:00 p.m. CT Monday through Friday except for designated holidays.

5.10.2 Contractor must have a customer service unit in place to answer member inquiries regarding, but not limited to, network and benefit issues.

5.10.3 Contractor shall refer any and all questions received from members regarding eligibility or premiums to MCHCP.

5.11 ID Cards: Contractor is responsible for developing, printing and mailing any necessary identification cards directly to the member's home. Contractor is responsible for these production and mailing costs.

5.12 Written Communications: Contractor shall agree that MCHCP reserves the right to review and approve all written communications and marketing materials developed and used by Contractor to communicate specifically with MCHCP members at any time during the contract period. This does not refer to items such as provider directories and plan-wide newsletters as long as they do not contain information on eligibility, enrollment, benefits, rates, etc., which MCHCP must review. Notwithstanding the foregoing, nothing herein prohibits contractor from communicating directly with members in the regular course of providing services under the contract (e.g., responding to member inquiries, etc.).

5.13 Contracted Network: Contractor must have in place a contracted provider network which will offer access to all MCHCP members nationwide to assure that all services will be accessible without unreasonable delay or unreasonable travel. The offered network must include a full range of general dental practitioners and dental specialists. Contractors are responsible for having a network available that can provide access to all covered services under this contract and to meet member needs within reasonable geography and reasonable time. MCHCP requires that network providers be responsible for obtaining all necessary pre-certifications, pre-authorizations, and filing claims for members. At a minimum, ninety percent (90%) of MCHCP members shall have access to a network general dentist provider within twenty (20) miles of their zip code. Contractor shall report network geographic access analysis results to MCHCP by January 31 of each year or within 30 days after a material network change.

5.14 Non-network paid as Network: Contractor shall pay covered services as a network benefit when provided by a non-network provider in the instance that the service is not available through a network provider within seventy-five (75) miles of the member's home or in a reasonable appointment availability time. The member must seek approval from the contractor before the date of service to have the non-network provider's claims approved as a network benefit. Such approval shall be granted for a minimum three (3) month period.

5.15 Provider Listings: No provider may be listed on Contractor's website or distributed to the membership through the dental plan's customer service unit unless a signed contract is in place. In the event a plan provides incorrect information and a member seeks treatment based on that information, Contractor agrees to recognize and be financially responsible for any services rendered by that provider, under the terms of this contract, as if the provider had been under contract.

5.16 Performance Guarantees: Contractor is obligated to follow the performance standards as outlined in Attachment x of this contract.

5.17 Information Technology and Eligibility File: The contractor shall be able to accept, via secure file transfer, all MCHCP eligibility information on a weekly basis utilizing the ASC X12N 834 (005010X095A1) transaction set. MCHCP will supply specific record set information in an electronic format and the contractor must process such information within 24 hours of receipt. The contractor must provide a dedicated technical contact that will provide support to MCHCP Information Technology Department for any EDI issues.

5.17.1 It is MCHCP's intent to send a transactional based eligibility file weekly and a periodic full eligibility reconciliation file. Contractor is expected to provide an audit report of this reconciliation for MCHCP review of accuracy.

5.17.2 MCHCP will provide a recommended data mapping for the 834 transaction set to the Contractor.

5.17.3 Within two business days after processing any eligibility related file, the contractor will provide a report that lists any errors and exceptions that occurred during processing. The report will also provide record counts, error counts and list the records that had an error, along with an error message to indicate why it failed. A list of the conditions the contractor audits will be provided to ensure the data MCHCP is sending will pass the contractor's audit tests.

5.17.4 The contractor shall provide access to view member data on their system via a web based "Employer Portal" to ensure MCHCP provided eligibility files are correctly updating the contractor's system, and for MCHCP member support to verify individual member specific information on demand.

5.17.5 Contractor will supply a data dictionary of the fields MCHCP is updating on their system and the allowed values for each field.

5.17.6 Contractor shall provide MCHCP with a monthly file ("eligibility audit file") in a mutually agreed upon format of contractor's eligibility records for all MCHCP members. Such file shall be utilized by MCHCP to audit contractor's records. Such eligibility audit file shall be provided to MCHCP no later than the second Thursday of each month.

5.17.7 The required method for all file transfers is Secure FTP. No PGP is required but can be implemented upon request. MCHCP will provide an account for the contractor transfers at ftp.mchcp.org.

5.18 Implementation: Contractor and MCHCP must agree to a final implementation schedule within 30 days of the contract award. At a minimum, the timeline must include the required dates for the following activities:

- Testing of eligibility file;
- Acceptable date for final eligibility file;
- ID card production and distribution;

- Enrollment kit printing
- Testing of claim file to data warehouse Contractor

5.18.1 Contractor must have a customer service unit in place to answer member inquiries. Note: Open enrollment is anticipated to be October 1-31, 2023 with coverage effective January 1, 2024. At a minimum, the customer service unit must be able to address network and benefit issues.

5.18.2 **Initial Eligibility File Testing**: Contractor must work with MCHCP to develop a schedule for testing of the eligibility test record set and error reporting responses. MCHCP requires that the contractor accept and run an initial test record set no later than October 15th, 2023. Results of the test must be provided to MCHCP by October 30th, 2023. Final acceptance of all eligibility file formats and responses are expected no later than November 30th, 2023.

5.19 Electronic Transmission Protocols: The contractor and all subcontractors shall maintain encryption standards of 2048 bits or greater for RSA key pairs, and 256 bit session key strength for the encryption of confidential information and transmission over public communication infrastructure. Batch transfers of files will be performed using SFTP or FTPS with similar standards and refined as needed to best accommodate provider configurations (i.e. port assignment, access control, etc.).

6 REPORTING

6.1 Contractor agrees that all data required by MCHCP shall be confidential and will not be public information. Contractor further agrees not to disclose this or similar information to any person or company, either directly or indirectly.

6.2 MCHCP reserves the right to retain a third party contractor (currently Merative) to receive claims-level data from Contractor and store the data on MCHCP's behalf. This includes a full claim file including, but not limited to all financial, demographic and utilization fields. The contractor agrees to cooperate with MCHCP's designated third party contractor in the fulfillment of Contractor's duties under this contract, including the provision of data as specified without constraint on its use. Contractor further agrees to:

6.2.1 Provide claims, person-level capitation and utilization data to MCHCP and/or MCHCP's data Contractor in a format specified by MCHCP with the understanding that the data shall be owned by MCHCP;

6.2.2 Provide data in an electronic form and within a time frame specified by MCHCP;

6.2.3 Place no restraints on use of the data, provided MCHCP has in place procedures to protect the confidentiality of the data consistent with HIPAA requirements; and

6.2.4 This obligation continues for a period of one year following contract termination.

6.3 Quarterly and Annual Reports: Contractor shall submit standard reports to MCHCP on a quarterly and annual basis. (MCHCP and Contractor will negotiate the format and content upon award of this contract.) The reports shall be submitted to MCHCP quarterly and are due within 30 days of the end of the quarter reported. Annual reports are due within 45 days of the end of the year.

6.4 Call Reports: Contractor shall provide quarterly reports detailing customer service telephone answer time and abandonment. A sample of the bidder's standard reports must be submitted with the proposal. The reports shall be submitted to MCHCP quarterly and are due within 30 days of the end of the quarter reported.

6.5 Annual Customer Satisfaction Survey: At the request of MCHCP and at Contractor's expense, Contractor agrees to conduct an annual customer satisfaction survey, and provide MCHCP with all information and responses in connection therewith.

6.6 Ad Hoc Reports: At the request of MCHCP, Contractor shall submit additional ad hoc reports on information and data readily available to Contractor.

6.7 Acceptance of Reports and Damages for Late Reports: MCHCP will determine the acceptability of all reports submitted based upon timeliness, format and content. If reports are not deemed to be acceptable or have not been submitted as requested, the contractor will receive written notice to this effect and the applicable liquidated damages, as defined in Exhibit X, will be assessed.

7 CANCELLATION, TERMINATION OR EXPIRATION

7.1 MCHCP's rights Upon Termination or Expiration of Contract: If this Contract is terminated, MCHCP, in addition to any other rights provided under this Contract, may require Contractor to transfer title and deliver to MCHCP in the manner and to the extent directed, any completed materials. MCHCP shall be obligated only for those services and materials rendered and accepted prior to termination.

7.2 Termination for Cause: MCHCP may terminate this Contract, or any part of this Contract, for cause under any one of the following circumstances: 1) Contractor fails to make delivery of goods or services as specified in this Contract; 2) Contractor fails to satisfactorily perform the work specified in this Contract; 3) Contractor fails to make progress so as to endanger performance of this Contract in accordance with its terms; 4) Contractor breaches any provision of this Contract; 5) Contractor assigns this Contract without MCHCP's approval; or 6) Insolvency or bankruptcy of Contractor. MCHCP shall have the right to terminate this Contract, in whole or in part, if MCHCP determines, at its sole discretion, that one of the above listed circumstances exists. In the event of termination, Contractor shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP, subject to any offset by MCHCP for actual damages including loss of any federal matching funds. Contractor shall be liable to MCHCP for any reasonable excess costs for such similar or identical services included within the terminated part of this Contract.

7.3 Termination Right: Notwithstanding any other provisions, MCHCP reserves the right to terminate this Contract at the end of any month by giving thirty (30) days' notice, without penalty.

7.4 Termination by Mutual Agreement: The parties may mutually agree to terminate this Contract or any part of this Contract at any time. Such termination shall be in writing and shall be effective as of the date specified in such agreement.

7.5 Arbitration, Damages, Warranties: Notwithstanding any language to the contrary, no interpretation shall be allowed to find MCHCP has agreed to binding arbitration, or the payment of damages or penalties upon the occurrence of a contingency. Further, MCHCP shall not agree to pay attorney fees and late payment charges beyond those available under this Contract, and, if applicable, no provision will be given effect which attempts to exclude, modify, disclaim or otherwise attempt to limit implied warranties of merchantability and fitness for a particular purpose.

7.6 Rights and Remedies: If this Contract is terminated, MCHCP, in addition to any other rights provided for in this Contract, may require Contractor to deliver to MCHCP in the manner and to the extent directed, any completed materials. In the event of termination, Contractor shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP subject to any offset by MCHCP for actual damages. The rights and remedies of MCHCP provided for in this Contract shall not be exclusive and are in addition to any other rights and remedies provided by law.

THE UNDERSIGNED PERSONS REPRESENT AND WARRANT THAT WE ARE LEGALLY FREE TO ENTER THIS AGREEMENT, OUR EXECUTION OF THIS AGREEMENT HAS BEEN DULY AUTHORIZED, AND OUR SIGNATURES BELOW SIGNIFY OUR CONSENT TO BE BOUND TO THE FOREGOING TERMS AND CONDITIONS.

Missouri Consolidated Health Care Plan	**CONTRACTOR**
By: ______________________________	By: ______________________________
Title: Executive Director	Title: ____________________________
Date: _____________________________	Date: _____________________________

EXHIBIT A-10
SAMPLE BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") between the Missouri Consolidated Health Care Plan (hereinafter "Covered Entity" or "MCHCP") and Dental Insurer. (hereinafter "Business Associate") is entered into as a result of the business relationship between the parties in connection with services requested and performed in accordance with the RFP Name ("RFP") and under Contract *#2024-DS-01*, as renewed and amended, (hereinafter the "Contract").

This Agreement supersedes all other agreements, including any previous business associate agreements, between the parties with respect to the specific matters addressed herein. In the event the terms of this Agreement are contrary to or inconsistent with any provisions of the Contract or any other agreements between the parties, this Agreement shall prevail, subject in all respects to the Health Insurance Portability and Accountability Act of 1996, as amended (the "Act"), and the HIPAA Rules, as defined in Section 2.1 below.

1 **Purpose**.

The Contract is for fully insured dental insurance for state and public entity members.

The purpose of this Agreement is to comply with requirements of the Act and the implementing regulations enacted under the Act, 45 CFR Parts 160 - 164, as amended, to the extent such laws relate to the obligations of business associates, and to the extent such laws relate to obligations of MCHCP in connection with services performed by Dental Insurer for or on behalf of MCHCP under the Contract. This Agreement is required to allow the parties to lawfully perform their respective duties and maintain the business relationship described in the Contract.

2 **Definitions**.

2.1 For purposes of this Agreement:

"Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to this Agreement, shall mean Dental Insurer.

"Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to this Agreement, shall mean MCHCP.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules set forth in 45 CFR Parts 160 and 164, as amended.

2.2 Unless otherwise expressly stated in this Agreement, all words, terms, specifications, and requirements used or referenced in this Agreement which are defined in the HIPAA Rules shall have the same meanings as described in the HIPAA Rules, including but not limited to: breach; data aggregation; designated record set; disclose or disclosure; electronic media; electronic protected health information ("ePHI"); family member; genetic information; health care; health information; health care operations; individual; individually identifiable health information; marketing; minimum necessary; notice of privacy practices; person; protected health information ("PHI"); required by law;

Secretary; security incident; standard; subcontractor; transaction; unsecured PHI; use; violation or violate; and workforce.

2.3 To the extent a term is defined in the Contract and this Agreement, the definition in this Agreement, subject in all material respects to the HIPAA Rules, shall govern.

2.4 Notwithstanding the forgoing, for ease of reference throughout this Agreement, Business Associate understands and agrees that wherever PHI is referenced in this Agreement, it shall be deemed to include all MCHCP-related PHI in any format or media including paper, recordings, electronic media, emails, and all forms of MCHCP-related ePHI in any data state, be it data in motion, data at rest, data in use, or otherwise.

3 **Obligations and Activities of Business Associate**.

3.1 Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as required by law.

3.2 Appropriate Safeguards. Business Associate agrees to implement, maintain, and use appropriate administrative, physical, and technical safeguards, and fully comply with all applicable standards, implementation specifications, and requirements of Subpart C of 45 CFR Part 164 with respect to ePHI, in order to: (i) ensure the confidentiality, integrity, and availability of ePHI created, received, maintained, or transmitted; (ii) protect against any reasonably anticipated threats or hazards to the security or integrity of such information; and (iii) protect against use or disclosure of ePHI by Business Associate, its workforce, and its subcontractors other than as provided for by this Agreement.

3.3 Subcontractors. Pursuant to §§ 164.308(b)(2) and 164.502(e)(1)(ii), Business Associate agrees it will not permit any subcontractors to create, receive, access, use, maintain, disclose, or transmit PHI in connection with, on behalf of, or under the direction of Business Associate in connection with performing its duties and obligations under the Contract unless and until Business Associate obtains satisfactory assurances in the form of a written contract or written agreement in accordance with §§ 164.504(e) and 164.314(a)(2) that the subcontractor(s) will appropriately safeguard PHI and in all respects comply with the same restrictions, conditions, and requirements applicable to Business Associate under the HIPAA Rules and this Agreement with respect to such information.

In addition to the forgoing, and in accordance with the Contract, Business Associate agrees it will not permit any subcontractor, or use any off-shore entity, to perform services under the Contract, including creation, use, storage, or transmission of PHI at any location(s) outside of the United States.

3.4 Reports to MCHCP. Business Associate agrees to report any use or disclosure of PHI not authorized or provided for by this Agreement, including breaches of unsecured PHI and any security incident involving MCHCP to MCHCP in accordance with the notice provisions prescribed in this Section 3.4. For purposes of the security incident reporting requirement, the term "security incident" shall not include inconsequential incidents that occur on a daily basis, such as scans, "pings," or other unsuccessful attempts to penetrate computer networks or servers containing ePHI maintained or transmitted by Business Associate.

3.4.1 The notice shall be delivered to, and confirmed received by, MCHCP without unreasonable delay, but in any event no later than three (3) business days of Business Associate's first discovery, as discovery is described under § 164.410, of the unauthorized use or disclosure, breach of unsecured PHI, or security incident.

3.4.2 The notice shall be in writing and sent to both of the following MCHCP workforce members and deemed delivered only upon personal confirmation, acknowledgement or receipt in any form, verbal or written, from one of the designated recipients:

- MCHCP's Privacy Officer → currently, Jennifer Stilabower, (573) 522-3242, Jennifer.Stilabower@mchcp.org, 832 Weathered Rock Court, Jefferson City, MO 65101

- MCHCP's Security Officer → currently, Brad Kifer, (573) 526-2858, Brad.Kifer@mchcp.org, 832 Weathered Rock Court, Jefferson City, MO 65101

If, and only if, Business Associate receives an email or voicemail response indicating neither of the intended MCHCP recipients are available and no designee(s) confirm receipt within eight (8) business hours on behalf of one or both of the above-named MCHCP Officers, Business Associate shall forward the written notice to their primary MCHCP contact with copies to the Privacy and Security Officers for documentation purposes.

3.4.3 The notice shall include to the fullest extent possible:

a) a detailed description of what happened, including the date, time, and all facts and circumstances surrounding the unauthorized use or disclosure, breach of unsecured PHI, or security incident;

b) the date, time, and circumstances surrounding when and how Business Associate first became aware of the unauthorized use or disclosure, breach of unsecured PHI, or security incident;

c) identification of each individual whose PHI has been, or is reasonably believed by Business Associate to have been involved or otherwise subject to possible breach;

d) a description of all types of PHI known or potentially believed to be involved or affected;

e) identification of any and all unauthorized person(s) who had access to or used the PHI or to whom an unauthorized disclosure was made;

f) all decisions and steps Business Associate has taken to date to investigate, assess risk, and mitigate harm to MCHCP and all potentially affected individuals;

g) contact information, including name, position or title, phone number, email address, and physical work location of the individual(s) designated by Business Associate to act as MCHCP's primary contact for purposes of the notice triggering event(s);

h) all corrective action steps Business Associate has taken or shall take to prevent future similar uses, disclosures, breaches, or incidents;

i) if all investigatory, assessment, mitigation, or corrective action steps are not complete as of the date of the notice, Business Associate's best estimated timeframes for completing each planned but unfinished action step; and

j) any action steps Business Associate believes affected or potentially affected individuals should take to protect themselves from potential harm resulting from the matter.

3.4.4 Business Associate agrees to cooperate with MCHCP during the course of Business Associate's investigation and risk assessment and to promptly and regularly update MCHCP in writing as supplemental information becomes available relating to any of the items addressed in the notice.

3.4.5 Business Associate further agrees to provide additional information upon and as reasonably requested by MCHCP; and to take any additional steps MCHCP reasonably deems necessary or advisable to comply with MCHCP's obligations as a covered entity under the HIPAA Rules.

3.4.6 Business Associate expressly acknowledges the presumption of breach with respect to any unauthorized acquisition, access, use, or disclosure of PHI, unless Business Associate is able to demonstrate otherwise in accordance with § 164.402(2), in which case, Business Associate agrees to fully document its assessment and all factors considered and provide MCHCP no later than ten (10) calendar days following Business Associate's discovery with its complete written risk assessment, conclusion reached, and all documentation supporting a conclusion that the unauthorized acquisition, access, use, or disclosure of PHI presents a low probability that PHI has been compromised.

3.4.7 The parties agree to work together in good faith, making every reasonable effort to reach consensus regarding whether a particular circumstance constitutes a breach or otherwise warrants notification, publication, or reporting to any affected individual, government body, or the public and also the appropriate means and content of any notification, publication, or report. Notwithstanding the foregoing, all final decisions involving questions of breach of PHI shall be made by MCHCP, including whether a breach has occurred, and any notification, publication, or public reporting required or reasonably advisable under the HIPAA Rules and MCHCP's Notice of Privacy Practices based on all objective and verifiable information provided to MCHCP by Business Associate under this Section 3.4

3.4.8 Business Associate agrees to bear all reasonable and actual costs associated with any notifications, publications, or public reports relating to breaches by Business Associate, any subcontractor of Business Associate, and any employee or workforce member of Business Associate and/or its subcontractors, as MCHCP deems necessary or advisable.

3.5 <u>Confidential Communications</u>. Business Associate agrees it will promptly implement and honor individual requests to receive PHI by alternative means or at an alternative location provided such request has been directed to and approved by MCHCP in accordance with § 164.522(b) applicable to covered entities. If Business Associate receives a request for confidential communications directly from an individual, Business Associate agrees to refer the individual, and promptly forward the individual's request, to MCHCP so that MCHCP can assess, accommodate, and coordinate reasonable requests of this nature in accordance with the HIPAA Rules and prepare a timely response to the individual.

3.6 Individual Access to PHI. If an individual requests access to PHI under § 164.524, Business Associate agrees it will make all PHI about the individual which Business Associate created or received for or from MCHCP that is in Business Associate's custody or control available in a designated record set to MCHCP or, at MCHCP's direction, to the requesting individual or his or her authorized designee, in order to satisfy MCHCP's obligations as follows:

3.6.1 If Business Associate receives a request for individual PHI in a designated record set from MCHCP, Business Associate will provide the requested information to MCHCP within five (5) business days from the date of the request in a readily accessible and readable form and manner or as otherwise reasonably specified in the request.

3.6.2 If Business Associate receives a request for PHI in a designated record set directly from an individual current or former MCHCP member, Business Associate will require that the request be made in writing and will also promptly notify MCHCP that a request has been made verbally. If the individual submits a written request for PHI in a designated record set directly to Business Associate, no later than five (5) business days thereafter, Business Associate shall provide MCHCP with: (i) a copy of the individual's request to MCHCP for purposes of determining an appropriate response to the request; (ii) the designated record sets in Business Associate's custody or control that are subject to access by the requesting individual(s) requested in the form and format requested by the individual if it is readily producible in such form and format, or if not, in a readable hard copy form; and (iii) the titles of the persons or offices responsible for receiving and processing requests for access by individual(s). MCHCP will direct Business Associate in writing within five (5) business days following receipt of the information described in (i), (ii), and (iii) of this subsection 3.6.2 whether Business Associate should send the requested designated data set directly to the individual or whether MCHCP will forward the information received from Business Associate as part of a coordinated response or if for any reason MCHCP deems the response should be sent from MCHCP or another Business Associate acting on behalf of MCHCP. If Business Associate is directed by MCHCP to respond directly to the individual, Business Associate agrees to provide the designated record set requested in the form and format requested by the individual if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by Business Associate and the individual. Business Associate will provide MCHCP's Privacy Officer with a copy of all responses sent to individuals pursuant to § 164.524 and the directives set forth in this subsection 3.6.2 for MCHCP's compliance and documentation purposes.

3.7 Amendments of PHI. Business Associate agrees it will make any amendment(s) to PHI in a designated record set as directed or agreed to by MCHCP pursuant to § 164.526, and take other measures as necessary and reasonably requested by MCHCP to satisfy MCHCP's obligations under § 164.526.

3.7.1 If Business Associate receives a request directly from an individual to amend PHI created by Business Associate, received from MCHCP, or otherwise within the custody or control of Business Associate at the time of the request, Business Associate shall promptly refer the individual to MCHCP's Privacy Officer, and, if the request is in writing, shall forward the individual's request three (3) business days to MCHCP's Privacy Officer so that MCHCP can evaluate, coordinate and prepare a timely response to the individual's request.

3.7.2 MCHCP will direct Business Associate in writing as to any actions Business Associate is required to take with regard to amending records of individuals who exercise their right to amend PHI under the HIPAA Rules. Business Associate agrees to follow the direction of MCHCP regarding such amendments and to provide written confirmation of such action within seven (7) business days of receipt of MCHCP's written direction or sooner if such earlier action is required to enable MCHCP to comply with the deadlines established by the HIPAA Rules.

3.8 PHI Disclosure Accounting. Business Associate agrees to document, maintain, and make available to MCHCP within seven (7) calendar days of a request from MCHCP for all disclosures made by or under the control of Business Associate or its subcontractors that are subject to accounting, including all information required, under § 164.528 to satisfy MCHCP's obligations regarding accounting of disclosures of PHI.

3.8.1 If Business Associate receives a request for accounting directly from an individual, Business Associate agrees to refer the individual, and promptly forward the individual's request, to MCHCP so that MCHCP can evaluate, coordinate and prepare a timely response to the individual's request.

3.8.2 In addition to the provisions of 3.8.1, all PHI accounting requests received by Business Associate directly from the individual shall be acted upon by Business Associate as a request from MCHCP for purposes of Business Associate's obligations under this section. Unless directed by MCHCP to respond directly to the individual, Business Associate shall provide all accounting information subject to disclosure under § 164.528 to MCHCP within seven (7) calendar days of the individual's request for accounting.

3.9 Privacy of PHI. Business Associate agrees to fully comply with all provisions of Subpart E of 45 CFR Part 164 that apply to MCHCP to the extent Business Associate has agreed or assumed responsibilities under the Contract or this Agreement to carry out one or more of MCHCP's obligation(s) under 45 CFR Part 164 Subpart E.

3.10 Internal Practices, Books, and Records. Upon request of MCHCP or the Secretary, Business Associate will make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of MCHCP available to MCHCP and/or the Secretary in a time and manner designated by MCHCP or the Secretary for purposes of determining MCHCP's and/or Business Associate's compliance with the HIPAA Rules.

4 **Permitted Uses and Disclosures of PHI by Business Associate**.

4.1 Contractual Authorization. Business Associate may access, create, use, and disclose PHI as necessary to perform its duties and obligations required by the Contract, including but not limited to specific requirements set forth in the Scope of Work (as such term is defined in the Contract), as amended. Without limiting the foregoing general authorization, MCHCP specifically authorizes Business Associate to access, create, receive, use, and disclose all PHI which is required to provide the services specified in the Contract. The parties agree that no provision of the Contract permits Business Associate to use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if used or disclosed in like manner by MCHCP except that:

4.1.1 This Agreement permits Business Associate to use PHI received in its capacity as a business associate of MCHCP, if necessary: (A) for the proper management and administration of Business Associate; or (B) to carry out the legal responsibilities of Business Associate.

4.1.2 This Agreement permits Business Associate to combine PHI created or received on behalf of MCHCP as authorized in this Agreement with PHI lawfully created or received by Business Associate in its capacity as a business associate of other covered entities to permit data analysis relating to the health care operations of MCHCP and other PHI contributing covered entities in order to provide MCHCP with such comprehensive, aggregate summary reports as specifically required by, or specially requested under, the Contract.

4.2 Authorization by Law. Business Associate may use or disclose PHI as permitted or required by law.

4.3 Minimum Necessary. Notwithstanding any other provision in the Contract or this Agreement, with respect to any and all uses and disclosures permitted, Business Associate agrees to request, create, access, use, disclose, and transmit PHI involving MCHCP members subject to the following minimum necessary requirements:

4.3.1 When requesting or using PHI received from MCHCP, a member of MCHCP, or an authorized party or entity working on behalf of MCHCP, Business Associate shall make reasonable efforts to limit all requests and uses of PHI to the minimum necessary to accomplish the intended purpose of the request or use. Business Associate agrees its reasonable efforts will include identifying those persons or classes of persons, as appropriate, in Business Associate’s workforce who need access to MCHCP member PHI to carry out their duties under the Contract. Business Associate further agrees to identify the minimally necessary amount of PHI needed by each such person or class and any conditions appropriate to restrict access in accordance with such assessment.

4.3.2 For any type of authorized disclosure of PHI that Business Associate makes on a routine basis to third parties, Business Associate shall implement procedures that limit the PHI disclosed to the amount minimally necessary to achieve the purpose of the disclosure. For all other authorized but non-routine disclosures, Business Associate shall develop and follow criteria for reviewing requests and limiting disclosures to the information minimally necessary to accomplish the purposes for which disclosure is sought.

4.3.3 Business Associate may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose if and when:

a) Making disclosures to public officials as permitted under § 164.512, if the public official represents that the information requested is the minimum necessary for the stated purpose(s); or

b) The information is requested by a professional who is a member of its workforce or is a business associate of MCHCP for the purpose of providing professional services to MCHCP, if the professional represents that the information requested is the minimum necessary for the stated purpose(s).

4.3.4 Minimum necessary does not apply to: uses or disclosures made to the individual; uses or disclosures made pursuant to a HIPAA-compliant authorization; disclosures made to the Secretary in accordance with the HIPAA Rules: disclosures specifically permitted or required under, and made in accordance with, the HIPAA Rules.

5 **Obligations of MCHCP**.

5.1 Notice of Privacy Practices. MCHCP shall notify Business Associate of any limitation(s) that may affect Business Associate's use or disclosure of PHI by providing Business Associate with MCHCP's Notice of Privacy Practices in accordance with § 164.520, the most recent copy of which is attached to this Agreement.

5.2 Individual Authorization Changes. MCHCP shall notify Business Associate in writing of any changes in, or revocation of, the authorization by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.3 Confidential Communications. MCHCP shall notify Business Associate in writing of individual requests approved by MCHCP in accordance with § 164.522 to receive communications of PHI from Business Associate by alternate means or at alternative locations, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.4 Individual Restrictions. MCHCP shall notify Business Associate in writing of any restriction to the use or disclosure of PHI that MCHCP has agreed and, if applicable, any subsequent revocation or termination of such restriction, in accordance with § 164.522, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.5 Permissible Requests by MCHCP. MCHCP shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by MCHCP.

6 **Term and Termination, Expiration, or Cancellation**.

6.1 Term. This Agreement is effective upon signature of both parties, and shall terminate upon the termination, expiration, or cancellation of the Contract, as amended, unless sooner terminated for cause under subsection 6.2 below.

6.2 Termination. Without limiting MCHCP's right to terminate the Contract in accordance with the terms therein, Business Associate also authorizes MCHCP to terminate this Agreement immediately by written notice and without penalty if MCHCP determines, in its sole discretion, that Business Associate has violated a material term of this Agreement and termination of this Agreement is in the best interests of MCHCP or its members. Without limiting the foregoing authorization, Business Associate agrees that MCHCP may, as an alternative or in addition to termination, require Business Associate to end the violation of the material term(s) and cure the breach of contract within the time and manner specified by MCHCP based on the circumstances presented. With respect to this subsection, MCHCP's remedies under this Agreement and the Contract are cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

6.3 Obligations of Business Associate Upon Termination. Upon termination, expiration, or cancellation of this Agreement for any reason, Business Associate agrees to return to MCHCP or deliver to another MCHCP business associate at MCHCP's direction all PHI received from MCHCP, any current or former Business Associate or workforce member of MCHCP, or any current or former member of MCHCP, as well as all PHI created, compiled, stored or accessible to Business Associate or any subcontractor, agent, affiliate, or workforce member of Business Associate, relating to MCHCP as a result of services provided under the Contract. All such PHI shall be securely transmitted in accordance with MCHCP's written directive in electronic format accessible and decipherable by the MCHCP designated recipient. Following confirmation of receipt and usable access of the transmitted PHI by the MCHCP designated recipient, Business Associate shall destroy all MCHCP-related PHI and thereafter retain no copies in any form for any purpose whatsoever. Within seven (7) business days following full compliance with the requirements of this subsection, an authorized representative of Business Associate shall certify in writing addressed to MCHCP's Privacy and Security Officers that Business Associate has fully complied with this subsection and has no possession, control, or access, directly or indirectly, to MCHCP-related PHI from any source whatsoever.

Notwithstanding the foregoing, Business Associate may maintain MCHCP-PHI after the termination of this Agreement to the extent return or destruction of the PHI is not feasible, provided Business Associate: (i) refrains from any further use or disclosure of the PHI; (ii) continues to safeguard the PHI thereafter in accordance with the terms of this Agreement; (iii) does not attempt to de-identify the PHI without MCHCP's prior written consent; and (iv) within seven (7) days following full compliance of the requirements of this subsection, provides MCHCP written notice describing all PHI maintained by Business Associate and certification by an authorized representative of Business Associate of its agreement to fully comply with the provisions of this paragraph.

6.4 Survival. All obligations and representations of Business Associate under this Section 6 and subsection 7.2 shall survive termination, expiration, or cancellation of the Contract and this Agreement.

7 **Miscellaneous**.

7.1 Satisfactory Assurance. Business Associate expressly acknowledges and represents that execution of this Agreement is intended to, and does, constitute satisfactory assurance to MCHCP of Business Associate's full and complete compliance with its obligations under the HIPAA Rules. Business Associate further acknowledges that MCHCP is relying on this assurance in permitting Business Associate to create, receive, maintain, use, disclose, or transmit PHI as described herein.

7.2 Indemnification. Each party shall, to the fullest extent permitted by law, protect, defend, indemnify and hold harmless the other party and its current and former trustees, employees, and agents from and against any and all losses, costs, claims, penalties, fines, demands, liabilities, legal actions, judgments, and expenses of every kind (including reasonable attorneys' fees and expenses, including at trial and on appeal) arising out of the acts or omissions of such party or any subcontractor, consultant, or workforce member of such party to the extent such acts or omissions violate the terms of this Agreement or the HIPAA Rules as applied to the Contract.

Notwithstanding the foregoing, if Business Associate maintains any MCHCP-related PHI following termination of the Contract and this Agreement pursuant to subsection 6.3, Business Associate shall be solely responsible for all PHI it maintains and, to the fullest extent permitted by law, Business Associate shall protect, defend, indemnify and hold harmless MCHCP and its current and former trustees, employees, and agents from and against any and all losses, costs, claims, penalties, fines, demands, liabilities, legal actions, judgments, and expenses of every kind (including reasonable attorneys' fees and expenses, including at trial and on appeal) arising out of the acts or omissions of Business Associate or any subcontractor, consultant, or workforce member of Business Associate regarding such PHI to the extent such acts or omissions violate the terms of the Act or the HIPAA Rules.

7.3 No Third Party Beneficiaries. There is no intent by either party to create or establish third party beneficiary status or rights or their equivalent in any person or entity, other than the parties hereto, that may be affected by the operation of this Agreement, and no person or entity, other than the parties, shall have the right to enforce any right, claim, or benefit created or established under this Agreement.

7.4 Amendment. The parties agree to work together in good faith to amend this Agreement from time to time as is necessary or advisable for compliance with the requirements of the HIPAA Rules. Notwithstanding the foregoing, this Agreement shall be deemed amended automatically to the extent any provisions of the Act or the HIPAA Rules not addressed herein become applicable to Business Associate during the term of this Agreement pursuant to and in accordance with any subsequent modification(s) or official and binding legal clarification(s), to the Act or the HIPAA Rules.

7.5 Interpretation. Any reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

THE UNDERSIGNED PERSONS REPRESENT AND WARRANT THAT WE ARE LEGALLY FREE TO ENTER THIS AGREEMENT, THAT OUR EXECUTION OF THIS AGREEMENT HAS BEEN DULY AUTHORIZED, AND THAT UPON BOTH OF OUR SIGNATURES BELOW THIS SHALL BE A BINDING AGREEMENT TO THE FOREGOING TERMS AND CONDITIONS OF THIS BUSINESS ASSOCIATE AGREEMENT.

Missouri Consolidated Health Care Plan	**Dental Insurer**
By: ______________________________	By: _______________________________
Title: Executive Director	Title: _____________________________
Date: _____________________________	Date: _____________________________

Dental Questionnaire

MCHCP requires that you provide concise responses to questions requiring explanation. Please note there is a 1,000 character limit on all textual responses. MCHCP expects that you will provide all explanations within the parameters of the questionnaire.

Proprietary Statement

1.1 Pursuant to Section 610.021 RSMo, proposals and related documents shall not be available for public review until a contract has been awarded or all proposals are rejected. MCHCP maintains copies of all bid file material for review by appointment. Regardless of any claim by the bidder as to material being proprietary and not subject to copying or distribution, or how a bidder characterizes any information provided in its proposal, all material submitted by the bidder in conjunction with this RFP is subject to release after the award of a contract in relation to a request for public records under the Missouri Sunshine Law (see Chapter 610 of the Missouri Revised Statutes). Neither MCHCP nor its consultant shall be obligated to return any materials submitted in response to this RFP. The use of MCHCP's name in any way is strictly prohibited. Confirm your agreement with the Confidentiality and Public Record Policy listed above.

- ○ Confirmed
- ○ Not confirmed (please explain)

Vendor Profile

2.1 Provide the following information about your company:

Full and legal company name

Name of parent organization (if applicable)

Corporate address

Name of contact person for questions regarding this RFP response

Telephone

Email address

2.2 How many years has your organization provided dental benefits to employer groups?

Number of years

2.3 How long has the company been in operation in Missouri?

Number of years

2.4 How many employer groups does your organization service for Dental Benefits Administration?

Number of groups of 30,000 employees or more

Number of groups of 20,000-29,999 employees

Number of groups of 10,000-19,999 employees

Number of groups less than 10,000 employees

2.5 How many participants does your organization service for dental benefits administration?

Number of current members

Number of new members last year (2022)

Number of new members year to date (2023)

2.6 Is there any significant litigation and/or government action pending against your company, or has there been any action taken or proposed against your company within the last five (5) years?

- ○ Yes (please explain)
- ○ No

2.7 Identify your company's General Liability and Errors & Omissions insurer protecting your clients. Describe the type and limits of each coverage.

	Name of Insurance Carrier	Type of Coverage	Coverage Amount	Pertinent Exclusions
Insurer				
Insurer (2nd)				

2.8 Confirm you have uploaded a document to the Reference Files from Vendor section describing the insurance in force that your firm has to cover any errors and omissions claims that may arise in connection with services on behalf of a client. Who is the carrier or what is the funding mechanism? What are the policy limits? Are all of your subcontractors and/or joint venture companies bound by such coverage? Name the file "Q2.8 E&O Insurance".

- ○ Document has been uploaded (list carrier name, funding mechanism, and policy limits, and describe whether subcontractors are bound by coverage)

○ Not provided (please explain)

2.9 What has been the average premium rate increase in your book of business during each of the last three years?

	2020-21	2021-22	2022-23
Plan-wide	%	%	%
Public sector book	%	%	%

2.10 Provide the following information for all subcontractors that will be used to fulfill the requirements of this contract:

	Company Name	Service provided	Number of years working with your organization
Subcontractor #1			
Subcontractor #2			
Subcontractor #3			
Subcontractor #4			
Subcontractor #5			

2.11 Describe the economic advantages that will be realized as a result of your organization performing the required services by providing responses to each item below. If necessary to provide a full description, upload a document to the Reference Files from Vendors section, and name the file "Q2.11 Economic Impact".

Provide a description of the proposed services that will be performed and/or the proposed products that will be provided by Missourians and/or Missouri products.

Provide a description of the economic impact returned to the State of Missouri through tax revenue obligations.

Provide a description of the company's economic presence within the State of Missouri (e.g. type of facilities; sales offices; sales outlets; divisions; manufacturing; warehouse; other), including Missouri employee statistics.

2.12 Confirm you have uploaded two years of your organization's audited financial statements to the Reference Files from Vendor section. Name the file "Q2.12 Audited Financial Statements".

○ Confirmed

○ Not confirmed (please explain)

2.13 Confirm you have uploaded a document to the Reference Files from Vendor section confirming appropriate licensure by the State of Missouri. Name the document "Q2.13 State of Missouri License".

○ Confirmed

○ Not confirmed (please explain)

Account Management and Implementation

3.1 Complete the following table regarding the team that would be compiled for MCHCP.

	Name	Location	Role for MCHCP	Brief work experience bio	Number of years at your organization	Number of years in their current role	Number of current accounts in this same role	Number of current members in accounts	Maximum number of accounts	Estimated percentage of time allocated to MCHCP
Account Management (Primary)										%
Account Management (Secondary)										%
Implementation (Primary)										%
Implementation (Secondary)										%

3.2 Confirm you have uploaded a detailed implementation plan that includes a high level overview and details on specific tasks, timelines and responsibilities. Upload the file to the Reference Files from Vendor section, and name the file "Q3.2 Implementation Plan".

○ Confirmed

○ Not confirmed (please explain)

3.3 What services, support, and information are needed from MCHCP in order to expedite implementation? Be specific.

Response

3.4 Confirm you have provided an organizational chart for the proposed account team, showing lines of authority up to and including the executive management level. Upload the document to the Reference Files from Vendor section, and name the document "Q3.4 Organizational Chart".

- ○ Confirmed
- ○ Not confirmed (please explain)

3.5 Is there a link between the sales team coordinating this RFP, the implementation team and the account management team? If no, provide an explanation on how you ensure there is no miscommunication between them.

- ○ Yes
- ○ No (please explain)

3.6 Will your implementation team and account management team commit to 8 business hour acknowledgement of phone calls and/or emails?

- ○ Yes
- ○ No (please explain)

3.7 Confirm that you have provided a sample member communication packet and identification card, if applicable. Upload the file to the Reference Files from Vendor section, and name the file "Q3.7 Sample Communication Materials".

- ○ Confirmed
- ○ Not confirmed (please explain)

Customer Service

4.1 Provide the following information about your Customer/Member Services Department(s) that would service the MCHCP account.

Location(s)

Days of operation

Hours of operation

Holidays observed

Number of customer/member services representatives assigned to MCHCP account

Number of other clients assigned customer/member services representatives are responsible for (average # per rep)

Experience level of staff (average # of yrs)

4.2 Will you provide MCHCP with a dedicated Customer/Member Services team?

- ○ Yes (please describe)
- ○ No (please explain)

4.3 Given your expected capacity with your current business, what additional staff will you hire to service the MCHCP account?

- ☐ Customer service representative (state how many)
- ☐ Other (describe and state how many)

4.4 What is the most recent annual turnover rate for your member services staff?

Percent %

4.5 Can Member Services Representatives provide assistance for selecting and/or locating network dentists?

- ○ Yes
- ○ No (please explain)

4.6 Does your company provide member service support via a single, national toll-free telephone number?

- ○ Yes
- ○ No (please explain)

4.7 Are all calls documented and/or recorded?

	Yes (please describe)	No (please explain)

Documented	◯	◯
Recorded	◯	◯

4.8 For the most recently completed calendar year, provide the data requested below for the call center to be used for MCHCP:

	Company standard	Company actual 2022
Average time to answer (in seconds)		
Call abandonment rate		
First call resolution		

4.9 How are overflow calls handled during busy call times (check all that apply)?

- ☐ Calls transferred to another call center (list locations)
- ☐ Voice mail
- ☐ IVR
- ☐ Other (please explain)

4.10 What features are available to the member via your website (check all that apply)?

- ☐ Access provider directory
- ☐ Verify eligibility
- ☐ Check claim status
- ☐ Request ID card
- ☐ Check status of deductibles, maximums, or limits
- ☐ Obtain a history of claims
- ☐ Map provider locations
- ☐ Other (please explain)

4.11 Provide the URL, a temporary ID and Password for members of the RFP review team to view the website available to members.

URL

ID

Password

4.12 If applicable, what is the ID card turnaround time (defined as the average number of business days between enrolling a new group/member and plan mailing ID cards to members) for each of the following:

- ☐ New contract
- ☐ Future plan years
- ☐ Newly eligible
- ☐ Member request
- ☐ Not applicable, plan does not issue ID cards

4.13 Provide your company's average response time to written inquiries for the most recently completed calendar year.

	Corporate standard (in days)	Actual results (in days)
Written inquiries		

4.14 Does your company conduct member satisfaction surveys?

- ◯ Yes (please describe, including frequency)
- ◯ No (please explain)

4.15 Confirm that you have uploaded results from your most recent satisfaction survey in the Reference Files from Vendor section, and named the file "Q4.15 Satisfaction Survey Results".

- ◯ Confirmed
- ◯ Not confirmed (please explain)

4.16 Confirm that you do not show the employee's Social Security Number (SSN) on printed materials (i.e. I.D. Cards, Explanation of Benefits).

- ◯ Confirmed

Not confirmed (please explain)

4.17 Describe the complaint, grievance and appeal procedure available to members.

Response

Technology and Security

5.1 When was the last major system/platform upgrade for each of the following systems? If an upgrade is planned within the next 24 months for any of the systems listed, provide the projected date.

Customer Relation Management (CRM) (MM/YYYY)

Eligibility (MM/YYYY)

Claims (MM/YYYY)

Other (please describe)

5.2 Describe any key differences from the initial implementation and ongoing integration of data services as it relates to assigned resources and scheduling requirements.

Response

5.3 Briefly describe your disaster recovery protocols, procedures and back-up systems for your call center and claims processing center. Can you rapidly shift service to another center if needed? Include the projected time required for full restoration of services.

Call center

Claims processing center

5.4 If you require Multi-Factor Authentication (MFA) for direct access to a member web portal, please provide a brief description of the member experience and security options offered.

Response

5.5 Regarding the member web portal, will Single Sign-On access be available from MCHCP without requiring a separate registration process? If so, please describe the member experience for portal access and Multi-Factor Authentication, both initially and on-going.

Response

5.6 Give a brief description of your database security and integrity practices (i.e. encryption, data-at-rest management, backups).

Response

5.7 Describe the necessary protocol (i.e. SAML, OpenID, OAuth) and any third party integration necessary for Single Sign-On functionality. MCHCP does not use Federated Identity Management and establishes unique connections with all vendors utilizing SAML 2.0.

Response

5.8 What practices do you have in place to protect the confidentiality of individual information when electronically storing and/or transferring information?

Response

5.9 Describe all relevant HIPAA-compliant security measures you have in place to insure data integrity and security.

Response

5.10 Describe your process for addressing security breaches.

Response

5.11 Do you adhere to the latest approved accessibility guidelines developed by the Web Accessibility Initiative of World Wide Web Consortium (W3C)?

Yes (please describe)

No (please explain)

5.12 What platform do you currently utilize to delivery web content/services? (i.e., Windows, Websphere)?

Response

5.13 MCHCP allows for retroactive terminations and enrollments of members. Do you anticipate any issues handling these circumstances? Please define any requirements or limitations you may have in this regard.

Response

5.14 Are mobile apps available for use by your membership?

○ Yes (please describe)
○ No (please explain)

5.15 Regarding weekly eligibility data updates and the monthly full eligibility data file for reconciliation in the Scope of Work, describe the format and detail of data MCHCP will receive and how it is to be provided.

Response

5.16 Confirm you have Secure FTP (FTPS or SFTP) capabilities for ad hoc record transfers.

○ Confirmed (please describe)
○ Not confirmed (please explain)

5.17 Describe your organization's IT infrastructure and development platform.

Response

5.18 Discuss your IT system's scalability and overall capacity to sufficiently support the expected volume increase if your organization is awarded this contract.

Response

5.19 Confirm you have uploaded metrics that demonstrate the reliability of your IT systems. Upload the file to the Reference Files from Vendor section, and name the file "Q5.19 Reliability Metrics".

○ Confirmed
○ Not confirmed (please explain)

5.20 Identify the type of systems that will be used to communicate with MCHCP (i.e. web services, SFTP, TLS).

Response

5.21 Describe how you protect PHI, including security controls embedded within your systems, networks, and processes.

Response

5.22 Have you ever experienced a security breach involving PHI?

○ Yes (provide details on when the breach occurred, actions taken and corrections implemented)
○ No

5.23 Describe how issues regarding the accuracy and agreement of eligibility data are prioritized and escalated?

Response

5.24 Please describe IT support structure to resolve issues.

Response

5.25 Provide contact information and alternates for the individual responsible for IT-related issues.

	Primary contact	Alternate #1 contact	Alternate #2 contact
Contact name			
Phone			
Email			

Reporting

6.1 Confirm that you have provided copies of your standard reporting package that will be made available to MCHCP. Upload the file to the Reference Files from Vendor section, and name the file "Q6.1 Sample Reports".

○ Confirmed
○ Not confirmed (please explain)

6.2 Confirm you have uploaded copies of the standard customer service reports that will be made available to satisfy the requirements stated in Exhibit B, Section B4.4 to the Reference Files from Vendor section. Name the document "Q6.2 Customer Service Report".

○ Confirmed
○ Not confirmed (please explain)

6.3 Does your organization currently provide data to Merative or any other decision support system vendor on behalf of clients (check all that apply)?

☐ Merative
☐ Other decision support system vendor(s) (list other vendors)
☐ No

6.4 Describe your experience and ability to provide claims-level data to third party vendors as described in Attachment 5.

Response

6.5 Do you have an internet-based reporting system that MCHCP will have access to?

◯ Yes, at no additional cost
◯ Yes, at an additional cost (indicate cost in Supplemental Pricing of Exhibit A-8)
◯ No (please explain)

Claims Administration

7.1 Identify the claims office location proposed to service the MCHCP account. List all locations if more than one location will service the account.

Response

7.2 How many years has the claims office that will service the MCHCP account been in operation.

Number of years in operation

7.3 What percentage of claims transactions are adjudicated automatically (i.e. without manual intervention)?

Percentage %

7.4 For your Missouri membership, what percentage of claims were submitted electronically last year?

Percentage %

7.5 For the claim office proposed, what is the average number of working days for a paper claim to be processed (check issued) from the date of receipt?

Number of working days

7.6 How do you handle members' claims incurred for services rendered by out-of-network providers?

Response

7.7 Describe any claim edits in your system that allow claim processors to detect, deny and re-price inappropriate, inaccurate or fraudulent claims before such claims are paid.

Response

7.8 Does your system maintain COB information on claimants?

◯ Yes (please describe)
◯ No (please explain)

7.9 How frequently do you require updates to COB data?

◯ Monthly
◯ Quarterly
◯ Annually
◯ At point of claim
◯ Other (please explain)

Access to Services and Benefits

8.1 Describe the process a member would follow to access services?

Response

8.2 Do you monitor average wait times for members to obtain an appointment from the time the member calls to being seen? If so, what are your targeted and actual wait times (in calendar days)?

	Target	Actual (2022)	Do not track
General dentist	☐	☐	☐

Dental specialist	☐	☐	☐

8.3 Describe any benefit pre-certification or vouchers that members are required to obtain before benefits are provided. Be sure to explain any documentation you will require for the two additional cleanings per year.

Response

8.4 Describe the components of a standard dental examination delivered by your network providers.

Response

8.5 Can employees access information regarding participating providers from the following (check all that apply):

☐ Plan's website
☐ Hard copy directories
☐ Via e-mail
☐ Plan's call center

8.6 Confirm you have provided a document describing any changes to plan designs you would recommend to MCHCP and why the change would benefit members and impact premium. Upload the file to the Reference Files from Vendor section, and name the file "Q8.6 Changes to Plan Design".

◯ Confirmed
◯ Not confirmed (please explain)

8.7 Confirm you have provided a document describing limitations (if any) for benefits offered in the proposed plan design. Upload the document to the Reference Files from Vendor section, and name the file "Q8.7 Benefit Limitations".

◯ Confirmed
◯ Not confirmed (please explain)

Provider Network

9.1 Is the proposed network(s) provided by the bidder or through a partnership arrangement? If provided by a partner, provide a document describing the partner in detail and what the arrangement contains. Upload the document to the Reference Files from Vendor section, and name the file "Q9.1 Network Partner".

◯ Bidder
◯ Partner, and document describing arrangement has been uploaded.

9.2 Confirm that you have uploaded the following access reports based on the required access standard of 1 general dentist within 20 miles. Bidders must utilize the enrollment file included as Attachment 3 of this RFP in producing these reports. Reports should be summarized at the county level, not by zip code or city. Upload the files to the Reference Files from Vendor section, and name the files "Q9.2 Access Reports".

	Confirmed (percent with/without access)	Not confirmed (please explain)
Summary of Employees with Access to General Dentist	◯ %	◯
Summary of Employees without Access to General Dentist	◯ %	◯

9.3 Confirm you have uploaded a provider network file to the Reference Files from Vendor section in the format provided in Attachment 5. Include only those providers located in Missouri. Name the file "Q9.3 Provider Network".

◯ Confirmed
◯ Not confirmed (please explain)

9.4 How many dentists were added to your Missouri network in each of the last two years? How many were dropped in each of the last two years?

	Added in 2021	Dropped in 2021	Added in 2022	Dropped in 2022
General dentists				
Specialty dentists				

9.5 Are you willing to recruit additional dentists in specific areas identified by MCHCP?

◯ Yes
◯ No (please explain)

9.6 In a typical network service area, on average, what percentage of available providers do you typically contract with? As an example, of all the general dentists in your service area, what percentage are included in your network?

General dentists

%

Specialty dentists %

9.7 Are you anticipating a material change in network size during the next 18-24 months?

- ◯ Yes, an increase in network size (please explain)
- ◯ Yes, a decrease in network size (please explain)
- ◯ No

9.8 Provide the number and percentage of network general and specialty dentists in Missouri with closed practices as of 1/1/2023.

Number of general dentists

Percent of general dentists %

Number of specialty dentists

Percent of specialty dentists %

9.9 Describe the credentialing process including information collected.

Response

9.10 Describe any differences between the initial credentialling process and the recredentialling process.

Response

9.11 Do you conduct provider network compliance inspections?

- ◯ Yes
- ◯ No (please explain)

9.12 How does your organization monitor the current licensure and "good standing" of network dentists?

Response

9.13 Do you monitor patient access to network dentists (e.g. office waiting time, appointment delays or cancellations)?

- ◯ Yes
- ◯ No (please explain)

9.14 Does the network you are proposing include dentists in all 50 states? If not, what states do not have contracted providers?

- ◯ Yes
- ◯ No (please list states with no dentists)

9.15 How frequently do you update provider listings on your website?

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Quarterly
- ◯ Other (please explain)

9.16 How may provider contracts be terminated and how much advance notice is required?

Response

9.17 How often are new providers added to your network?

Response

9.18 Do you notify affected members when a participating provider leaves the network? If so, how soon after the termination are they notified?

- ◯ Yes (please describe)
- ◯ No

9.19 Confirm you have uploaded samples of communications to providers to notify them of benefit changes and/or updates. Upload the document to the Reference Files from Vendor section, and name the file "Q9.19 Provider Communications".

- ◯ Confirmed
- ◯ Not confirmed (please explain)

Performance Guarantees

10.1 Account Management - Satisfaction. The following category will be measured and reported on Implementation and annually beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Contractor guarantees MCHCP's satisfaction with account management services	Satisfactory or better			$2,000 plus $0.10 PEPM	

10.2 Account Management - Responsiveness. The following category will be reported and measured quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Timely issues resolution by the account management team (e.g. issues resolvable by account management are acknowledged and responded to within 1 business day)	Acknowledgement and response within 8 business hours			For each incident not acknowledged within 8 business hours, $500 plus $0.10 PEPM	

10.3 Member Service - Average response time. The following category will be measured and reported quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Average number of seconds for call to be answered by a live customer service representative	25 seconds or less			For each full second above standard, $2,000 plus $0.10 PEPM	

10.4 Member Service - Average abandonment rate. The following category will be measured and reported quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Percent of calls abandoned	< 2%			For each full percentage point above standard, $2,000 plus $0.10 PEPM	

10.5 Member Service - Response to written inquiries. The following category will be measured and reported quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Average number of days within which written inquiries will be responded to	5 business days or less			For each business day above standard, $500 plus $0.10 PEPM	

10.6 Eligibility - Timeliness of Installations. The following category will be measured and reported quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Electronic eligibility files will be installed and eligibility status will be effective within an average of 24 hours of receipt.	95% within 24 hours			For each full hour beyond 24 hours, $500 plus $0.10 PEPM	

10.7 Eligibility - Accuracy of Installations. The following category will be reported and measured quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk)
Electronic eligibility records loaded with 99.5% accuracy. This standard is contingent upon receipt of clean eligibility	100%			For each full percentage point below standard, $2,000 plus $0.10	

data delivered in an agreed upon format.				PEPM	

10.8 ID Card Distribution (if applicable) - Initial/New Contract Year Distribution. The following category will be measured on implementation and each subsequent year.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
ID cards mailed no later than one week prior to effective date of each year	100 percent of all ID cards mailed one week prior to effective date			For each day after stated deadline, $500 plus $0.10 PEPM	

10.9 ID Card Distribution (if applicable) - Ongoing. The following category will be reported and measured quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
ID cards mailed within 10 business days of receipt of eligibility data (for monthly changes) or request for replacement card	100 percent of all ID cards mailed within 10 business days of receipt of eligibility file or request			For each day beyond the 10th business day, $500 plus $0.10 PEPM	

10.10 Reporting - The following categories will be reported and measured quarterly beginning January, 2024. Penalties will be applied for each month the contractor fails to meet these standards.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Claim file must be submitted to MCHCP's data vendor no later than 15th of the month for prior month's services	100%		MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	
Claim file must be submitted to MCHCP's data vendor in proper format on first submission of the month	100%		MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	
Data submission to MCHCP's data vendor must include 100 percent of all required financial fields	100%		MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	
Data submission to MCHCP's data vendor must include all required key fields (subscriber SSN, member DOB, and member gender)	100%		MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	
Data submission to MCHCP's data vendor must include all required key fields (diagnostic coding, provider type, provider ID, etc.)	100%		MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	

10.11 Implementation - The following categories will be measured at Implementation.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Eligibility file is tested and loaded accurately prior to January 1, 2024	Testing completed by November 16, 2023		MCHCP will determine acceptability of testing	$2,000 plus $0.10 PEPM	
Contractor's customer service center is prepared to answer MCHCP member questions by October 1, 2023	Customer service center is operational and has been trained on MCHCP's benefit		MCHCP will determine contractor's readiness to address member questions	$2,000 plus $0.10 PEPM	

10.12 Reporting - The following categories will be measured and reported quarterly beginning January 1, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Standard reporting must be submitted to MCHCP in the agreed upon format and within 30 days of end of quarter.	Due within 30 days of end of quarter		MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $2,000 plus $0.10 PEPM	

Customer service reporting must be submitted to MCHCP in the agreed upon format and within 30 days of end of quarter.	Due within 30 days of end of quarter		MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $2,000 plus $0.10 PEPM	

10.13 Monthly eligibility audit file - The following category will be measured and reported quarterly beginning January, 2024. Penalties will be applied for each month the contractor fails to meet this standard.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Eligibility audit file must be provided on the second Thursday of each month in the agreed upon format	Audit file available by the second Thursday of each month		MCHCP will determine acceptability of file	For each day file was not transmitted on time, $2,000 plus $0.10 PEPM	

10.14 Claims financial accuracy - The following category will be measured and reported quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum amount at risk
Percentage of claims processed free of financial error	>= 99%			$2,000 plus $0.10 PEPM for each full percentage point below standard	

10.15 Claims processing accuracy - The following category will be measured and reported quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum amount at risk
Percentage of claims processed correctly	>= 99%			$2,000 plus $0.10 PEPM for each full percentage point below standard	

10.16 Claim turnaround time - Network providers - The following category will be measured and reported quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum amount at risk
Percent of claims from network providers processed within 5 days	>= 95%			$2,000 plus $0.10 PEPM for each full percentage point below standard	

10.17 Claim turnaround time - Out of Network providers - The following category will be measured and reported quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum amount at risk
Percent of claims from non-network providers processed within 5 days	>= 95%			$2,000 plus $0.10 PEPM for each full percentage point below standard	

10.18 Network retention rate - The following category will be measured and reported annually beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum amount at risk
Network provider retention rate (based on voluntary turnover)	>= 98%			$2,000 plus $0.10 PEPM for each full percentage point below standard	

10.19 Overall Satisfaction with contractor - The following category will be measured and reported quarterly beginning January, 2024.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum amount at risk
Percent of members rating contractor satisfactory or better	95%			$2,000 plus $0.10 PEPM for each full percentage point below standard	

10.20 Preventive care - The following category will be measured and reported annually beginning January, 2024.

	Guarantee	Will you	Measurement	Minimum amount at risk	Maximum dollar

		guarantee this standard (Yes or No)	process		amount at risk
Percent of members accessing preventive care	55 percent of members who are continuously enrolled will receive at least one preventive exam per year			For each full percentage point below standard, $2,000 plus $0.10 PEPM	

10.21 Please indicate your willingness to submit your performance metrics results via an online tool.

- Confirmed
- Not Confirmed (please explain)

MBE-WBE Participation Commitment

If the bidder is committing to participation by or if the bidder is a qualified MBE/WBE, the bidder must provide the required information in the appropriate table(s) below for the organization proposed and must submit the completed Exhibit A-6 with the bidder's proposal. For Minority Business Enterprise (MBE) and/or Woman Business Enterprise (WBE) Participation, if proposing an entity certified as both MBE and WBE, the bidder must either (1) enter the participation percentage under MBE or WBE, or must (2) divide the participation between both MBE and WBE. If dividing the participation, do not state the total participation on both the MBE and WBE Participation Commitment tables below. Instead, divide the total participation as proportionately appropriate between the tables below.

11.1 MBE Participation Commitment Table

	Name of Qualified Minority Business Enterprise (MBE) Proposed	Committed Percentage of Participation for MBE	Description of Products/Services to be Provided by MBE
Company 1		%	
Company 2		%	
Company 3		%	
Company 4		%	
Total MBE Percentage		%	

11.2 WBE Participation Commitment Table

	Name of Qualified Women Business Enterprise (WBE) Proposed	Committed Percentage of Participation for WBE	Description of Products/Services to be Provided by WBE
Company 1		%	
Company 2		%	
Company 3		%	
Company 4		%	
Total WBE Percentage		%	

References

12.1 Provide references for three current clients. If possible, use companies of similar size and needs as MCHCP. One reference must be a group that is currently being serviced by the proposed account manager. We will not contact these references without discussing it with you first; however, having information on references is crucial.

	Company Name	Contact Name	Phone Number	E-mail address	Services provided by your organization	Number of Covered Employees	Number of years working with your organization
Current Client #1							
Current Client #2							
Current Client #3							

12.2 Provide references for two clients who have terminated your services. If possible please use companies of similar size and needs as MCHCP. We will not contact these references without discussing it with you first; however, having information on references is crucial.

	Company Name	Services provided by your organization	Number of Covered Employees	Number of years working with your organization	Reason for termination of relationship
Terminated Client #1					
Terminated Client #2					

Scope of Work

13.1 Confirm you will meet all General requirements as stated in Exhibit B, Section B1.

- ○ Confirmed
- ○ Not confirmed (please explain)

13.2 Confirm you will meet all Eligibility requirements as stated in Exhibit B, Section B2.

- ○ Confirmed
- ○ Not confirmed (please explain)

13.3 Confirm you will meet all Level of Benefits requirements as stated in Exhibit B, Section B3.

- ○ Confirmed
- ○ Not confirmed (please explain)

13.4 Confirm you will meet all Reporting requirements as stated in Exhibit B, Section B4.

- ○ Confirmed
- ○ Not confirmed (please explain)

13.5 Confirm you will agree to all Payment requirements as stated in Exhibit B, Section B5.

- ○ Confirmed
- ○ Not confirmed (please explain)

13.6 Confirm you will meet all General Service requirements as stated in Exhibit B, Section B6.

- ○ Confirmed
- ○ Not confirmed (please explain)

13.7 Confirm you will meet all Account Management requirements as stated in Exhibit B, Section B7.

- ○ Confirmed
- ○ Not confirmed (please explain)

13.8 Confirm you will meet all Customer Service requirements as stated in Exhibit B, Section B8.

- ○ Confirmed
- ○ Not confirmed (please explain)

13.9 Confirm you will meet all Information Technology and Eligibility File requirements as stated in Exhibit B, Section B9.

- ○ Confirmed
- ○ Not confirmed (please explain)

13.10 Confirm you will meet all Implementation requirements as stated in Exhibit B, Section B10.

- ○ Confirmed
- ○ Not confirmed (please explain)

13.11 Confirm you will meet all Contracted Network requirements as stated in Exhibit B, Section B11.

- ○ Confirmed
- ○ Not confirmed (please explain)

Attachment Checklist

14.1 Confirm the following have been provided with your proposal. A check mark below indicates they have been uploaded to the Reference Files from Vendor section of the RFP.

- ☐ Q2.8 E&O insurance document
- ☐ Q2.11 Economic impact
- ☐ Q2.12 Audited financial statements
- ☐ Q2.13 State of Missouri license
- ☐ Q3.2 Implementation plan
- ☐ Q3.4 Organizational chart
- ☐ Q3.7 Sample communication materials
- ☐ Q4.15 Satisfaction survey results
- ☐ Q5.19 Reliability metrics

- ☐ Q6.1 Sample reports
- ☐ Q6.2 Customer service report
- ☐ Q8.6 Changes to plan design
- ☐ Q8.7 Benefit limitations
- ☐ Q9.1 Network partner
- ☐ Q9.2 Access reports
- ☐ Q9.3 Provider network file
- ☐ Q9.19 Provider communications

Mandatory Contract Provisions Questionnaire

Mandatory Contract Provisions

Bidders are expected to closely read the Mandatory Contract Provisions. Rejection of these provisions may be cause for rejection of a bidder's proposal. MCHCP requires that you provide concise responses to questions requiring explanation. Please note, there is a 1,000 character limit on all textual responses. MCHCP expects that you will provide all explanations within the parameters of this questionnaire.

1.1 Term of Contract: The term of this Contract is for a period of one (1) year from January 1, 2024 through December 31, 2024. This Contract may be renewed for four (4) additional one-year periods at the sole option of the MCHCP Board of Trustees. Prices for Years 1-3 must be submitted with this RFP. The submitted pricing arrangement for the first year (January 1 - December 31, 2024) is a firm, fixed price. The submitted prices for the subsequent (2nd - 3rd) years of the contract period (January 1 - December 31, 2025 and January 1 - December 31, 2026 respectively) are guaranteed not-to-exceed maximum prices and are subject to negotiation. Actual pricing for the one-year renewal periods are due to MCHCP by May 15 for the following year's renewal. All prices are subject to best and final offer which may result from subsequent negotiation.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.2 Contract Documents: The following documents will be hereby incorporated by reference as if fully set forth within the Contract entered into by MCHCP and the Contractor: (1) Written and duly executed Contract (sample is provided and rinal will be negotiated if necessary prior to award); (2) amendments to the executed Contract; (3) The completed and uploaded Exhibits set forth in this RFP; and (4) This Request for Proposal.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.3 Audit Rights: MCHCP and its designated auditors shall have access to and the right to examine any and all pertinent books, documents, papers, files, or records of Contractor involving any and all transactions related to the performance of this Contract. Contractor shall furnish all information necessary for MCHCP to comply with all Missouri and/or federal laws and regulations. MCHCP shall bear the cost of any such audit or review. MCHCP and Contractor shall agree to reasonable times for Contractor to make such records available for audit.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.4 Breach and Waiver: Waiver or any breach of any contract term or condition shall not be deemed a waiver of any prior or subsequent breach. No contract term or condition shall be held to be waived, modified, or deleted except by a written instrument signed by the parties thereto. If any contract term or condition or application thereof to any person(s) or circumstances is held invalid, such invalidity shall not affect other terms, condition or application. To this end, the contract terms and conditions are severable.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.5 Confidentiality: Contractor will have access to private and/or confidential data maintained by MCHCP to the extent necessary to carry out its responsibilities under this Contract. No private or confidential data received, collected, maintained, transmitted, or used in the course of performance of this Contract shall be disseminated by Contractor except as authorized by MCHCP, either during the period of this Contract or thereafter. Contractor must agree to return any or all data furnished by MCHCP promptly at the request of MCHCP in whatever form it is maintained by Contractor. On the termination or expiration of this Contract, Contractor will not use any of such data or any material derived from the data for any purpose and, where so instructed by MCHCP, will destroy or render it unreadable.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.6 Electronic Transmission Protocols:The contractor and all subcontractors shall maintain encryption standards of 2048 bits or greater for RSA key pairs, and 256 bit session key strength for the encryption of confidential information and transmission over public communication infrastructure. Batch transfers of files will be performed using SFTP or FTPS with similar standards and refined as needed to best accommodate provider configurations (i.e. port assignment, access control, etc.).

◯ Confirmed

◯ Not confirmed (please explain)

1.7 Force Majeure: Neither party will incur any liability to the other if its performance of any obligation under this Contract is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but aren't limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, and strikes other than by Contractor's or its subcontractor's employees.

◯ Confirmed

◯ Not confirmed (please explain)

1.8 Governing Law: This Contract shall be governed by the laws of the State of Missouri and shall be deemed executed at Jefferson City, Cole County, Missouri. All contractual agreements shall be subject to, governed by, and construed according to the laws of the State of Missouri.

◯ Confirmed

◯ Not confirmed (please explain)

1.9 Jurisdiction: All legal proceedings arising hereunder shall be brought in the Circuit Court of Cole County in the State of Missouri.

◯ Confirmed

◯ Not confirmed (please explain)

1.10 Independent Contractor: Contractor represents itself to be an independent contractor offering such services to the general public and shall not represent itself or its employees to be an employee of MCHCP. Therefore, Contractor shall assume all legal and financial responsibility for taxes, FICA, employee fringe benefits, worker's compensation, employee insurance, minimum wage requirements, overtime, etc. and agrees to indemnify, save, and hold MCHCP, its officers, agents, and employees, harmless from and against, any and all loss; cost (including attorney fees); and damage of any kind related to such matters. Contractor assumes sole and full responsibility for its acts and the acts of its personnel.

◯ Confirmed

◯ Not confirmed (please explain)

1.11 Injunctions: Should MCHCP be prevented or enjoined from proceeding with this Contract before or after contract execution by reason of any litigation or other reason beyond the control of MCHCP, Contractor shall not be entitled to make or assess claim for damage by reason of said delay.

◯ Confirmed

◯ Not confirmed (please explain)

1.12 Integration: This Contract, in its final composite form, shall represent the entire agreement between the parties and shall supersede all prior negotiations, representations or agreements, either written or oral, between the parties relating to the subject matter hereof. This Contract between the parties shall be independent of and have no effect on any other contracts of either party.

◯ Confirmed

◯ Not confirmed (please explain)

1.13 Modification of the Contract: This Contract shall be modified only by the written agreement of the parties. No alteration or variation in terms and conditions of the Contract shall be valid unless made in writing and signed by the parties. Every amendment shall specify the date on which its provisions shall be effective.

◯ Confirmed

◯ Not confirmed (please explain)

1.14 Notices: All notices, demands, requests, approvals, instructions, consents or other communications (collectively "notices") which may be required or desired to be given by either party to the other during the

course of this contract shall be in writing and shall be made by personal delivery or by overnight delivery, prepaid, to the other party at a designated address or to any other persons or addresses as may be designated by notice from one party to the other. Notices to MCHCP shall be addressed as follows: Missouri Consolidated Health Care Plan, ATTN: Executive Director, P.O. Box 104355, Jefferson City, MO 65110-4355.

○ Confirmed

○ Not confirmed (please explain)

1.15 Ownership: All data developed or accumulated by Contractor under this Contract shall be owned by MCHCP. Contractor may not release any data without the written approval of MCHCP. MCHCP shall be entitled at no cost and in a timely manner to all data and written or recorded material pertaining to this Contract in a format acceptable to MCHCP. MCHCP shall have unrestricted authority to reproduce, distribute, and use any submitted report or data and any associated documentation that is designed or developed and delivered to MCHCP as part of the performance of this Contract.

○ Confirmed

○ Not confirmed (please explain)

1.16 Payment: Upon implementation of the undertaking of this Contract and acceptance by MCHCP, Contractor shall be paid as stated in this Contract.

○ Confirmed

○ Not confirmed (please explain)

1.17 Rights and Remedies: If this Contract is terminated, MCHCP, in addition to any other rights provided for in this Contract, may require Contractor to deliver to MCHCP in the manner and to the extent directed, any completed materials. In the event of termination, Contractor shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP subject to any offset by MCHCP for actual damages. The rights and remedies of MCHCP provided for in this Contract shall not be exclusive and are in addition to any other rights and remedies provided by law.

○ Confirmed

○ Not confirmed (please explain)

1.18 Solicitation of Members: Contractor shall not use the names, home addresses or any other information contained about members of MCHCP for the purpose of offering for sale any property or services which are not directly related to services negotiated in this RFP without the express written consent of MCHCP's Executive Director.

○ Confirmed

○ Not confirmed (please explain)

1.19 Statutes: Each and every provision of law and clause required by law to be inserted or applicable to the services provided in the Contract shall be deemed to be inserted herein and the Contract shall be read and enforced as though it were included herein. If through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then on the application of either party the Contract shall be amended to make such insertion or correction.

○ Confirmed

○ Not confirmed (please explain)

1.20 Termination Right: Notwithstanding any other provision, MCHCP reserves the right to terminate this Contract at the end of any month by giving thirty (30) days' notice.

○ Confirmed

○ Not confirmed (please explain)

1.21 Off-shore Services: All services under this Contract shall be performed within the United States. Contractor shall not perform, or permit subcontracting of services under this Contract, to any off-shore companies or locations outside of the United States. Any such actions shall result in the Contractor being in breach of this Contract.

○ Confirmed

○ Not confirmed (please explain)

1.22 Compliance with Laws: Contractor shall comply with all applicable federal and state laws and regulations and local ordinances in the performance of this Contract, including but not limited to the provisions listed below.

○ Confirmed

○ Not confirmed (please explain)

1.23 Non-discrimination, Sexual Harassment and Workplace Safety: Contractor agrees to abide by all applicable federal, state and local laws, rules and regulations prohibiting discrimination in employment and controlling workplace safety. Contractor shall establish and maintain a written sexual harassment policy and shall inform its employees of the policy. Contractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subcontract so that such provisions will be binding upon each subcontractor. Any violations of applicable laws, rules and regulations may result in termination of the Contract.

○ Confirmed

○ Not confirmed (please explain)

1.24 Americans with Disabilities Act (ADA): Pursuant to federal regulations promulgated under the authority of The Americans with Disabilities Act (ADA), Contractor understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Contract or from activities provided for under this Contract on the basis of such disability. As a condition of accepting this Contract, Contractor agrees to comply with all regulations promulgated under ADA which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

○ Confirmed

○ Not confirmed (please explain)

1.25 Patient Protection and Affordable Care Act (PPACA): If applicable, Contractor shall comply with the Patient Protection and Affordable Care Act (PPACA) and all regulations promulgated under the authority of PPACA, including any future regulations promulgated under PPACA, which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

○ Confirmed

○ Not confirmed (please explain)

1.26 Health Insurance Portability and Accountability Act of 1996 (HIPAA): Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations, as amended, including compliance with the Privacy, Security and Breach Notification regulations and the execution of a Business Associate Agreement with MCHCP.

○ Confirmed

○ Not confirmed (please explain)

1.27 Genetic Information Nondiscrimination Act of 2008: Contractor shall comply with the Genetic Information Nondiscrimination Act of 2008 (GINA) and implementing regulations, as amended.

○ Confirmed

○ Not confirmed (please explain)

1.28 Contractor shall be responsible for and agrees to indemnify and hold harmless MCHCP from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against MCHCP as a result of Contractor's, or any associate's or subcontractor's of Contractor, failure to comply with paragraphs 1.23, 1.24, 1.25, 1.26, and 1.27 above.

○ Confirmed

○ Not confirmed (please explain)

1.29 Prohibition of Gratuities: Neither Contractor nor any person, firm or corporation employed by Contractor in the performance of this Contract shall offer or give any gift, money or anything of value or any promise for future reward or compensation to any employee of MCHCP at any time.

◯ Confirmed

◯ Not confirmed (please explain)

1.30 Subcontracting: Subject to the terms and conditions of this section, this Contract shall be binding upon the parties and their respective successors and assigns. Contractor shall not subcontract with any person or entity to perform all or any part of the work to be performed under this Contract without the prior written consent of MCHCP. Contractor may not assign, in whole or in part, this Contract or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of MCHCP. Contractor agrees that any and all subcontracts entered into by Contractor for the purpose of meeting the requirements of this Contract are the responsibility of Contractor. MCHCP will hold Contractor responsible for assuring that subcontractors meet all the requirements of this Contract and all amendments thereto. Contractor must provide complete information regarding each subcontractor used by Contractor to meet the requirements of this Contract.

◯ Confirmed

◯ Not confirmed (please explain)

1.31 Industry Standards: If not otherwise provided, materials or work called for in this Contract shall be furnished and performed in accordance with best established practice and standards recognized by the contracted industry and comply with all codes and regulations which shall apply.

◯ Confirmed

◯ Not confirmed (please explain)

1.32 Hold Harmless: Contractor shall hold MCHCP harmless from and indemnify against any and all claims for injury to or death of any persons; for loss or damage to any property; and for infringement of any copyright or patent to the extent caused by Contractor or Contractor's employee or its subcontractor. MCHCP shall not be precluded from receiving the benefits of any insurance Contractor may carry which provides for indemnification for any loss or damage to property in Contractor's custody and control, where such loss or destruction is to MCHCP's property. Contractor shall do nothing to prejudice MCHCP's right to recover against third parties for any loss, destruction or damage to MCHCP's property.

◯ Confirmed

◯ Not confirmed (please explain)

1.33 Insurance and Liability: Contractor must maintain sufficient liability insurance, including but not limited to general liability, professional liability, and errors and omissions coverage, to protect MCHCP against any reasonably foreseeable recoverable loss, damage or expense under this engagement. Contractor shall provide proof of such insurance coverage upon request from MCHCP. MCHCP shall not be required to purchase any insurance against loss or damage to any personal property to which this Contract relates. Contractor shall bear the risk of any loss or damage to any personal property in which Contractor holds title.

◯ Confirmed

◯ Not confirmed (please explain)

1.34 Access to Records: Upon reasonable notice, Contractor must provide, and cause its subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are directly pertinent to the performance of the services. Such access must be provided to MCHCP and, upon execution of a confidentiality agreement, to any independent auditor or consultant acting on behalf of MCHCP; and any other entity designated by MCHCP. Contractor agrees to provide the access described wherever Contractor maintains such books, records, and supporting documentation. Further, Contractor agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, or other conveniences deemed reasonably necessary to fulfill the purposes described in this section. Contractor shall require its subcontractors to provide comparable access and accommodations. MCHCP shall have the right, at reasonable times and at a site designated by MCHCP, to audit the books, documents and records of Contractor to the extent that the books, documents and records relate to costs or pricing data for this Contract. Contractor agrees to maintain records which will support the prices charged and costs incurred for performance of services performed under this Contract. To the extent described herein, Contractor shall give full and free access to all records to MCHCP and/or their authorized representatives.

◯ Confirmed

◯ Not confirmed (please explain)

1.35 Acceptance: No contract provision or use of items by MCHCP shall constitute acceptance or relieve Contractor of liability in respect to any expressed or implied warranties.

◯ Confirmed

◯ Not confirmed (please explain)

1.36 Termination for Cause: MCHCP may terminate this contract, or any part of this contract, for cause under any one of the following circumstances: 1) Contractor fails to make delivery of goods or services as specified in this Contract; 2) Contractor fails to satisfactorily perform the work specified in this Contract; 3) Contractor fails to make progress so as to endanger performance of this Contract in accordance with its terms; 4) Contractor breaches any provision of this Contract; 5) Contractor assigns this Contract without MCHCP's approval; or 6) Insolvency or bankruptcy of the Contractor. MCHCP shall have the right to terminate this Contract, in whole or in part, if MCHCP determines, at its sole discretion, that one of the above listed circumstances exists. In the event of termination, Contractor shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP, subject to any offset by MCHCP for actual damages including loss of any federal matching funds. Contractor shall be liable to MCHCP for any reasonable excess costs for such similar or identical services included within the terminated part of this Contract.

◯ Confirmed

◯ Not confirmed (please explain)

1.37 Arbitration, Damages, Warranties: Notwithstanding any language to the contrary, no interpretation shall be allowed to find MCHCP has agreed to binding arbitration, or the payment of damages or penalties upon the occurrence of a contingency. Further, MCHCP shall not agree to pay attorney fees and late payment charges beyond those available under this Contract, and no provision will be given effect which attempts to exclude, modify, disclaim or otherwise attempt to limit implied warranties of merchantability and fitness for a particular purpose.

◯ Confirmed

◯ Not confirmed (please explain)

1.38 Assignment: Contractor shall not assign, convey, encumber, or otherwise transfer its rights or duties under this Contract without prior written consent of MCHCP. This Contract may terminate in the event of any assignment, conveyance, encumbrance or other transfer by Contractor made without prior written consent of MCHCP. Notwithstanding the foregoing, Contractor may, without the consent of MCHCP, assign its rights to payment to be received under this Contract, provided that Contractor provides written notice of such assignment to MCHCP together with a written acknowledgment from the assignee that any such payments are subject to all of the terms and conditions of this Contract. For the purposes of this Contract, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the Contractor provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company. Any assignment consented to by MCHCP shall be evidenced by a written assignment agreement executed by Contractor and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of this Contract and to assume the duties, obligations, and responsibilities being assigned. A change of name by Contractor, following which Contractor's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. Contractor shall give MCHCP written notice of any such change of name.

◯ Confirmed

◯ Not confirmed (please explain)

1.39 Compensation/Expenses: Contractor shall be required to perform the specified services at the price(s) quoted in this Contract. All services shall be performed within the time period(s) specified in this Contract. Contractor shall be compensated only for work performed to the satisfaction of MCHCP. Contractor shall not be allowed or paid travel or per diem expenses except as specifically set forth in this Contract.

◯ Confirmed

◯ Not confirmed (please explain)

1.40 Contractor Expenses: Contractor will pay and will be solely responsible for Contractor's travel expenses and out-of-pocket expenses incurred in connection with providing the services. Contractor will be

responsible for payment of all expenses related to salaries, benefits, employment taxes, and insurance for its staff.

◯ Confirmed
◯ Not confirmed (please explain)

1.41 Conflicts of Interest: Contractor shall not knowingly employ, during the period of this Contract or any extensions to it, any professional personnel who are also in the employ of the State of Missouri or MCHCP and who are providing services involving this Contract or services similar in nature to the scope of this Contract to the State of Missouri. Furthermore, Contractor shall not knowingly employ, during the period of this Contract or any extensions to it, any employee of MCHCP who has participated in the making of this Contract until at least two years after his/her termination of employment with MCHCP.

◯ Confirmed
◯ Not confirmed (please explain)

1.42 Patent, Copyright, and Trademark Indemnity: Contractor warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of this Contract which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to MCHCP under this Contract. Contractor shall defend any suit or proceeding brought against MCHCP on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of this Contract. This is upon condition that MCHCP shall provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, MCHCP may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by MCHCP at the Contractor's written request, it shall be at Contractor's expense, but the responsibility for such expense shall be only that within Contractor's written authorization. Contractor shall indemnify and hold MCHCP harmless from all damages, costs, and expenses, including attorney's fees that the Contractor or MCHCP may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of this Contract. If any of the products provided by Contractor in such suit or proceeding are held to constitute infringement and the use is enjoined, Contractor shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal performance products or modify them so that they are no longer infringing. If Contractor is unable to do any of the preceding, Contractor agrees to remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of MCHCP, only those items of equipment or software which are held to be infringing, and to pay MCHCP: 1) any amounts paid by MCHCP towards the purchase of the product, less straight line depreciation; 2) any license fee paid by MCHCP for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee presenting the time remaining in any period of maintenance paid for. The obligations of Contractor under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of Contractor without its written consent.

◯ Confirmed
◯ Not confirmed (please explain)

1.43 Tax Payments: Contractor shall pay all taxes lawfully imposed on it with respect to any product or service delivered in accordance with this Contract. MCHCP is exempt from Missouri state sales or use taxes and federal excise taxes for direct purchases. MCHCP makes no representation as to the exemption from liability of any tax imposed by any governmental entity on Contractor.

◯ Confirmed
◯ Not confirmed (please explain)

1.44 Disclosure of Material Events: Contractor agrees to immediately disclose any of the following to MCHCP to the extent allowed by law for publicly traded companies: (*) Any material adverse change to the financial status or condition of Contractor; (*) Any merger, sale or other material change of ownership of Contractor; (*) Any conflict of interest or potential conflict of interest between Contractor's engagement with MCHCP and the work, services or products that Contractor is providing or proposes to provide to any current or prospective customer; and (1) Any material investigation of Contractor by a federal or state agency or self-regulatory organization; (2) Any material complaint against Contractor filed with a federal or state agency or

self-regulatory organization; (3) Any material proceeding naming Contractor before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming Contractor as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken against Contractor by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against Contractor as a result of any material criminal or civil action in which Contractor was a party; or (7) Any other matter material to the services rendered by Contractor pursuant to this Contract. For the purposes of this paragraph, "material" means of a nature or of sufficient monetary value, or concerning a subject which a reasonable party in the position of and comparable to MCHCP would consider relevant and important in assessing the relationship and services contemplated by this Contract. It is further understood that in fulfilling its ongoing responsibilities under this paragraph, Contractor is obligated to make its best faith efforts to disclose only those relevant matters which to the attention of or should have been known by Contractor's personnel involved in the engagement covered by this Contract and/or which come to the attention of or should have been known by any individual or office of Contractor designated by Contractor to monitor and report such matters. Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to terminate this Contract.

◯ Confirmed

◯ Not confirmed (please explain)

1.45 MCHCP's rights Upon Termination or Expiration of Contract: If this Contract is terminated, MCHCP, in addition to any other rights provided under this Contract, may require Contractor to transfer title and deliver to MCHCP in the manner and to the extent directed, any completed materials. MCHCP shall be obligated only for those services and materials rendered and accepted prior to termination.

◯ Confirmed

◯ Not confirmed (please explain)

1.46 Termination by Mutual Agreement: The parties may mutually agree to terminate this Contract or any part of this Contract at any time. Such termination shall be in writing and shall be effective as of the date specified in such agreement.

◯ Confirmed

◯ Not confirmed (please explain)

1.47 Retention of Records: Unless MCHCP specifies in writing a shorter period of time, Contractor agrees to preserve and make available all of its books, documents, papers, records and other evidence involving transactions related to this contract for a period of seven (7) years from the date of the expiration or termination of this contract. Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds seven (7) years. Contractor agrees that authorized federal representatives, MCHCP personnel, and independent auditors acting on behalf of MCHCP and/or federal agencies shall have access to and the right to examine records during the contract period and during the seven (7) year post contract period. Delivery of and access to the records shall be at no cost to MCHCP.

◯ Confirmed

◯ Not confirmed (please explain)

1.48 Change in Laws: Contractor agrees that any state and/or federal laws, applicable rules and regulations enacted during the terms of the Contract which are deemed by MCHCP to necessitate a change in the contract shall be deemed incorporated into the Contract. MCHCP will review any request for additional fees resulting from such changes and retains final authority to make any changes. In consultation with Contractor, a consultant may be utilized to determine the cost impact.

◯ Confirmed

◯ Not confirmed (please explain)

1.49 Response/Compliance with Audit or Inspection Findings: Contractor must take action to ensure its subcontractors' compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to the services or any other deficiency contained in any audit, review, or inspection. This action will include Contractor's delivery to MCHCP, for MCHCP's approval, a corrective action plan that address deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s).

◯ Confirmed

○ Not confirmed (please explain)

1.50 Inspections: Upon notice from MCHCP, Contractor will provide, and will cause its subcontractors to provide, such auditors and/or inspectors as MCHCP may from time to time designate, with access to Contractor service locations, facilities or installations. The access described in this section shall be for the purpose of performing audits or inspections of the Services and the business of MCHCP. Contractor must provide as part of the services any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

○ Confirmed
○ Not confirmed (please explain)

Missouri Consolidated Health Care Plan
Responses to Vendor Questions
2024 Dental RFP
March 17, 2023

These responses are provided by MCHCP to questions received from potential bidders for the 2024 Dental RFP.

	Question	Response
1	Is it possible to provide the claims experience by each plan option separated for the same 2021-22 timeframe?	MCHCP currently offers only one dental plan design. Additional detail on the current plan design can be found at http://www.mchcp.org/stateMembers/dental/index.asp.
2	We did not find a census file, just references to total subscribers and dependents. Are you able to provide a census file that contains each subscriber's zip code, rate tier (e.g., Employee only, Employee plus spouse, etc.), and plan option?	Census files are available as Attachments 2 and 3 after receipt of the completed Exhibit A-2 Limited Data Use Agreement. The data fields included in each census file can be found in Attachment 1.
3	We found only one set of rates. Will you please provide current and/or renewal rates for each plan option?	MCHCP currently offers only one dental plan design. The current contract with MetLife expires Dec. 31, 2023; there are no renewal options remaining.
4	Please confirm if MCHCP considers Puerto Rico to be onshore, since technically it is a US territory.	MCHCP does not consider Puerto Rico to be onshore for this contract. Please detail what obligations under the contract are provided in Puerto Rico on Exhibit A-3 Proposed Bidder Modifications for evaluation whether an exception could be granted.
5	Please provide us with current enrollment counts by tier by plan.	MCHCP currently offers only one dental plan design. Please see attached for enrollment by tier.
6	Please provide the MetLife benefits summary with descriptions of coverages, exclusions, limitations, etc.	Please refer to the MCHCP website at http://www.mchcp.org/stateMembers/dental/index.asp.
7	Please provide the MetLife dental certificate/SPD, with a full description of coverages, exclusions, limitations, etc.	Please see attached.
8	What is the current out-of-network reimbursement schedule? Please provide the scheduled amounts of the OON reimbursements for the top 20-25 procedure codes so that we can properly analyze the impact of moving to the requested 90th percentile for OON.	MCHCP does not have the reimbursement schedule as this is a fully-insured product. Please refer to Attachment 6 for in-network claim utilization.
9	What is the current OON reimbursement with MetLife?	The current contract is a MAC Plan for out of network claims.
10	Will you provide network reporting showing network utilization and discounts?	Please refer to Attachment 6 of the RFP.
11	Are there any service issues with MetLife or anything MCHCP is dissatisfied with?	No.

Missouri Consolidated Health Care Plan
Responses to Vendor Questions
2024 Dental RFP
March 17, 2023

Question		Response
12	Exhibit A-3 Bidder's Proposed Modifications asks us to clearly identify by subsection number any exceptions to the Request for Proposal (RFP) provisions and include an explanation as to why the bidder cannot comply with the specific provision. Are we to identify all RFP exceptions on this form or only those that apply to the Mandatory Contract Provisions?	All requested modifications by the bidder should be outlined in Exhibit A-3.
13	Are there currrently separate rates for active and retired employees and for different plans?	No. Active employees and retirees pay the same rate. MCHCP currently offers only one dental plan design.

	Question	Response
14	Have there been any plan changes from 1-1-21 to date? If so, please provide details and effective dates of change.	Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 10 Years have passed since the most recent time that: • a Cast Restoration was installed for the same tooth; or • a Cast Restoration for the same tooth was replace Core buildup, but no more than once per tooth in a period of 10 Years. Prefabricated crown, but no more than one replacement for the same tooth within 10 Years. Posts and cores, but no more than once per tooth in a period of 10 Years. Labial veneers, but no more than once per tooth in a period of 10 Years. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 10 Year period. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 Year period. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 Year period. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 Year period. Emergency palliative treatment to relieve tooth pain. Oral exams and problem-focused exams, but no more than one exam (whether the exam is an oral exam or problem-focused exam) every 6 months. • Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than once every 6 months. • Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than once every 6 months. • Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) but no more than once every 6 months. If Dentally Necessary, two additional cleanings per Year will also be covered
15	Please provide dental experience split by active and retired.	Active employees and retirees pay the same rate. MCHCP currently offers only one dental plan design.

Question		Response
16	If there is currently more than one plan, please provide census that indicates plan option along with all other census information.	MCHCP currently offers only one dental plan design.
17	Please describe in detail what services are required to be onshore (e.g., claims processing, member touchpoints, customer touchpoints, provider touchpoints, IT services, other).	The requirements described in the RFP are required to be onshore.
18	Please provide the current performance guarantees.	Please see attached.
19	Please confirm current and proposed rates exclude commissions.	Confirmed.
20	Please confirm Willis Towers Watson is BOR on the case.	MCHCP does not have a broker of record for this procurement.
21	Please confirm the current benefit administration method.	MCHCP maintains an enrollment system for employees and retirees to select the dental plan. Plan selections are then sent to the Contractor through an eligibility file as described in the RFP.
22	Can we get claims broken out by In- vs. out-of-network?	This will not be provided.
23	Can we get claims for January and February, 2023?	Please see attached.
24	In order to consider providing a quote in a multi-carrier scenario, we need to know the following: 1. Is it the intent of MCHCP to have each carrier offer dual options, or would one carrier offer the basic plan, and one carrier offer the classic plan? 2. If each carrier is to offer a dual choice plan, is it possible that one carrier would offer basic and classic, and the other carrier offer basic and classic with ortho? 3. If each carrier is to offer a dual choice plan, is MCHCP open to allowing one of the carriers to offer plans not requested (or plans that include enhancements), rather than adhering to the requested plan designs?	Each contractor would offer both plan designs. If the bidder would like to propose alternative options, MCHCP would like to hear from the bidder what the proposed offering would be. Please provide an explanation of the offering proposed along with proposed rates. However, please be aware that MCHCP retains the right to reject the proposed alternative option.
25	Are carriers permitted to include minimum participation requirements?	No.
26	Please add services and billed amounts to the Exhibit A-7 Provider Match file.	This will not be provided.
27	If MCHCP chooses to award multiple contracts, will both companies be offering both plan designs selected? For example, if the Basic Plan and Classic Plan with ortho are chosen, would company A and company B both be offering each of the two plans?	Each contractor would offer both plan designs. If the bidder would like to propose alternative options, MCHCP would like to hear from the bidder what the proposed offering would be. Please provide an explanation of the offering proposed along with proposed rates. However, please be aware that MCHCP retains the right to reject the proposed alternative option.

	Question	Response
28	If MCHCP chooses to award multiple contracts, and one of the plan designs selected from Exhibit A-8 (tab: Enhanced Benefit Pricing), will both companies be permitted to offer the Enhanced benefit plan at an appropriate rate?	Each contractor would offer both plan designs. If the bidder would like to propose alternative options, MCHCP would like to hear from the bidder what the proposed offering would be. Please provide an explanation of the offering proposed along with proposed rates. However, please be aware that MCHCP retains the right to reject the proposed alternative option.
29	During open enrollment will each employee/retiree be required to actively select their carrier and plan choice (i.e. no default option)?	The Board of Trustees has not yet made a decision regarding passive versus active enrollment.
30	What will the opportunity be to communicate with prospective enrollees?	The opportunity for marketing will be negotiated after contract award.
31	Can MCHCP please confirm the desire to change the current plan offering from a Maximum Allowable Charge (PPO-MAC, PPO fees for non-PPO network reimbursement), to 90th percentile standard R&C, set by an independent third-party, such as FAIR Health, that is updated at least once per year?	Confirmed. If the bidder would like to propose alternative options, MCHCP would like to hear from the bidder what the proposed offering would be. Please provide an explanation of the offering proposed along with proposed rates. However, please be aware that MCHCP retains the right to reject the proposed alternative option.
32	Would it be possible to provide a claims detail file for re-price analysis? We would not ask that you provide any proprietary data and would appreciate it if the file could include the following fields: Date of Service, CDT/ADA Code, Dentist Tax ID, Provider Name, Provider Street Address, Provider City, Provider State Code, Provider Zip Code, and Submitted Fee.	This will not be provided.
33	Can you please provide a provider utilization report for 2022 that includes billed charges?	This will not be provided.
34	Can you please provide a provider utilization report for 2022 that includes paid amount for each provider?	This will not be provided.
35	Has MCHCP made any plan changes to the dental plan in the last few years and if so, can you outline the change(s) made and the year the change was implemented?	Please see response to #14 above.
36	Would it be possible for you to provide the dental claims experience for 2019 and 2020?	This will not be provided.
37	What is the orthodontic lifetime maximum you would like to have included on the Classic Plan with Ortho?	It is as stated in the plan design.
38	We were wondering if your decision is solely based on pricing, or if a much richer plan with a small price increase would be entertained? We would be looking at an increase starting at $1000/yr ($6/pay check). This would be with the second largest dental network in the country.	Please refer to the Introduction and Instructions document for instructions and the evaluation criteria used for potential award of a contract resulting from this RFP.

Missouri Consolidated Health Care Plan
Dental Subscriber Enrollment
March, 2023

Active Employees	
Employee Only	15,062
Employee and Spouse	3,180
Employee and Child(ren)	6,559
Employee, Spouse and Child(ren)	3,700
Subtotal	28,501
Retirees	
Retiree Only	6,491
Retire and Spouse	2,718
Retiree and Child(ren)	328
Retiree, Spouse and Child(ren)	213
Subtotal	9,750
Total	38,251

MISSOURI CONSOLIDATED HEALTH CARE PLAN

Dental - Monthly

Coverage	Month	Employee Lives	Member Lives	Premium	Claims	EOBs
			State			
Dental	01/01/2019	43,486	63,968	$1,658,984	$768,002	6,527
Dental	02/01/2019	43,667	64,179	$1,663,428	$1,333,695	10,085
Dental	03/01/2019	43,719	64,235	$1,664,572	$1,499,832	11,230
Dental	04/01/2019	43,737	64,223	$1,663,221	$1,649,379	12,201
Dental	05/01/2019	43,725	64,174	$1,662,324	$1,600,056	12,817
Dental	06/01/2019	43,693	64,095	$1,659,052	$1,474,992	10,985
Dental	07/01/2019	43,693	64,095	$1,659,343	$1,611,550	11,650
Dental	08/01/2019	43,585	63,901	$1,653,677	$1,623,064	11,947
Dental	09/01/2019	43,516	63,765	$1,650,090	$1,387,120	10,051
Dental	10/01/2019	43,531	63,762	$1,649,880	$1,605,170	11,886
Dental	11/01/2019	43,615	63,846	$1,651,687	$1,433,950	10,224
Dental	12/01/2019	43,654	63,844	$1,651,633	$1,576,906	10,696
Dental	01/01/2020	44,044	64,558	$1,711,978	$1,524,725	10,779
Dental	02/01/2020	44,130	64,674	$1,714,682	$1,483,545	10,506
Dental	03/01/2020	44,149	64,688	$1,714,625	$1,566,558	10,529
Dental	04/01/2020	44,146	64,654	$1,714,067	$346,996	2,346
Dental	05/01/2020	44,104	64,557	$1,710,748	$748,020	5,759
Dental	06/01/2020	44,017	64,421	$853,058	$1,643,203	11,374
Dental	07/01/2020	43,931	64,298	$1,703,806	$1,723,852	11,973
Dental	08/01/2020	43,736	64,019	$1,696,560	$1,596,044	11,308
Dental	09/01/2020	43,600	63,810	$1,691,039	$1,532,225	10,483
Dental	10/01/2020	43,418	63,507	$1,683,005	$1,497,089	10,113
Dental	11/01/2020	43,287	63,300	$1,677,920	$1,303,218	8,453
Dental	12/01/2020	43,213	63,188	$1,674,144	$1,629,709	10,587
Dental	01/01/2021	43,563	63,908	$1,686,520	$1,409,861	9,510
Dental	02/01/2021	43,495	63,789	$1,683,903	$1,416,984	9,198
Dental	03/01/2021	43,425	63,684	$1,680,877	$1,844,232	12,560
Dental	04/01/2021	43,284	63,455	$1,674,959	$1,702,795	11,274
Dental	05/01/2021	43,204	63,340	$1,672,704	$1,584,895	10,132
Dental	06/01/2021	43,023	63,066	$1,665,663	$1,664,074	11,018
Dental	07/01/2021	42,861	62,838	$1,658,946	$1,644,421	11,066
Dental	08/01/2021	42,717	62,616	$1,653,096	$1,673,022	11,443
Dental	09/01/2021	42,656	62,462	$1,648,412	$1,537,512	10,463
Dental	10/01/2021	42,523	62,248	$1,641,404	$1,557,144	10,890
Dental	11/01/2021	42,416	62,065	$1,636,476	$1,576,453	10,575
Dental	12/01/2021	42,340	61,902	$1,631,582	$1,744,742	11,244
Dental	01/01/2022	42,729	62,588	$1,697,244	$1,386,947	9,458
Dental	02/01/2022	42,718	62,521	$1,694,721	$1,344,623	8,818
Dental	03/01/2022	42,630	62,361	$1,691,540	$1,913,097	12,986
Dental	04/01/2022	42,613	62,287	$1,688,138	$1,763,781	11,553
Dental	05/01/2022	42,674	62,337	$1,688,254	$1,641,781	10,813
Dental	06/01/2022	42,788	62,473	$1,691,863	$1,699,376	11,327
Dental	07/01/2022	42,854	62,493	$1,691,258	$1,534,776	10,203
Dental	08/01/2022	42,973	62,624	$1,693,867	$1,703,819	11,598
Dental	09/01/2022	43,091	62,728	$1,694,609	$1,575,028	10,752
Dental	10/01/2022	43,111	62,711	$1,694,094	$1,564,933	10,781
Dental	11/01/2022	43,152	62,793	$1,697,101	$1,603,122	11,132
Dental	12/01/2022	43,215	62,846	$1,698,600	$1,614,150	10,687
Dental	01/01/2023	43,810	63,808	$1,746,088	$1,492,686	10,463
Dental	02/01/2023	43,810	63,808	$1,746,088	$1,531,922	10,372

Coverage	Month	Employee Lives	Member Lives	Premium	Claims	EOBs
			Public Entity			
Dental	01/01/2019	389	471	$11,277	$5,047	42
Dental	02/01/2019	390	472	$11,304	$10,105	64
Dental	03/01/2019	387	468	$11,210	$7,128	67
Dental	04/01/2019	383	465	$11,143	$7,164	64
Dental	05/01/2019	380	460	$11,029	$6,731	89
Dental	06/01/2019	387	467	$11,189	$6,136	63
Dental	07/01/2019	387	467	$11,212	$8,978	76
Dental	08/01/2019	387	468	$11,212	$8,523	68
Dental	09/01/2019	386	467	$11,221	$5,925	50
Dental	10/01/2019	387	466	$11,197	$7,786	65
Dental	11/01/2019	392	472	$11,368	$7,102	59
Dental	12/01/2019	389	468	$11,275	$6,963	60
Dental	01/01/2020	389	468	$11,569	$8,965	56
Dental	02/01/2020	350	425	$10,588	$6,683	65
Dental	03/01/2020	349	425	$10,623	$4,808	41
Dental	04/01/2020	348	425	$10,657	$2,293	11
Dental	05/01/2020	347	423	$10,608	$1,946	23
Dental	06/01/2020	345	420	$5,252	$8,740	63
Dental	07/01/2020	329	398	$9,878	$6,747	53
Dental	08/01/2020	325	391	$9,645	$11,481	68
Dental	09/01/2020	326	392	$9,668	$7,205	59
Dental	10/01/2020	327	392	$9,634	$7,137	47
Dental	11/01/2020	334	398	$9,775	$5,935	37
Dental	12/01/2020	352	423	$10,373	$7,033	56
Dental	01/01/2021	391	473	$11,702	$8,031	52
Dental	02/01/2021	396	477	$11,761	$6,769	57
Dental	03/01/2021	395	475	$11,714	$11,886	73
Dental	04/01/2021	392	474	$11,725	$9,657	73
Dental	05/01/2021	383	464	$11,522	$10,929	60
Dental	06/01/2021	384	464	$11,553	$8,505	61
Dental	07/01/2021	382	461	$11,392	$7,635	56
Dental	08/01/2021	380	461	$11,421	$8,665	67
Dental	09/01/2021	384	463	$11,468	$8,417	65
Dental	10/01/2021	381	459	$11,374	$8,784	58
Dental	11/01/2021	381	457	$11,281	$10,746	64
Dental	12/01/2021	386	461	$11,340	$8,139	71
Dental	01/01/2022	438	536	$13,791	$10,414	60
Dental	02/01/2022	439	536	$13,789	$6,836	58
Dental	03/01/2022	435	531	$13,574	$10,562	94
Dental	04/01/2022	437	534	$13,707	$8,601	76
Dental	05/01/2022	437	532	$13,622	$9,469	74
Dental	06/01/2022	432	527	$13,526	$11,674	79
Dental	07/01/2022	428	521	$13,354	$9,166	67
Dental	08/01/2022	425	517	$13,257	$9,291	76
Dental	09/01/2022	424	517	$13,318	$7,905	68
Dental	10/01/2022	429	522	$13,449	$9,101	72
Dental	11/01/2022	427	522	$13,417	$8,428	67
Dental	12/01/2022	433	528	$13,595	$6,223	59
Dental	01/01/2023	524	663	$17,565	$8,066	72
Dental	02/01/2023	524	663	$17,565	$10,914	80

MetLife Performance Guarantees

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
Account Management - Satisfaction. The following category will be measured and reported on Implementation and annually beginning January, 2019.	Contractor guarantees MCHCP's satisfaction with account management services	Satisfactory or better	MetLife will conduct a semi-annual survey to measure satisfaction with account management services. The survey is conducted by a third party and results will be shared with MCHCP. MetLife will receive, from designated customer respondents, an average for the year of at least a 5 rating on a 7 point scale to the question "Overall Satisfaction with the MetLife Account Team" on the MetLife Account Management Survey. Our seven point scale equates a score of 4 or 5 to satisfied and 6 or 7 to very satisfied.	$2,000 plus $0.10 PEPM	17000.00
Account Management - Responsiveness. The following category will be reported and measured quarterly beginning January, 2019.	Timely issues resolution by the account management team (e.g. issues resolvable by account management are acknowledged and responded to within 1 business day)	Acknowledgement and response within 8 business hours	The Client Service Consultant is responsible for documenting all client issues in an action log. This log tracks the receipt date and all status updates through resolution. This log is reviewed weekly by the management team and will be shared with MCHCP.	For each incident not acknowledged within 8 business hours, $500 plus $0.10 PEPM	17000.00
Member Service - Average response time. The following category will be measured and reported quarterly beginning January, 2019.	Average number of seconds for call to be answered by a live customer service representative	25 seconds or less	< = 25 seconds - Based on the overall Book of Business. All incoming calls received by the customer service telephone line will be answered within 25 seconds or less. Response time will be measured from the time the caller completes the prompts of the automated telephone system to the time the caller reaches a Customer Service Representative.	For each full second above standard, $2,000 plus $0.10 PEPM	8500.00

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
Member Service - Average abandonment rate. The following category will be measured and reported quarterly beginning January, 2019.	Percent of calls abandoned	< 2%	< 2% - Based on the overall Book of Business. MetLife maintains a level of service less than 2% of all incoming calls received by the customer service telephone line to be answered without the caller hanging up. The Abandonment Rate is defined as the number of incoming calls not reaching a Customer Service Reprentative divided by the total number of incoming calls expressed as a percentage.	For each full percentage point above standard, $2,000 plus $0.10 PEPM	8500.00
Member Service - Response to written inquiries. The following category will be measured and reported quarterly beginning January, 2019.	Average number of days within which written inquiries will be responded to	80 percent of emails wil be responded to within 1 business day	Based on the overall Book of Business. Measured by Customer Service Representative email response timeliness.	For each percentage point above standard, $500 plus $0.01 PEPM	8500.00
Eligibility - Timeliness of Installations. The following category will be measured and reported quarterly beginning January, 2019.	Electronic eligibility files will be installed and eligibility status will be effective within an average of 36 hours of receipt.	95% within 24 hours	We agree to apply 95% of ongoing eligibility file updates within 24 hours of receipt. We will log receipt date/time of the file and track the file through successful application into our system. This average turnaround time is contingent on the quality of the file submitted, which encompasses the file being named correctly and containing valid data.	For each full hour beyond 24 hours, $500 plus $0.10 PEPM	8500.00
Eligibility - Accuracy of Installations. The following category will be reported and measured quarterly beginning January, 2019.	Electronic eligibility records loaded with 99.5% accuracy. This standard is contingent upon receipt of clean eligibility data delivered in an agreed upon format.	100%	We agree to load electronic eligibility records with 100% accuracy based on total member numbers. Reports summarizing the file received and loaded will be provided to the client and Client Service Consultant for verification of accuracy of the file.	For each full percentage point below standard, $2,000 plus $0.10 PEPM	8500.00
Reporting - The following categories will be reported and measured quarterly beginning January, 2019. Penalties will be applied for each month the contractor fails to meet these standards.	Claim file must be submitted to MCHCP's data vendor no later than 15th of the month for prior month's services	100%	MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	8500.00

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
	Claim file must be submitted to MCHCP's data vendor in proper format on first submission of the month	100%	MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	8500.00
	Data submission to MCHCP's data vendor must include 100 percent of all required financial fields	100%	MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	8500.00
	Data submission to MCHCP's data vendor must include all required key fields (subscriber SSN, member DOB, and member gender)	100%	MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	8500.00
	Data submission to MCHCP's data vendor must include all required key fields (diagnostic coding, provider type, provider ID,etc.)	100%	MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	8500.00
Reporting - The following categories will be measured and reported quarterly beginning January 1, 2019.	Standard reporting must be submitted to MCHCP in the agreed upon format and within 30 days of end of quarter.	Due within 30 days of end of quarter	MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $2,000 plus $0.10 PEPM	8500.00
	Customer service reporting must be submitted to MCHCP in the agreed upon format and within 30 days of end of quarter.	Due within 30 days of end of quarter	MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $2,000 plus $0.10 PEPM	8500.00
Monthly eligibility audit file - The following category will be measured and reported quarterly beginning January, 2019. Penalties will be applied for each month the contractor fails to meet this standard.	Eligibility audit file must be provided on the second Thursday of each month in the agreed upon format	Audit file available by the second Thursday of each month	MCHCP will determine acceptability of file	For each day file was not transmitted on time, $2,000 plus $0.10 PEPM	8500.00

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
Claims financial accuracy - The following category will be measured and reported quarterly beginning January, 2019.	Percentage of claims processed free of financial error	>= 99%	99.5% - Based on MCHCP-specific results. "Financial Accuracy" is defined as the performance standard used to evaluate the Dental Processing Group's payment performance in dollar amounts. {(Total dollars of Actual Claims for Benefits and Estimated Claims for Benefits in the Book of Business Sample) - (total dollars of Overpaid Claims + total dollars of Underpaid Claims)} divided by (total dollars of Actual Claims for Benefits and Estimated Claims for Benefits in the Book of Business Sample).	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00
Claims processing accuracy - The following category will be measured and reported quarterly beginning January, 2019.	Percentage of claims processed correctly	>= 99%	99% Based on MCHCP-specific results. "Procedural Accuracy" is defined as the performance standard used to evaluate AAR Claim processing performance with respect to claim data line entries. A "Procedural Error" is defined as any error by the Dental Processing Group that results in the incorrect entry of data within a Line of Entry, including, without limitation, Procedural Errors that result in overpayments or underpayments. "Procedural Accuracy Rate" will be determined by the following formula and expressed as a percentage: (Total Lines of Entry in Book of Business sample - Procedural Errors in Book of Business Sample) divided by Total Lines of Entry in Book of Business sample).	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
Claim turnaround time - Network providers - The following category will be measured and reported quarterly beginning January, 2019.	Percent of claims from network providers processed within 10 days	>= 95%	95% within 10 business days Based on MCHCP-specific results. Turnaround Time is the performance standard used to measure the period of time which transpires from the date a Claim is considered Processed to Conclusion. A Claim is considered "Processed to Conclusion" on the date when MetLife issues an explanation of benefits.	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00
Claim turnaround time - Out of Network providers - The following category will be measured and reported quarterly beginning January, 2019.	Percent of claims from non-network providers processed within 5 days	>= 95%	95% within 10 business days Based on MCHCP-specific results. Turnaround Time is the performance standard used to measure the period of time which transpires from the date a Claim is considered Processed to Conclusion. A Claim is considered "Processed to Conclusion" on the date when MetLife issues an explanation of benefits.	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00
Network retention rate - The following category will be measured and reported annually beginning January, 2019.	Network provider retention rate (based on voluntary turnover)	>= 98%	Overall network provider retention rate (based on voluntary dentist turnover) of >= 98% annually. Based on Book of Business.	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00
Overall Satisfaction with contractor - The following category will be measured and reported quarterly beginning January, 2019.	Percent of members rating contractor satisfactory or better	95%	MetLife uses a 4 point survey scale to measure customer satisfaction with employees. The scale ranges from "Very Satisfied" to "Very Dissatisfied". We can commit to an employee satisfaction score of 95%, representing employees that rated us as either "Very Satisfied" or "Satisfied".	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
Preventive care - The following category will be measured and reported annually beginning January, 2019.	Percent of members accessing preventive care	55 percent of members who are continuously enrolled will receive at least one preventive exam per year	We will provide an annual report following the plan year that includes the percentage of members who have received preventive care for the prior year. In addition, if the percent of members falls below the guarantee, we will proactively complete an outreach to all employees regarding preventive exams.	For each full percentage point below standard, $2,000 plus $0.10 PEPM	8500.00
Network Access - The following category will be measured and reported annually beginning January, 2019.	Percent of members with access to general dentist	94 percent of members will have access to 1 general dentist within 20 miles	GeoAccess reporting	0.5% of premium	
Network Development and Growth - The following category will be measured and reported annually beginning January, 2019.	Percentage growth of network dentist access points	PDP Plus network growth of 5 percent of network dentist access points	MetLife will calculate the Network Growth Penalty, if any, and will notify MCHCP of the calculation no later than ninety (90) days following the end of the applicable Policy Period. MetLife will remit payment of such Network Growth Penalty no later than thirty (30) days following the date of such notification.	0.5% of premium for failing to meet network growth guarantee, and 0.25% of premium for growing network by more than 50% but less than 100% of the 5% target	

MetLife's overall maximum aggregate amount at risk for all performance guarantees combined is 3% of annual premium.

YOUR BENEFIT PLAN

Missouri Consolidated Health Care Plan

State
Full-Time Employees,
excluding residents of Alaska and Montana

Dental Insurance for You and Your Dependents

Certificate Date: January 1, 2019

Certificate Number 1

Missouri Consolidated Health Care Plan
832 Weathered Rock Court
Jefferson City, MO 65101

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Missouri Consolidated Health Care Plan

MetLife

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company (“MetLife”), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a legal contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	Missouri Consolidated Health Care Plan
Group Policy Number:	215367-1-G
Type of Insurance:	Dental Insurance
MetLife Toll Free Number(s):	
For Claim Information	FOR DENTAL CLAIMS: 1-844-222-9106

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For Residents of North Dakota: If You are not satisfied with Your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of Our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if You elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under Your Certificate will not be covered.

For New Mexico Residents: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that You have health insurance coverage. If You do not have other health insurance coverage, You may be subject to a federal tax penalty.

GCERT2000
fp as amended by GEND16-NM-DSC

For New Hampshire Residents: 30 Day Right to Examine Certificate.
Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at:

1-844-222-9106

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de MetLife's para obtener información o para presentar una queja al:

1-844-222-9106

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Sitio Web: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con MetLife primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU CERTIFICADO: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

NOTICE FOR RESIDENTS OF LOUISIANA, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, TEXAS, UTAH AND WASHINGTON

The Definition Of Child Is Modified For The Coverages Listed Below:

For Louisiana Residents (Dental Insurance):

The term also includes Your grandchildren residing with You. The age limit for children and grandchildren will not be less than 21, regardless of the child's or grandchild's student status or full-time employment status. In addition, the age limit for students will not be less than 24. Your natural child, adopted child, stepchild or grandchild under age 21 will not need to be supported by You to qualify as a Child under this insurance.

For Minnesota Residents (Dental Insurance):

The term also includes:

- Your grandchildren who are financially dependent upon You and reside with You continuously from birth;
- children for whom You or Your Spouse is the legally appointed guardian; and
- children for whom You have initiated an application for adoption.

The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status. Your natural child, adopted child stepchild or children for whom You or Your Spouse is the legally appointed guardian under age 25 will not need to be supported by You to qualify as a Child under this insurance.

For New Hampshire Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

For New Mexico Residents (Dental Insurance):

The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied dental insurance coverage under this certificate because:

- that child was born out of wedlock;
- that child is not claimed as Your dependent on Your federal income tax return; or
- that child does not reside with You.

For Texas Residents (Dental Insurance):

The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child's or grandchild's student status, full-time employment status or military service status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance. A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child. In addition, grandchildren must be able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Insurance.

NOTICE FOR RESIDENTS OF LOUISIANA, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, TEXAS, UTAH AND WASHINGTON (continued)

For Utah Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. The term includes a child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Dental plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

- the date the Child attains the limiting age in order to continue coverage; or
- You enroll a Child to be covered under this provision;

and at reasonable intervals after such date, but no more often than annually after the two-year period immediately following the date the Child qualifies for coverage under this provision.

For Washington Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

NOTICE FOR RESIDENTS OF ALL STATES WHO ARE INSURED FOR DENTAL INSURANCE

Notice Regarding Your Rights and Responsibilities

Rights:

- We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to dental treatment are the responsibility of You and the Dentist. We neither require nor prohibit any specified treatment. However, only certain specified services are covered for benefits. Please see the Dental Insurance sections of this certificate for more details.
- You may request a pre-treatment estimate of benefits for the dental services to be provided. However, actual benefits will be determined after treatment has been performed.
- You may request a written response from MetLife to any written concern or complaint.
- You have the right to receive an explanation of benefits which describes the benefit determinations for Your dental insurance.

Responsibilities:

- You are responsible for the prompt payment of any charges for services performed by the Dentist. If the dentist agrees to accept part of the payment directly from MetLife, You are responsible for prompt payment of the remaining part of the dentist's charge.
- You should consult with the Dentist about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. You should share with the Dentist the most current, complete and accurate information about Your medical and dental history and current conditions and medications.
- You should follow the treatment plans and health care recommendations agreed upon by You and the Dentist.

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
(501) 371-2640 or (800) 852-5494

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904

1-844-222-9106

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

WEBSITE: http://www.insurance.ca.gov/

1-800-927-4357 (within California)
1-213-897-8921 (outside California)

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

California law provides that for dental insurance, domestic partners of California's residents must be treated the same as spouses. If the certificate does not already have a definition of domestic partner, then the following definition applies:

> **"Domestic Partner** means each of two people, one of whom is an employee of the Policyholder, a resident of California and who have registered as domestic partners or members of a civil union with the California government or another government recognized by California as having similar requirements."

If the certificate already has a definition of domestic partner, that definition will apply to California residents, as long as it recognizes as a domestic partner any person registered as the employee's domestic partner with the California government or another government recognized by California as having similar requirements.

Wherever the term **"Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term step-child appears, it is replaced by step-child or child of Your Domestic Partner.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company

1-844-222-9106

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf , or any covered Dependent may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF DENTAL INSURANCE

1. If Your Dental Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your Dental Insurance ends because:

   - You cease to be in an Eligible Class; or
   - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Dental Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

CONTINUATION OF DENTAL INSURANCE FOR YOUR FORMER SPOUSE

If the judgment of divorce dissolving Your marriage provides for continuation of insurance for Your former Spouse when You remarry, Dental Insurance for Your former Spouse that would otherwise end may be continued.

To continue Dental insurance under this provision:

1. You must make a written request to the employer to continue such insurance;
2. You must make any required premium to the employer for the cost of such insurance.

The request form will be furnished by the Employer.

Such insurance may be continued from the date Your marriage is dissolved until the earliest of the following:

- the date Your former Spouse remarries;
- the date of expiration of the period of time specified in the divorce judgment during which You are required to provide Dental Insurance for Your former Spouse;
- the date coverage is provided under any other group health plan;
- the date Your former Spouse becomes entitled to Medicare;
- the date Dental Insurance under the policy ends for all active employees, or for the class of active employees to which You belonged before Your employment terminated;
- the date of expiration of the last period for which the required premium payment was made; or
- the date such insurance would otherwise terminate under the policy.

If Your former Spouse is eligible to continue Dental Insurance under this provision and any other provision of this Policy, all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

NOTICE FOR RESIDENTS OF MISSISSIPPI

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-844-222-9106.

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the FILING A CLAIM section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will review Your claim and notify You of its decision to approve or deny Your claim.

If Your claim is a Clean Claim and it is approved by MetLife, benefits will be paid within 25 days after MetLife receives due written proof in electronic form of a covered loss, or within 35 days after receipt of due written proof in paper form of a covered loss. Due written proof includes, but is not limited to, information essential for Us to administer coordination of benefits.

"Clean Claim" means a claim that:

- does not require further information, adjustment or alteration by You or the provider of the services in order for MetLife to process and pay it;
- does not have any defects;
- does not have any impropriety, including any lack of supporting documentation; and
- does not involve a particular circumstance required special treatment that substantially prevents timely payments from being made on the claim.

A Clean Claim does not include a claim submitted by a provider more than 30 days after the date of service, or if the provider does not submit the claim on Your behalf, a claim submitted more than 30 days after the date the provider bills You.

If MetLife is unable to pay a claim for Dental Insurance benefits because MetLife needs additional information or documentation, or there is a particular circumstance requiring special treatment, within 25 days after the date MetLife receives the claim if it is submitted in electronic form, or within 35 days after the date MetLife receives the claim if it is submitted in paper form, MetLife will send You notice of what supporting documentation or information MetLife needs. Any claim or portion of a claim for Dental Insurance benefits that is resubmitted with all of the supporting documentation requested in Our notice and becomes payable will be paid to You within 20 days after MetLife receives it.

Clean Claim (Continued)

If MetLife does not deny payment of such benefits to You by the end of the 25 day period for clean claims submitted in electronic form, or 35 day period for clean claims submitted in paper form, and such benefits remain due and payable to You, interest will accrue on the amount of such benefits at the rate of 1½ percent per month until such benefits are finally settled. If MetLife does not pay benefits to You when due and payable, You may bring action to recover such benefits, any interest which has accrued with respect to such benefits and any other damages which may be allowed by law. MetLife will pay benefits when MetLife receives satisfactory Written proof of Your claim.

Proof must be given to MetLife not later than 90 days after the end of the Dental Expense Period in which the Covered Dental Expenses were incurred. If proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the proof is given as soon as possible.

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. Upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

As part of each appeal, You may submit any written comments, documents, records, or other information relating to Your claim.

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify You in writing of its final decision within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send You a final written decision that states the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

CONTINUATION OF YOUR DENTAL INSURANCE

If You are a resident of New Hampshire, Your Dental Insurance may be continued if it ends because Your employment ends unless:

- Your employment ends due to Your gross misconduct;
- this Dental Insurance ends for all employees;
- this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;
- You are entitled to enroll in Medicare; or
- Your Dental Insurance ends because You failed to pay the required premium.

The Employer must give You written notice of:

- Your right to continue Your Dental Insurance;
- the amount of premium payment that is required to continue Your Dental Insurance;
- the manner in which You must request to continue Your Dental Insurance and pay premiums; and
- the date by which premium payments will be due.

The premium that You must pay for Your continued Dental Insurance may include:

- any amount that You contributed for Your Dental Insurance before it ended;
- any amount the Employer paid; and
- an administrative charge which will not to exceed two percent of the rest of the premium.

To continue Your Dental Insurance, You must:

- send a written request to continue Your Dental Insurance; and
- pay the first premium within 30 days after the date Your employment ends.

The maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date Your Employment ends; or
- 18 months.

Your continued Dental Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Dental Insurance ends;
- the date this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;
- the date You are entitled to enroll for Medicare;
- if You do not pay the required premium to continue Your Dental Insurance; or
- the date You become eligible for coverage under any other group Dental coverage.

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE

If You are a resident of New Hampshire, Your Dental Insurance for Your Dependents may be continued if it ends because Your employment ends, Your marriage ends in divorce or separation, or You die, unless:

- Your employment ends due to Your gross misconduct;
- this Dental Insurance ends for all Dependents;
- this Dental Insurance is changed, for the class of employees to which You belong, to end Dental Insurance for Dependents;
- the Dependent is entitled to enroll in Medicare; or
- Your Dental Insurance for Your Dependents ends because You fail to pay a required premium.

If Dental Insurance for Your Dependents ends because Your marriage ends in divorce or separation, the party responsible under the divorce decree or separation agreement for payment of premium for continued Dental Insurance must notify the employer, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred. If You and Your divorced or separated Spouse share responsibility for payment of the premium for continued Dental Insurance, both You and Your divorced or separated Spouse must provide the notification.

The Employer must give You, or Your former Spouse if You have died or Your marriage has ended, written notice of:

- Your right to continue Your Dental Insurance for Your Dependents;
- the amount of premium payment that is required to continue Your Dental Insurance for Your Dependents;
- the manner in which You or Your former Spouse must request to continue Your Dental Insurance for Your Dependents and pay premiums; and
- the date by which premium payments will be due.

The premium that You or Your former Spouse must pay for continued Dental Insurance for Your Dependents may include:

- any amount that You contributed for Your Dental Insurance before it ended; and
- any amount the Employer paid.

To continue Dental Insurance for Your Dependents, You or Your former Spouse must:

- send a written request to continue Dental Insurance for Your Dependents; and
- must pay the first premium within 30 days of the date Dental Insurance for Your Dependents ends.

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Dental Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Dental Insurance for Your Dependents will end.

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE (Continued)

The maximum continuation period will be the longest of the following that applies:

- 36 months if Dental Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Dental Insurance for Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months if Dental Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Dental Insurance the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months with respect to a Dependent Child if Dental Insurance ends because the Child ceases to be a Dependent Child;
- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if Dental Insurance for Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Dental Insurance for Your Dependents ends because Your employment ends.

A Dependent's continued Dental Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Dental Insurance ends;
- the date this Dental Insurance is changed to end Dental Insurance for Dependents for the class of employees to which You belong;
- the date the Dependent becomes entitled to enroll for Medicare;
- if You do not pay a required premium to continue Dental Insurance for Your Dependents; or
- the date the Dependent becomes eligible for coverage under any other group dental coverage.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

The following service will be a Covered Service for New Hampshire residents whether or not general anesthesia or intravenous sedation is already specified elsewhere as covered:

General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when

- the covered person is a Child under the age of 6 who is determined by a licensed Dentist in conjunction with a licensed Physician to have a dental condition of significant complexity which requires the Child to receive general anesthesia for the treatment of such condition;
- the covered person has exceptional medical circumstances or a developmental disability as determined by a licensed Physician which place the person at serious risk; or
- We determine such anesthesia is necessary in accordance with generally accepted dental standards.

NOTICE FOR RESIDENTS OF PENNSYLVANIA

Dental Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- continues to qualify as a Child, except for the age limit; and
- submits the required Proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, this continuation will continue until the earliest of the date:

- the insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- the child is no longer a full-time student.

NOTICE FOR RESIDENTS OF TEXAS

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

NOTICE FOR RESIDENTS OF TEXAS

The exclusion of services which are primarily cosmetic will not apply to the treatment or correction of a congenital defect of a newborn child.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

NOTICE FOR RESIDENTS OF TEXAS

If You reside in Texas, note the following Procedures for Dental Claims will be followed:

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-844-222-9106.

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the FILING A CLAIM section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will notify You acknowledging receipt of Your claim, commence with any investigation, and request any additional information within 15 days of receipt of Your claim.

MetLife will notify You in writing of the acceptance or rejection of Your claim within 15 business days of receipt of all information needed to process Your claim.

If MetLife cannot accept or reject Your claim within 15 business days after receipt of all information, MetLife will notify You within 15 business days stating the reason why we require an extension. If an extension is requested, We will notify You of our decision to approve or deny Your claim within 45 days. Upon notification of approval, Your claim will be paid within 5 business days.

If MetLife denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. Upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee;
- Name of the Plan;
- Reference to the initial decision;
- Whether the appeal is the first or second appeal of the initial determination;
- An explanation why You are appealing the initial determination.

As part of each appeal, You may submit any written comments, documents, records, or other information relating to Your claim.

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify You in writing of its final decision within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send You a final written decision that states the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

NOTICE FOR RESIDENTS OF THE STATE OF VERMONT

Vermont law provides that the following apply to Your certificate:

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "**Spouse**" appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE TO RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-275-4638

If You have any questions regarding an appeal or grievance concerning the dental services that You have been provided that have not been satisfactorily addressed by this Dental Insurance, You may contact the Virginia Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

Office of Licensure and Certification
Division of Acute Care Services
Virginia Department of Health
9960 Mayland Drive
Suite 401
Henrico, Virginia 23233-1463
Phone number: 1-800-955-1819/ local: 804-367-2106
Fax: (804) 527-4503
MCHIP@vdh.virginia.gov

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the FILING A CLAIM section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. Upon your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee;
- Name of the Plan;
- Reference to the initial decision;
- Whether the appeal is the first or second appeal of the initial determination;
- An explanation why You are appealing the initial determination.

As part of each appeal You may submit any written comments, documents, records or other information relating to Your claim.

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.
MetLife will notify You in writing of its final determination within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the 30 day period, state the reason(s) why an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send You a final written decision that states the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

Policies and Procedures for Emergency and Urgent Care

Urgent care and Emergency services: All member dentists of the MetLife Preferred Dentist Program are required to have 24-hour emergency coverage or have alternate arrangements for emergency care for their patients. Since the MetLife Preferred Dentist Program is a freedom-of-choice PPO program, there is no primary care physician. No authorization of a service is necessary by a Primary Care Physician, nor is it necessary to obtain a pre-authorization of services. The patient is free to use the dentist of their choice.

An important distinction to be made for this section is the difference between Urgent Care in a dental situation versus that found in medical. Urgent care is defined more narrowly in dental to mean the alleviation of severe pain (as there are no life-threatening situations in dental). Additionally, the alleviation of pain in dental is a simple palliative treatment, which is not subject to claim review.

The benefit amount will be consistent with the terms contained in the insured's contract.

NOTICE TO RESIDENTS OF VIRGINIA (continued)

Urgent Care Submission:

A small number of claims for dental expense benefits may be urgent care claims. Urgent care claims for dental expense benefits are claims for reimbursement of dental expenses for services which a dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course any such claim may always be submitted in accordance with the normal claim procedures. However your dentist may also submit such a claim to MetLife by telephoning MetLife and informing MetLife that the claim is an Urgent Care Claim. Urgent Care Claims are processed according to the procedures set out above, however once a claim for urgent care is submitted MetLife will notify you of the determination on the claim as soon as possible, but no later than 72 hours after the claim is filed. If you or your covered dependent does not provide the claims administrator with enough information to decide the claim, MetLife will notify you within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, MetLife will then notify you of the claim decision within 48 hours after MetLife received the information. If the needed information is not provided, MetLife will notify you or your covered dependent of its decision within 120 hours after the claim was received.

If your urgent care claim is denied but you receive the care, you may appeal the denial using the normal claim procedures. If your urgent care claim is denied and you do not receive the care, you can request an expedited appeal of your claim denial by phone or in writing. MetLife will provide you any necessary information to assist you in your appeal. MetLife will then notify you of its decision within 72 hours of your request in writing. However, MetLife may notify you by phone within the same time frames above and then mail you a written notice.

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

Wherever the term "**Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
1-844-222-9106

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

- for which You and Your Dependents become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS	
Dental Insurance For You and Your Dependents		
Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	100%	100%
Type B Services	80%	80%
Type C Services	50%	50%
Deductibles for:		
Yearly Individual Deductible	$50 for the following Covered Services Combined: Type B; Type C	$50 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	$2,000 for the following Covered Services: Type A; Type B; Type C. Certain Type A and Type B benefits are not subject to the annual maximum. Those Covered Services include: exams (including problem-focused exams), bitewing x-rays, full mouth or panoramic x-rays, intraoral-periapical –x-rays, X-rays, except as mentioned elsewhere, oral prophylaxis (cleanings, including periodontal cleanings) and topical fluoride treatment.	$2,000 for the following Covered Services: Type A; Type B; Type C. Certain Type A and Type B benefits are not subject to the annual maximum. Those Covered Services include: exams (including problem-focused exams), bitewing x-rays, full mouth or panoramic x-rays, intraoral-periapical –x-rays, X-rays, except as mentioned elsewhere, oral prophylaxis (cleanings, including periodontal cleanings) and topical fluoride treatment

Benefit Waiting Periods

Type A Services..No waiting period

Type B Services..No waiting period

Type C Services .... 12 month waiting period

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a full-time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Cast Restoration means an inlay, onlay, or crown.

Certificateholder means a member of an eligible class who is insured under the Group Policy. If an insured employee who is a member of an eligible class dies, or if an insured retired employee who is a member of an eligible class dies, and if such employee's or retired employee's surviving Dependent elects to continue Dental Insurance in effect on the date of the insured employee's or retired employee's death, such surviving Dependent will be deemed the Certificateholder thereafter. If coverage is continued, a newly acquired Child of the insured employee's surviving Spouse is eligible to become enrolled for coverage and a newly acquired spouse of the insured employee's surviving Dependent is eligible to become enrolled for coverage.

Child means the following: (for residents of Louisiana, Minnesota, New Hampshire, New Mexico, Texas, Utah and Washington, the Child Definition is modified as explained in the Notice pages of this certificate - please consult the Notice)

Your natural or adopted child; Your stepchild; or Your foster child; and who, in each case, is under age 26.

The definition of Child includes newborns.

The definition of Child includes an adopted Child beginning on the later of:

- the child's date of birth; or
- the date You initiate an application for adoption of the child.

If You provide Us notice, a Child also includes a child for whom You must provide Dental Insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

Contributory Insurance means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Dental Insurance.

Covered Percentage means the percentage of the Maximum Allowed Charge that We will pay for a Covered Service performed by an In-Network Dentist or an Out-of-Network Dentist after any required Deductible is satisfied.

Covered Service means a dental service used to treat Your or Your Dependent's dental condition which is:

- prescribed or performed by a Dentist while such person is insured for Dental Insurance;
- Dentally Necessary to treat the condition; and
- described in the SCHEDULE OF BENEFITS or DENTAL INSURANCE sections of this certificate.

Deductible means the amount You or Your Dependents must pay before We will pay for Covered Services.

Dental Hygienist means a person trained to:

- remove calcareous deposits and stains from the surfaces of teeth; and
- provide information on the prevention of oral disease.

Dentally Necessary means that a dental service or treatment is performed in accordance with generally accepted dental standards as determined by Us and is:

- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

Dentist means:

- a person licensed to practice dentistry in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Dentist's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.

For purposes of Dental Insurance, the term will include a Physician who performs a Covered Service.

Dentures means fixed partial dentures (bridgework), removable partial dentures and removable full dentures.

Dependent(s) means Your Spouse and/or Child.

In-Network Dentist means a Dentist who participates in the Preferred Dentist Program and has a contractual agreement with Us to accept the Maximum Allowed Charge as payment in full for a dental service.

Maximum Allowed Charge means the lesser of:

- the amount charged by the Dentist; or
- the maximum amount which the In-Network Dentist has agreed with Us to accept as payment in full for the dental service.

Out-of-Network Dentist means a Dentist who does not participate in the Preferred Dentist Program.

DEFINITIONS (continued)

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse.

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

We, **Us** and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Year or **Yearly**, for Dental Insurance, means the 12 month period that begins January 1.

You and **Your** mean a Certificateholder who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All State employees of the Policyholder, excluding residents of Alaska and Montana, who are included in one of the following classes:

Class 1: Full-Time Regular Employees who are employed by the Policyholder and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.

Class 2: Variable Hour Employees who are employed by the Policyholder and who are Employees of the Policyholder who qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period.

Full-Time Employee means an employee who qualifies as full-time under the following eligibility rules: There are 2 categories of Full-Time Employees:

- Employees of the Policyholder who are classified by the Policyholder as Full-Time Regular Employees based on the expectation that they will work an average of 30 or more hours per week based on their position within the Policyholder.
- Employees of the Policyholder who are Variable Hour Employees that qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period.

See also Eligibility Definitions below.

DATE YOU ARE ELIGIBLE FOR INSURANCE

For Eligible Class 1:

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

If You are in an eligible class on January 1, 2019, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2019, You will be eligible for insurance on the first day of the calendar month following the date You enter that class.

Your eligibility for insurance will continue, subject to the Date Your Insurance Ends section, until such time as Your employment ends or Your employment classification changes to a non-full-time status, as determined by the Policyholder based upon status classification changes and/or a reduction in hours worked.

For Eligible Class 2:

Eligibility Rules – Employees Who Are Hired on or After January 1, 2019

You will qualify for Variable Hour Employee status if the Policyholder determines that You have worked an average of 30 or more hours per week during the Initial Measurement Period. If You qualify for Variable Hour Employee status during the Initial Measurement Period, You will be eligible for insurance during the Initial Stability Period, provided that Your employment continues. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Initial Stability Period, unless the Policyholder determines that You re-qualify for Variable Hour Employee status during an Ongoing Measurement Period.

Eligibility Rules – Ongoing Employees

If You are classified on or after January 1, 2019 as a Variable Hour Employee by the Policyholder following Your Initial Stability Period, You must work an average of 30 hours or more per week during any Ongoing Measurement Period. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Variable Hour Employee status during an Ongoing Measurement Period.

If You were not initially classified as a Variable Hour Employee by the Policyholder on Your date of hire the following eligibility rules apply on and after January 1, 2019 regardless of whether You were eligible for insurance during the Initial Stability Period:

If You qualify for Variable Hour Employee status by working an average of 30 or more hours per week as determined by the Policyholder during any Ongoing Measurement Period You will be eligible for insurance during the immediately following Ongoing Stability Period, subject to the Waiting Period, provided that Your employment continues. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Variable Hour Employee status during an Ongoing Measurement Period.

Eligibility Definitions

For purposes of the above eligibility rules, the following terms and their meanings are indicated.

Initial Measurement Period means a period that starts with the first pay period that begins immediately after Your hire date, and ends on the last day of the pay period that contains the eleventh (11^{th}) month anniversary of Your hire.

Initial Stability Period means a 12 month period that starts on the first day of the 13^{th} calendar month following Your date of hire.

Ongoing Measurement Period means an annual 12 month period that starts on the first payroll period in January of the immediately preceding calendar year and ends with the start of the first payroll period in January in the immediately subsequent (i.e. current) calendar year.

Ongoing Stability Period means the 12 month period that starts on the first day of the calendar year following the end of the immediately preceding Ongoing Measurement Period.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

The Dental Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Dental Insurance only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

For new hires, if You complete the enrollment process within 31 days of becoming eligible for Dental Insurance, such insurance will take effect as follows:

If You are in Eligible Class 1, the Dental Insurance described in this certificate will take effect on the later of:

1. January 1, 2019; and
2. the first day of the calendar month following the date You enter Eligible Class 1;

provided You are Actively at Work in Eligible Class 1 on that date.

If You are in Eligible Class 2, i.e., You are a variable hour Employee who has qualified for Full-Time status by working an average of 30 hours or more per week as determined by the Policyholder during Your Initial Measurement Period, the Insurance described in this certificate will take effect on the later of:

1. January 1, 2019; and
2. the first day of the calendar month following the thirteenth month anniversary of Your date of hire;

provided You are Actively at Work in Eligible Class 2 on that date.

If You are a variable hour Employee who has qualified for Full-Time status by working an average of 30 hours or more per week as determined by the Policyholder during an Ongoing Measurement Period, the Insurance described in this certificate will take effect on the next January 1 provided You are Actively at Work in Eligible Class 2 on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for insurance until the next annual enrollment period for Dental Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. The changes to Your insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.

Enrollment Due to a Qualifying Event

You may enroll for insurance, for which You are eligible, or change the amount of Your insurance between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days or 60 days, dependent on the Qualifying Event as shown below, from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event, will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Qualifying Event includes:

You will have 31 days from the date of the following Qualifying Events to make a request:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines); or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

You will have 60 days from the date of the following Qualifying Events to make a request:

- You previously did not enroll for Dental Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage;
  3. COBRA Continuation of the other group coverage was exhausted;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
  - You to provide health coverage for Your child or dependent foster child; or
  - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage; or
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the date You cease to be in an eligible class;
4. the end of the period for which the last premium has been paid for You;
5. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;

6. the date You cease to be Actively at Work in Eligible Class 1 and provided that You have not become eligible as a variable hour employee under Eligible Class 2, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
7. the end of the last Stability Period for which You have been determined by the Policyholder to be a variable hour employee as a member of Eligible Class 2 due to Your work in a prior Measurement Period and provided that You have not become eligible as a full-time regular employee under Eligible Class 1, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All State employees of the Policyholder, excluding residents of Alaska and Montana, who are included in one of the following classes:

Class 1: Full-Time Regular Employees who are employed by the Policyholder and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.

Class 2: Variable Hour Employees who are employed by the Policyholder and who are Employees of the Policyholder who qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period

Full-Time Employee means an employee who qualifies as full-time under the eligibility rules that follow. There are 2 categories of Full-Time Employees:

- Employees of the Policyholder who are classified by the Policyholder as Full-Time Regular Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.
- Employees of the Policyholder who are Variable Hour Employees that qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period.

See also Eligibility Definitions below.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

For Eligible Cass 1:

You may only become eligible for the Dependent insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for Dependent insurance described in this certificate on the latest of:

1. January 1, 2019; and
2. the first day of the calendar month following the date You enter a class eligible for insurance; and
3. the date You obtain a Dependent.

Your eligibility for insurance will continue, subject to the Date Your Insurance Ends section, until such time as Your employment ends or Your employment classification changes to a non-full-time status, as determined by the Policyholder based upon status classification changes and/or a reduction in hours worked.

No person may be insured as a Dependent of more than one employee.

For Eligible Class 2:

Eligibility Rules – Employees Who Are Hired on or After January 1, 2019

If on the date of Your hire, You are classified as a Variable Hour Employee by the Policyholder, You may later qualify for Full-Time Employee status if the Policyholder determines that You have worked an average of 30 or more hours per week during the Initial Measurement Period. If You qualify for Full-Time Employee status during the Initial Measurement Period and if You have a Dependent, You will be eligible for insurance during the Initial Stability Period, provided that Your employment continues. Your eligibility for Insurance for Your Dependents will terminate when You no longer have any Dependents. If earlier,

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Your eligibility for Insurance for Your Dependents will terminate subject to the Date Your Insurance For Your Dependents Ends section, or at the end of the Initial Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

Eligibility Rules – Ongoing Employees

If You are a Variable Hour Employee and were not initially classified or designated as a Full-Time Regular Employee by the Policyholder on Your date of hire the following eligibility rules apply regardless of whether You were eligible for insurance during the Initial Stability Period.

If You qualify for Full-Time Employee status by working an average of 30 or more hours per week as determined by the Policyholder during any Ongoing Measurement Period and if You have a Dependent You will be eligible for insurance during the immediately following Ongoing Stability Period, provided that Your employment continues. Your eligibility for Insurance for Your Dependents will terminate when You no longer have any Dependents. If earlier, Your eligibility for Insurance for Your Dependents will terminate subject to the Date Your Insurance For Your Dependents Ends section, or at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

No person may be insured as a Dependent of more than one employee.

Eligibility Definitions

For purposes of the above eligibility rules, the following terms and their meanings are indicated.

Initial Measurement Period means a period that starts with the first pay period that begins immediately after Your hire date, and ends on the last day of the pay period that contains the eleventh (11^{th}) month anniversary of Your hire.

Initial Stability Period means a 12 month period that starts on the first day of the 13^{th} calendar month following Your date of hire.

Ongoing Measurement Period means an annual 12 month period that starts on the first payroll period in January of the immediately preceding calendar year and ends with the start of the first payroll period in January in the immediately subsequent (i.e. current) calendar year.

Ongoing Stability Period means the 12 month period that starts on the first day of the calendar year following the end of the immediately preceding Ongoing Measurement Period.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing for each Dependent to be insured. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

In order to enroll for Dental Insurance for Your Dependents, You must either (a) already be enrolled for Dental Insurance for You or (b) enroll at the same time for Dental Insurance for You.

The Dental Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Dependent Dental Insurance only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

For new hires, if You complete the enrollment process for Dependent insurance within 31 days of becoming eligible for Dependent insurance, such insurance will take effect for each enrolled Dependent as follows:

If You are in Eligible Class 1, the Dependent Insurance described in this certificate will take effect on the later of:

1. January 1, 2019;
2. the first day of calendar month following the date You enter Eligible Class 1 and have one or more Dependents;

provided You are Actively at Work in Eligible Class 1 on that date and You satisfy the benefit waiting periods as shown in the SCHEDULE OF BENEFITS.

If You are a variable hour Employee who has one or more Dependents and who has qualified for Full-Time status by working an average of 30 hours or more per week as determined by the Policyholder during Your Initial Measurement Period, the Dependent Insurance described in this certificate will take effect on the later of:

1. January 1, 2019; and
2. the first day of the calendar month after the thirteenth month anniversary of Your date of hire;

provided You are Actively at Work in Eligible Class 2 on that date.

If You are a variable hour Employee who has one or more Dependents and who has qualified for Full-Time status by working an average of 30 hours or more per week as determined by the Policyholder during an Ongoing Measurement Period, the Dependent Insurance described in this certificate will take effect on the next January 1 provided You are Actively at Work in Eligible Class 2 on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent Insurance until the next annual enrollment period for Dental Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for Dependent Insurance for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. The changes to Your Dependent Insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment Due to a Qualifying Event

You may enroll for Dependent Insurance for which You are eligible or change the amount of Your Dependent Insurance between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days or 60 days, dependent on the Qualifying Event as shown below, from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Qualifying Event includes:

You will have 31 days from the date of the following Qualifying Events to make a request:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines); or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

You will have 60 days from the date of the following Qualifying Events to make a request:

- You previously did not enroll for Dental Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage;
  3. COBRA Continuation of the other group coverage was exhausted;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
  - You to provide health coverage for Your child or dependent foster child; or
  - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage; or
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility.

Once You have enrolled one Child for Dependent Insurance, each succeeding Child will automatically be insured for such insurance on the date the Child qualifies as a Dependent.

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

A Dependent's insurance will end on the earliest of:

1. the date You die;
2. the date Dental Insurance for You ends;
3. the date You cease to be in an eligible class;
4. the date the Group Policy ends;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
8. the day in which You cease to be Actively at Work in Eligible Class 1 and provided that You have not become eligible as a variable hour Employee under Eligible Class 2, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
9. the end of the last Stabilization Period for which You have been determined by the Policyholder to be a variable hour Employee as a member of Eligible Class 2 due to Your work in a prior Measurement Period and provided that You have not become eligible as a Full-Time Regular Employee under Eligible Class 1, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
10. the end of the period for which the last premium has been paid; or
11. the last day of the calendar month the person ceases to be a Dependent.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE

The following rules will apply if this Dental Insurance replaces other group dental coverage provided to You by the Policyholder.

Prior Plan means the group dental coverage provided to You by the Policyholder on the day before the Replacement Date.

Replacement Date means the effective date of this Dental Insurance under the Group Policy.

Rules if You or You and Your Dependents were Covered Under the Prior Plan on the Day Before the Replacement Date:

1. if You and Your Dependents were covered under the Prior Plan on the day before the Replacement Date, You will be eligible for this Dental Insurance on the Replacement Date if You are in an eligible class on such date;

2. if any of the following conditions occurred while coverage was in effect under the Prior Plan, We will treat such conditions as though they occurred while this Dental Insurance is in effect:

   - the loss of a tooth; and
   - the accumulation of amounts toward:
     a) Annual Deductibles;
     b) Annual Maximum Benefits;

3. if a dental service was received while the Prior Plan was in effect and such service would be a Covered Service subject to frequency and/or time limitations if performed while this Dental Insurance is in effect, the receipt of such prior service will be counted toward the time and frequency limitations under this Dental Insurance;

4. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:

   - the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or
   - the date this Dental Insurance ends.

Rules if You or You and Your Dependents were <u>NOT</u> covered under the Prior Plan on the Day Before the Replacement Date:

1. You will be eligible for this Dental Insurance when You meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU;

2. Your Dependents will be eligible for this Dental Insurance when they meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS; and

3. We will credit any time accumulated toward any eligibility waiting period under the Prior Plan to the satisfaction of any eligibility waiting period required to be met under this Dental Insurance.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

COBRA CONTINUATION FOR DENTAL INSURANCE

If Dental Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of Your summary plan description or contact the Policyholder for information regarding continuation of insurance under COBRA.

AT YOUR OPTION – CONTINUATION OF DENTAL INSURANCE FOR YOUR DEPENDENTS AFTER A COBRA CONTINUATION ENDS

When Continuation Is Available

Dental Insurance for Your Dependents may be continued when the continuation period expires under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) if:

- Dental Insurance for Your Dependents as provided under this policy has been continued under the provisions of COBRA;
- such continuation occurred because of:
  1. Your death;
  2. Your legal separation from Your Spouse; or
  3. the dissolution of Your marriage by divorce or annulment; and
- such Spouse is at least 55 years of age when the continuation period expires under COBRA.

What Your Spouse Must Do to Continue Dental Insurance

In order to continue dental insurance under the policy, Your Spouse must notify the Policyholder in Writing:

- of Your death, within 30 days of Your death or, prior to the end of the 36 month continuation of dental insurance under COBRA; or
- of the legal separation or dissolution of the marriage, within 60 days of such separation or entry of the decree of dissolution or, prior to the end of the 36 month continuation of dental insurance under COBRA.

The notice must include the mailing address of Your Spouse.

Within 14 days of receipt of such notice, the Policyholder will send the following to the mailing address specified in the notice:

- a notice of Your Spouse's rights to continue dental insurance;
- the request form to continue coverage with instructions; and
- a statement of the periodic premiums.

Your Spouse will have sixty days after the date of the Policyholder's mailing to request continuation of the Dental Insurance.

Failure of Your Spouse to exercise the election in accordance with this section will terminate the right to continue Dental Insurance.

When Continued Dental Insurance Ends

Continued Dental Insurance will end on the earliest of the following dates:

For a Dependent Child, on the date such Dependent Child ceases to meet the definition of Child or becomes covered for dental coverage under any other group plan;

For all Dependents on:

- the date of expiration of the last period for which the required premium payment was made;
- the date the coverage would otherwise terminate under the policy;
- on the date of Your Spouse's remarriage;
- on the date Your Spouse becomes covered for dental insurance under any other group plan; or
- the date Your Spouse attains age 65.

AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your insurance is continued, insurance for Your Dependents may also be continued.

Insurance will continue for the following periods:

1. if You cease Active Work due to any other Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
2. if You cease Active Work due to layoff, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
3. if You cease Active Work due to injury or sickness, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
4. if You cease Active Work due to part-time work, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
5. if You cease Active Work due to strike, for a period in accordance with the Policyholder's general practice for an employee in Your job class.
6. if You are an insured employee of the Policyholder who dies or if You are a retired employee who dies, Dental Insurance for Your surviving Spouse may be continued for a period in accordance with the Policyholder's general practice for an employee in Your job class and Dental Insurance for Your surviving Child may be continued for a period in accordance with the Policyholder's general practice for an employee in Your job class or until the date such person ceases to qualify as a Child due to reaching the maximum age, if earlier. If coverage is continued, a newly acquired Child of the insured

employee's surviving Spouse is eligible to become enrolled for coverage and a newly acquired spouse of the insured employee's surviving Dependent is eligible to become enrolled for coverage.

The Policyholder's general practice for employees in a job class determines which employees with the above types of absences are to be considered as still insured and for how long among persons in like situations.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

If Your insurance ends, Your Dependents' insurance will also end in accordance with the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.

DENTAL INSURANCE

If You or a Dependent incur a charge for a Covered Service, Proof of such service must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the insurance in effect on the date that service was completed.

This Dental Insurance gives You access to Dentists through the MetLife Preferred Dentist Program. Dentists participating in the MetLife Preferred Dentist Program have agreed to limit their charge for a dental service to the Maximum Allowed Charge for such service. Under the MetLife Preferred Dentist Program, We pay benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, You may be able to reduce Your out-of-pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with Us to limit their charges. You are always free to receive services from any Dentist. You do not need any authorization from Us to choose a Dentist.

The MetLife Preferred Dentist Program does not provide dental services. Whether or not benefits are available for a particular service, does not mean You should or should not receive the service. You and Your Dentist have the right and are responsible at all times for choosing the course of treatment and services to be performed. After services have been performed,We will determine the extent to which benefits, if any, are payable.

When requesting a Covered Service from an In-Network Dentist, We recommend that You:

- identify Yourself as an insured in the Preferred Dentist Program; and
- confirm that the Dentist is currently an In-Network Dentist at the time that the Covered Service is performed.

The amount of the benefit will not be affected by whether or not You identify Yourself as a member in the Preferred Dentist Program.

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-844-222-9106 or by visiting Our website at www.metlife.com/dental.

BENEFIT AMOUNTS

We will pay benefits in an amount equal to the Covered Percentage for charges incurred by You or a Dependent for a Covered Service as shown in the SCHEDULE OF BENEFITS, subject to the conditions set forth in this certificate.

In-Network

If a Covered Service is performed by an In-Network Dentist, We will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

If an In-Network Dentist performs a Covered Service, You will be responsible for paying:

- the Deductible; and
- any other part of the Maximum Allowed Charge for which We do not pay benefits.

Out-of-Network

If a Covered Service is performed by an Out-of-Network Dentist, We will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

Out-of-Network Dentists may charge You more than the Maximum Allowed Charge. If an Out-of-Network Dentist performs a Covered Service, You will be responsible for paying:

- the Deductible;
- any other part of the Maximum Allowed Charge for which We do not pay benefits; and
- any amount in excess of the Maximum Allowed Charge charged by the Out-of-Network Dentist.

DENTAL INSURANCE (continued)

Maximum Benefit Amounts

The SCHEDULE OF BENEFITS sets forth Maximum Benefit Amounts We will pay for Covered Services received In-Network and Out-of-Network. We will never pay more than the greater of the In-Network Maximum Benefit Amount or the Out-of-Network Maximum Benefit Amount.

For example, if a Covered Service is received Out-of-Network and We pay $300 in benefits for such service, $300 will be applied toward both the In-Network and the Out-of-Network Maximum Benefit Amounts applicable to such service.

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

The Yearly Individual Deductible is the amount that You and each Dependent must pay for Covered Services to which such Deductible applies each Year before We will pay benefits for such Covered Services.

The amount We apply toward satisfaction of a Deductible for a Covered Service is the amount We use to determine benefits for such service. The Deductible Amount will be applied based on when Dental Insurance claims for Covered Services are processed by Us. The Deductible Amount will be applied to Covered Services in the order that Dental Insurance claims for Covered Services are processed by Us regardless of when a Covered Service is "incurred". When several Covered Services are incurred on the same date and Dental Insurance benefits are claimed as part of the same claim, the Deductible Amount is applied based on the Covered Percentage applicable to each Covered Service. The Deductible Amount will be applied in the order of highest Covered Percentage to lowest Covered Percentage.

Alternate Benefit

If We determine that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, We will pay benefits based upon the less costly service if such service:

- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a Covered Service.

For example:

- when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, We may base Our benefit determination upon the amalgam filling which is the less costly service;
- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, We may base Our benefit determination upon the partial denture which is the less costly service.

If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You or Your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this certificate, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, We will only pay benefits for the root canal therapy.

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $300, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After We receive this information, We will provide You with an estimate of the Dental Insurance benefits available for the service. The estimate is not a guarantee of the amount We will pay. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service that You choose. You are required to submit Proof on or after the date the dental service is completed in order for Us to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pretreatment estimate of benefits. As always, You or Your Dependent and the Dentist are responsible for choosing the services to be performed.

Benefits We Will Pay After Insurance Ends

We will pay benefits for a 31 day period after Your insurance ends for the completion of installation of a prosthetic device if:

- the Dentist prepared the abutment teeth or made impressions before Your insurance ends; and
- the device is installed within 31 days after the date the insurance ends.

We will pay benefits for a 31 day period after Your insurance ends for the completion of installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before Your insurance ends; and
- the Cast Restoration is installed within 31 days after the date the insurance ends.

We will pay benefits for a 31 day period after Your insurance ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before Your insurance ends; and
- the treatment is finished within 31 days after the date the insurance ends.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams and problem-focused exams, but no more than two exams (whether the exam is an oral exam or problem-focused exam) in a Year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than twice in a Year.
4. Bitewing x-rays 1 set in a Year.
5. Pulp vitality tests.
6. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) but no more than twice in a Year. If Dentally Necessary, two additional cleanings per Year will also be covered.
7. Topical fluoride treatment for a Child under age 14 once in a Year.
8. Sealants or sealant repairs which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 5 Years.
9. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 5 Years.
10. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 5 Years.
11. Full mouth debridements, but not more than once per lifetime.
12. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during such year.
13. Brush Biopsies once in a 24 month period.

Type B Covered Services

1. Full mouth or panoramic x-rays once every 5 Years.
2. Intraoral-periapical x-rays.
3. X-rays, except as mentioned elsewhere.
4. Emergency palliative treatment to relieve tooth pain.
5. Amalgam fillings.
6. Replacement of an existing amalgam filling, but only if:
   - at least 2 Years have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
7. Resin-based composite fillings.
8. Replacement of an existing resin-based composite filling, but only if:
   - at least 2 Years have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
9. Protective (sedative) fillings.
10. Simple extractions.
11. Injections of therapeutic drugs.
12. Space maintainers for a Child under age 14, once in 5 Years per tooth area.

13. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

Type C Covered Services

Certain benefit waiting periods may need to be satisfied before expenses for these services are payable. Refer to the SCHEDULE OF BENEFITS for the benefit waiting period that applies.

1. Biopsies of hard or soft oral tissue.
2. Pulp capping (excluding final restoration).
3. Therapeutic pulpotomy (excluding final restoration).
4. Pulp therapy.
5. Apexification/recalcification.
6. Pulpal regeneration, but not more than once per lifetime.
7. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
8. Initial installation of full or partial Dentures (other than implant supported prosthetics).
9. Addition of teeth to a partial removable Denture.
10. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 7 Years prior to replacement.
11. Replacement of a non-serviceable removable Denture if such Denture was installed more than 7 Years prior to replacement.
12. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
13. Other removable prosthetic services not described elsewhere.
14. Other fixed Denture prosthetic services not described elsewhere.
15. Relinings and rebasings of existing removable Dentures:
    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36 month period.
16. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
17. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.
18. Precision attachments.
19. Initial installation of Cast Restorations (except implant supported Cast Restorations).
20. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 7 Years have passed since the most recent time that:
    - a Cast Restoration was installed for the same tooth; or
    - a Cast Restoration for the same tooth was replaced.
21. Prefabricated crown, but no more than one replacement for the same tooth within 7 Years.
22. Core buildup, but no more than once per tooth in a period of 7 Years.
23. Posts and cores, but no more than once per tooth in a period of 7 Years.
24. Labial veneers, but no more than once per tooth in a period of 7 Years.
25. Oral surgery, except as mentioned elsewhere in this certificate.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

26. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image but not more than twice in a Year.
27. Other consultations but not more than twice in a Year.
28. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once every 2 Years for the same tooth.
29. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
30. Periodontal scaling and root planning once per quadrant in any 2 year period.
31. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 3 Year period.
32. Surgical extractions.
33. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 7 Year period.
34. Repair of implants, but no more than once in a 12 month period.
35. Implant supported Cast Restorations, but no more than once for the same tooth position in a 7 Year period.
36. Implant supported fixed Dentures, but no more than once for the same tooth position in a 7 Year period.
37. Implant supported removable Dentures, but no more than once for the same tooth position in a 7 Year period.
38. Tissue conditioning, but not more than once in a 36 month period.
39. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
40. Occlusal adjustments - limited, but not more than once in a 12 month period.
41. Cleaning and inspection of a removable appliance twice in a Year.

DENTAL INSURANCE: EXCLUSIONS

We will not pay Dental Insurance benefits for charges incurred for:

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
    - scaling and polishing of teeth; or
    - fluoride treatments;
5. services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn Child;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the Employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. temporary or provisional restorations;
16. temporary or provisional appliances;
17. prescription drugs;
18. services for which the submitted documentation indicates a poor prognosis;
19. the following, when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control, such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
20. caries susceptibility tests;
21. local chemotherapeutic agents;
22. fixed and removable appliances for correction of harmful habits;
23. appliances or treatment for bruxism (grinding teeth);
24. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
25. duplicate prosthetic devices or appliances;
26. replacement of a lost or stolen appliance, Cast Restoration or Denture;
27. orthodontic services or appliances;
28. repair or replacement of an orthodontic device;

29. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
30. diagnostic casts;
31. intra and extraoral photographic images;
32. occlusal adjustments – complete;
33. bacteriological studies for determination of bacteriologic agents;
34. collection and preparation of genetic sample material for laboratory analysis and report.

DENTAL INSURANCE: COORDINATION OF BENEFITS

When You or a Dependent incur charges for Covered Services, there may be other Plans, as defined below, that also provide benefits for those same charges. In that case, We may reduce what We pay based on what the other Plans pay. This Coordination of Benefits section explains how and when We do this.

DEFINITIONS

In this section, the terms set forth below have the following meanings:

Allowable Expense means a necessary dental expense for which both of the following are true:

- a covered person must pay it; and
- it is at least partly covered by one or more of the Plans that provide benefits to the covered person.

If a Plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred), such benefits are Allowable Expenses.

If a Plan provides benefits in the form of services, We treat the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by that Plan.

The term does not include:

- expenses for services performed because of a Job-Related Injury or Sickness;
- any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more Plans compute their benefit payments on the basis of reasonable and customary fees;
- any amount of expenses in excess of the higher negotiated fee for a service, if two or more Plans compute their benefit payments on the basis of negotiated fees; and
- any amount of benefits that a Primary Plan does not pay because the covered person fails to comply with the Primary Plan's managed care or utilization review provisions, these include provisions requiring:
  - second surgical opinions;
  - pre-certification of services;
  - use of providers in a Plan's network of providers; or
  - any other similar provisions.

We won't use this provision to refuse to pay benefits because an HMO member has elected to have dental services provided by a non-HMO provider and the HMO's contract does not require the HMO to pay for providing those services.

Claim Determination Period means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

Custodial Parent means a Parent awarded custody, other than joint custody, by a court decree. In the absence of a court decree, it means the Parent with whom the child resides more than half of the Year without regard to any temporary visitation.

HMO means a Health Maintenance Organization or Dental Health Maintenance Organization.

Job-Related Injury or **Sickness** means any injury or sickness:

- for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.

Parent means a person who covers a child as a dependent under a Plan.

Plan means any of the following, if it provides benefits or services for an Allowable Expense:

- a group insurance plan;
- an HMO;
- a blanket plan;
- uninsured arrangements of group or group type coverage;
- a group practice plan;
- a group service plan;
- a group prepayment plan;
- any other plan that covers people as a group;
- motor vehicle No Fault coverage if the coverage is required by law; and
- any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

- individual or family insurance or subscriber contracts;
- individual or family coverage through closed panel Plans or other prepayment, group practice or individual practice Plans;
- hospital indemnity coverage;
- a school blanket plan that only provides accident-type coverage on a 24 hour basis, or a "to and from school basis," to students in a grammar school, high school or college;
- disability income protection coverage;
- accident only coverage;
- specified disease or specified accident coverage;
- nursing home or long term care coverage; or
- any government program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

The provisions of This Plan, which limit benefits based on benefits or services provided under plans which the Policyholder (or an affiliate) contributes to or sponsors will not be affected by these Coordination of Benefits provisions.

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not.

This Plan means the dental benefits described in this certificate, except for any provisions in this certificate that limit insurance based on benefits for services provided under plans which the Policyholder (or an affiliate) contributes to or sponsors.

Primary Plan means a Plan that pays its benefits first under the “Rules to Decide Which Plan Is Primary” section. A Primary Plan pays benefits as if the Secondary Plans do not exist.

Secondary Plan means a Plan that is not a Primary Plan. A Secondary Plan may reduce its benefits by amounts payable by the Primary Plan. If there are more than two Plans that provide coverage, a Plan may be Primary to some plans, and Secondary to others.

RULES TO DECIDE WHICH PLAN IS PRIMARY

When more than one Plan covers the person for whom Allowable Expenses were incurred, We determine which plan is primary by applying the rules in this section.

When there is a basis for claim under This Plan and another Plan, This Plan is Secondary unless:

- the other Plan has rules coordinating its benefits with those of This Plan; and
- this Plan is primary under This Plan's rules.

The first rule below, which will allow Us to determine which Plan is Primary, is the rule that We will use.

Dependent or Non-Dependent: A Plan that covers a person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is Primary and shall pay its benefits before a Plan that covers the person as a dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

- Secondary to the Plan covering the person as a dependent; and
- Primary to the Plan covering the person as other than a dependent (e.g., a retired employee);

then the order of benefits between the two Plans is reversed and the Plan that covers the person as a dependent is Primary.

Child Covered Under More Than One Plan – Court Decree: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, and the specific terms of a court decree state that one of the Parents must provide health coverage or pay for the Child's health care expenses, that Parent's Plan is Primary, if the Plan has actual knowledge of those terms. This rule applies to Claim Determination Periods that start after the Plan is given notice of the court decree.

Child Covered Under More Than One Plan – The Birthday Rule: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, the Primary Plan is the Plan of the Parent whose birthday falls earlier in the Year if:

- the Parents are married; or
- the Parents are not separated (whether or not they have ever married); or
- a court decree awards joint custody without specifying which Parent must provide health coverage.

If both Parents have the same birthday, the Plan that covered either of the Parents longer is the Primary Plan.

However, if the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

Child Covered Under More than One Plan – Custodial Parent: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, if the Parents are not married, or are separated (whether or not they ever married), or are divorced, the Primary Plan is:

- the Plan of the Custodial Parent; then
- the Plan of the spouse of the Custodial Parent; then
- the Plan of the non-custodial Parent; and then
- the Plan of the spouse of the non-custodial Parent.

Active or Inactive Employee: A Plan that covers a person as an employee who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired employee (or as that person's Dependent). If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage: The Plan that covers a person as an active employee, member or subscriber (or as that employee's Dependent) is Primary to a Plan that covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Plan that covers the person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

Longer/Shorter Time Covered: If none of the above rules determine which Plan is Primary, the Plan that has covered the person for the longer time shall be Primary to a Plan that has covered the person for a shorter time.

No Rules Apply: If none of the above rules determine which Plan is Primary, the Allowable Expenses shall be shared equally between all the Plans. In no event will This Plan pay more than it would if it were Primary.

EFFECT ON BENEFITS OF THIS PLAN

If This Plan is Secondary, when the total Allowable Expenses incurred by a covered person in any Claim Determination Period are less than the sum of:

- the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and
- the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

then We will reduce the benefits that would otherwise be payable under This Plan. The sum of these reduced benefits, plus all benefits payable for such Allowable Expenses under all other Plans, will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been made on time.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We need certain information to apply the Coordination of Benefits rules. We have the right to decide which facts We need. We may get facts from or give them to any other organization or person. We do not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a covered person who incurs Allowable Expenses should file a claim under each Plan which covers the person. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes benefits provided in the form of services, in which case We may pay the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount We pay is more than We should have paid under this Coordination of Benefits provision, We may recover the excess from one or more of:

- the person We have paid or for whom We have paid;
- insurance companies; or
- other organizations.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

FILING A CLAIM

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder. The Policyholder will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-844-222-9106. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR DENTAL INSURANCE BENEFITS

When a claimant files a claim for Dental Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days of the date of a loss.

Claim and Proof may be given to Us by following the steps set forth below:

Step 1
A claimant can request a claim form by calling Us at 1-844-222-9106.

Step 2
We will send a claim form to the claimant within 15 days of the request. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

Step 3
When the claimant receives the claim form, the claimant should fill it out as instructed and return it with the required Proof described in the claim form.

Step 4
The claimant must give Us Proof not later than 90 days after the date of the loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Claims for Medicaid Eligible Individuals

As required by law, to the extent that payment has been made by the Missouri Division of Medical Services for Covered Services furnished to a medicaid eligible individual, the Missouri Division of Medical Services is considered to have acquired the rights of the medicaid eligible individual to payment by Us for such Covered Services.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-844-222-9106.

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required Proof as described in the FILING A CLAIM section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will review Your claim and notify You of its decision to approve or deny Your claim.

Such notification will be provided to You within a 30 day period from the date You submitted Your claim; except for situations in which additional information is required. If MetLife needs such an extension, MetLife will send You notification prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If such extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from MetLife.

If MetLife denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. Upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

As part of each appeal, You may submit any written comments, documents, records, or other information relating to Your claim.

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify You in writing of its final decision within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send You a final written decision that states the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Upon receipt of a Covered Service, You may assign Dental Insurance benefits to the Dentist providing such service.

Claims for Medicaid Eligible Individuals

As required by law, to the extent that payment has been made by the Missouri Division of Medical Services for Covered Services furnished to a Medicaid eligible individual, the Missouri Division of Medical Services is considered to have acquired the rights of the Medicaid eligible individual to payment by Us for such Covered Services.

Dental Insurance: Who We Will Pay

If You assign payment of Dental Insurance benefits to Your or Your Dependent's Dentist, We will pay benefits directly to the Dentist. Otherwise, We will pay Dental Insurance benefits to You.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty.

Evidence of insurability will not be required nor will any statement made by You, which relates to insurability, be used:

1. to contest the validity of the insurance benefits; or
2. to reduce the insurance benefits.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Overpayments

Recovery of Dental Insurance Overpayments

We have the right to recover any amount that We determine to be an overpayment, whether for services received by You or Your Dependents. Except in cases of fraud or misrepresentation We will not request a refund nor offset a claim more than 12 months after an overpayment has occurred.

An overpayment occurs if We determine that:

- the total amount paid by Us on a claim for Dental Insurance is more than the total of the benefits due to You under this certificate; or
- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us.

How We Recover Overpayments

We may recover the overpayment from You by:

- stopping or reducing any future benefits payable for Dental Insurance;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

THIS IS THE END OF THE CERTIFICATE

THE FOLLOWING IS ADDITIONAL INFORMATION

PLAN PRIVACY INFORMATION

Notwithstanding any other Plan provision in this or other sections of this Plan, the Plan will operate in accordance with the HIPAA privacy laws and regulations as set forth in 45 CFR Parts 160 and 164, and as they may be amended ("HIPAA") with respect to protected health information ("PHI") as that term is defined therein. The Plan Administrator and/or his or her designee retains full discretion in interpreting these rules and applying them to specific situations. All such decisions shall be given full deference unless the decision is determined to be arbitrary and capricious.

The term "Plan Sponsor" means Missouri Consolidated Health Care Plan.

The term "Plan Administrator" means the entity designated as Plan Administrator by the Plan documents pursuant to which the plan is operated. If a Plan Administrator is not designated by the plan documents, the Plan Sponsor shall be deemed to the Plan Administrator.

I. Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor

The Plan and the Plan Sponsor are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- For general plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.
- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan.
- Other uses relating to plan administration which are approved in writing by the Plan Administrator or Plan Privacy Officer.
- At the request of an individual, to assist in resolving an individual's benefit or claim issues.

II. Uses and Disclosures of PHI by the Plan and the Plan Sponsor for Required Purposes

The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:

- Judicial and administrative proceedings, in response to lawfully executed process such as a court order or subpoena.
- For public health and health oversight activities and other governmental activities accompanied by lawfully executed process.
- As otherwise may be required by law.

III. Sharing of PHI With the Plan Sponsor

As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;
- Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- Report to the Plan any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures of which it becomes aware;

- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures required by HIPAA;

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

- If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

- Ensure adequate separation between the Plan and Plan Sponsor in accordance with the following requirements:

    (A) Employees to be Given Access to PHI: The following employees (or class of employees) of the Plan Sponsor are the only individuals that may access PHI provided by the Plan:

    Director of Vendor Relations, Director of Benefit Administration, Members Services Manager, Member Services Supervisor, Benefit Counselor, Information Technology Specialist

    (B) Restriction to Plan Administration Functions: The access to and use of PHI by the employees of the Plan Sponsor designated above will be limited to plan administration functions that the Plan Sponsor performs for the Plan.

    (C) Mechanism for Resolving issues of Noncompliance: If the Plan Administrator or Privacy Officer determines that an employee of the Plan Sponsor designated above has acted in noncompliance with the plan document provisions outlined above, then the Plan Administrator or Privacy Officer shall take or seek to have taken appropriate disciplinary action with respect to that employee, up to and including termination of employment as appropriate. The Plan Administrator or Privacy Officer shall also document the facts of the violation, actions that have been taken to discipline the offending party, and the steps taken to prevent future violations.

- Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents have been amended to incorporate the provisions of this Section III.

Uniformed Services Employment And Reemployment Rights Act

This section describes the right that you may have to continue coverage for yourself and your covered dependents under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation of Group Dental Insurance:

If you take a leave from employment for "service in the uniformed services," as that term is defined in USERRA, and as a consequence your dental insurance coverage under your employer's group dental insurance policy ends, you may elect to continue dental insurance for yourself and your covered dependents, for a limited period of time, as described below.

The law requires that your employer notify you of your rights, benefits and obligations under USERRA including instructions on how to elect to continue insurance, the amount and procedure for payment of premium. If permitted by USERRA, your employer may require that you elect to continue coverage within a period of time specified by your employer.

You may be responsible for payment of the required premium to continue insurance. If your leave from employment for service in the uniformed services lasts less than 31 days, your required premium will be no more than the amount you were required to pay for dental insurance before the leave began; for a leave lasting 31 or more days, you may be required to pay up to 102% of the total dental insurance premium, including any amount that your employer was paying before the leave began.

Your and your covered dependents' insurance that is continued pursuant to USERRA will end on the earliest of the following:

- the end of 24 consecutive months from the date your leave from employment for service in the uniformed services begins; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You and your covered dependent may become entitled to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") while you have dental insurance coverage under your employer's group dental insurance policy pursuant to USERRA. Contact your employer for more information.

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE RIDER

Group Policy No.: **215367-1-G**

Policyholder: **Missouri Consolidated Health Care Plan**

Effective Date: **January 1, 2020**

The certificate is changed as follows:

Applicable to Dental Insurance for all State employees of the Policyholder, excluding residents of Alaska and Montana, who are included in one of the following classes:

Class 1: Full-Time Regular Employees who are employed by the Policyholder and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.

Class 2: Variable Hour Employees who are employed by the Policyholder and who are Employees of the Policyholder who qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period.

1. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 10. under **Type C Covered Services** with the following:

   “10. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement.”

2. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 11. under **Type C Covered Services** with the following:

   “11. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement.”

3. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 20. under **Type C Covered Services** with the following:

   “20. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 10 Years have passed since the most recent time that:

   - a Cast Restoration was installed for the same tooth; or
   - a Cast Restoration for the same tooth was replaced.”

4. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 21. under **Type C Covered Services** with the following:

   “21. Prefabricated crown, but no more than one replacement for the same tooth within 10 Years.”

5. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 22. under **Type C Covered Services** with the following:

   "22. Core buildup, but no more than once per tooth in a period of 10 Years."

6. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 23. under **Type C Covered Services** with the following:

   "23. Posts and cores, but no more than once per tooth in a period of 10 Years."

7. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 24. under **Type C Covered Services** with the following:

   "24. Labial veneers, but no more than once per tooth in a period of 10 Years."

8. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 33. under **Type C Covered Services** with the following:

   "33. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 10 Year period."

9. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 35. under **Type C Covered Services** with the following:

   "35. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 Year period."

10. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 36. under **Type C Covered Services** with the following:

    "36. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 Year period."

11. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 37. under **Type C Covered Services** with the following:

    "37. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 Year period."

12. In **DENTAL INSURANCE,** replace **Alternate Benefit** with the following:

    "**Alternate Benefit**

    If We determine that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, We will pay benefits based upon the less costly service if such service:

    - would produce a professionally acceptable result under generally accepted dental standards; and
    - would qualify as a Covered Service.
    - when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service;

For example:

- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, We may base Our benefit determination upon the partial denture which is the less costly service.

If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You or Your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this certificate, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, We will only pay benefits for the root canal therapy."

This rider is to be attached to and made part of the certificate.

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE RIDER

Group Policy No.: **215367-1-G**

Policyholder: **Missouri Consolidated Health Care Plan**

Effective Date: **January 1, 2021**

The certificate is changed as follows:

Applicable to Dental Insurance

1. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, delete the following item under **Type B Covered Services:**

   "4. Emergency palliative treatment to relieve tooth pain."

2. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, add the following item under **Type A Covered Services:**

   "Emergency palliative treatment to relieve tooth pain."

This rider is to be attached to and made part of the certificate.

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE RIDER

Group Policy No.: **215367-1-G**

Policyholder: **Missouri Consolidated Health Care Plan**

Effective Date: **January 1, 2023**

The certificate is changed as follows:

Applicable to Dental Insurance for all State employees of the Policyholder, excluding residents of Alaska and Montana, who are included in one of the following classes:

Class 1: Full-Time Regular Employees who are employed by the Policyholder and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.

Class 2: Variable Hour Employees who are employed by the Policyholder and who are Employees of the Policyholder who qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period.

1. In **DEFINITIONS**, replace **Maximum Allowed Charge** with the following:

   "**Maximum Allowed Charge** means:

   1. with respect to In-Network Dentists, the lesser of:

      a. the amount charged by the In-Network Dentist; or
      b. the maximum amount which the In-Network Dentist has agreed to accept as payment in full for the dental service;

   2. with respect to Out-of-Network Dentists, the lesser of:

      a. the amount charged by the Out-of-Network Dentist; or
      b. the Out-of-Network scheduled amount for the state where the dental service is performed."

2. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 1. under **Type A Covered Services** with the following:

   "1. Oral exams and problem-focused exams, but no more than one exam (whether the exam is an oral exam or problem-focused exam) every 6 months."

Certificate Number 1.2

Group Policy No.: **215367-1-G**

Policyholder: **Missouri Consolidated Health Care Plan**

Effective Date: **January 1, 2023**

3. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 2. under **Type A Covered Services** with the following:

   “2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than once every 6 months.”

4. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 3. under **Type A Covered Services** with the following:

   “3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than once every 6 months.”

5. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 6. under **Type A Covered Services** with the following:

   “6. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) but no more than once every 6 months. If Dentally Necessary, two additional cleanings per Year will also be covered.”

This rider is to be attached to and made part of the certificate.

Certificate Number 1.2

Missouri Consolidated Health Care Plan
Response to Vendor Questions
2024 Dental RFP
March 22, 2023

These responses are provided by MCHCP to additional questions received from potential bidders for the 2024 Dental RFP.

	Question	Response
1	One of our questions for the Q&A was regarding what orthodontia lifetime maximum you were wanting quoted for the Classic Plan with Ortho. The response states that it is as shown in the plan design. I am seeing the annual maximum for the plan is $2,000, but I am not seeing an ortho lifetime maximum listed. Are you wanting this to also be $2,000? If not, what benefit amount are you wanting the plan to pay up to for orthodontia?	The only maximum given is the annual $2,000 OOP maximum. There is no lifetime maximum. Should you propose a different design, please indicate what you would recommend along with pricing for the change. Please be aware that MCHCP may reject the proposed change in plan design.
1	Question 9.3 in the Dental Questionnaire states the following: Confirm you have uploaded a provider network file to the Reference Files from Vendor section in the format provided in Attachment 5. We note that Attachment 5 is a claims file layout and does not seem to be aligned with this question. Please clarify what information/documentation providers should include in Vendor Reference File "Q9.3 Provider Network".	The correct attachment number is Attachment 4.

Missouri Consolidated Health Care Plan
Response to Vendor Questions
2024 Dental RFP
March 27, 2023

This response is provided by MCHCP to an additional question received from a potential bidder for the 2024 Dental RFP.

	Question	Response
1	MCHCP has requested a fully-insured bid for dental benefit plans. For a typical insured plan, a BAA would not be executed as the dental insurer is the Covered Entity under HIPAA, not a Business Associate. Entering into a BAA introduces confusion about the respective responsibilities and obligations of the parties. Please confirm the BAA will be required as part of the contracting process and if required, MCHCP's willingness to negotiate terms to mitigate conflicting obligations for the selected insurer(s).	MCHCP recognizes that a fully insured plan brings different nuances to the table; however MCHCP, as a covered entity itself, must not inappropriately share information. MCHCP is willing to negotiate the BAA to best reflect this unique relationship. Please include any suggested edits in a redlined version of the sample BAA as part of your bid.