
REQUEST FOR PROPOSALS

August 8, 2008

RFP #2009-1364-2205

**City of Newport News
OFFICE OF THE PURCHASING DIRECTOR
2400 Washington Avenue
Newport News, VA 23607**



Phone: (757) 926-8721/ Fax: (757) 926-8038

Group Dental Program

ADDENDUM 1

PROPOSAL DUE: August 22, 2008 at Close of Business (COB)

Contract Officer:

Bill Lindsey, CPPO, C.P.M., Purchasing Administrator

This Addendum duplicates and provides Section III (Questionnaire) in an electronic Word format.

Note: No changes have been made to the official document contained within the RFP. This addendum is provided as a courtesy in response to requests that the document be provided in an electronic format.

Company Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Fax No.: _____ E-Mail: _____

Fed. Tax ID (or Social Security #): _____

Print Name: _____ Title: _____

Signature: _____ Date: _____

This form must be signed. All signatures must be original and not photocopies

III. Questionnaire

General and Administrative

1. How does your organization transition employees/dependents currently undergoing dental treatment? Your response should address employees/dependents that are in the process of non-orthodontic and orthodontic treatment.
2. Please provide at least two references. References should include employers who are of similar size and location as the City of Newport News. Your reference list should include the contact's name, title, address and telephone number.
3. Who would be the company representative with overall responsibility for the City of Newport News account? Please indicate the management and service team that you propose to handle this account, including each team member's name, title, location, and job responsibility.
4. Confirm that your proposal does not include any minimum participation requirements and that changes in participation will not affect plan rates during rate guarantee periods.
5. Confirm that your organization does not require an enrollment form to be submitted. (The City of the Newport News may provide eligibility data to you electronically.) Confirm your willingness to accept initial and ongoing eligibility information in the electronic format provided to you by the City of Newport News.
6. Describe on-line/web-based access your organization provides to clients with respect to checking/verifying your eligibility files, checking claim status, etc.
7. Provide your company ratings for the most recent three years from A.M. Best, Standard & Poor's, Duff & Phelps or similar rating services. Explain any changes in rating over the last three years.
8. Confirm that there will be no claim forms for members for in-network services.
9. Explain how participants identify themselves as members when accessing care. Does your organization issue individual ID cards or do members use a unique identifier code in lieu of ID cards?
10. Please provide samples of the types of reports that will be provided to the City of Newport News without charge. Include the frequency of reports and whether they can be provided in electronic format. Also identify the availability of additional reports and the associated costs.
11. What are your standards for claim payment accuracy and timeliness? How has performance been relative to the standards?
12. Will your organization provide performance guarantees with fees at risk for claims and member services as well as implementation? If yes, please provide samples of measurement criteria and fees at risk.

FINANCIAL

1. What is your current annual trend for PPO dental claims?
2. Describe your organization's requirements for self-funded plans including banking arrangements and remittance of funds. Identify who is responsible for opening the bank account and paying the associated fees.
3. Do you require self-insured customers to fund a reserve (held by your organization) for IBNR claims? If yes, please describe.
4. Confirm that all renewal information will be communicated to the City of Newport News no later than 120 days prior to the renewal date.

ENROLLMENT

1. If ID cards are issued, how soon after enrollment will employees receive ID cards? Confirm that there are no charges for initial and replacement card production.
2. Confirm that you will provide all initial and ongoing administrative materials at no charge (directories, SPDs, claim forms, enrollment and change forms).

PROVIDER RELATIONS

1. What are your provider credentialing procedures? How often are they reviewed?
2. How are providers monitored for utilization/quality?

MEMBER SERVICES AND SATISFACTION

1. How often do you survey your members for member satisfaction? Please share the results of your most recent survey.
2. Confirm that you will prepare and provide electronic copies SPDs and SPDs will be provided to the City of Newport News and their consultants Hilb, Rogal, and Hobbs, no later than 60 days after the effective date of the plan. Please confirm that SPDs can be posted via the City of Newport News intranet.
3. Are Member Services centralized or provided locally? Indicate hours and days of operation, and how calls are monitored. How are calls handled when the office is not staffed?
4. Identify the location of the claims office(s) that will process dental claims for this client. Is this a different location than the member services location?

NETWORK

1. Please provide a brief description of your network.

| PPO Dental Network | |
|-----------------------------|--|
| Number of General Dentists | |
| Number of Periodontists | |
| Number of Orthodontists | |
| Number of Oral Surgeons | |
| Number of Other Specialists | |
| Average Claims Discount* | |
| Provider Turnover Rate | |

*Provide the average claims discount off average charges. If discounts off average charges are not available, please provide another measurement of discounts and specify the basis.

2. What percentages of all licensed dentists are contracted with your network?
3. How are dentists reimbursed under your dental plan (e.g., discounted fee schedule, etc.)?
4. Non-network claims should be reimbursed based on the 90th percentile of R&C. Please discuss how your organization defines R&C for non-network services. Indicate (a) the source of your data (i.e., HIAA) and (b) the frequency of updates.
5. Does your organization own 100% of the network you are proposing? If not, please explain the ownership structure/arrangement?
6. Please confirm that you have completed the attached Excel spreadsheet with your contracted rates for the specified dental procedures and 3-digit zip codes.

IV. Bid Form A – Financials

Please indicate below rates for the proposed plan design.

1. Proposed Plan Option I – Current Plan Design

| Passive PPO Monthly Fee per Covered Employee | PPO Plan | Premier Plan |
|---|---------------------|-------------------------|
| Administrative Fee | \$ | \$ |
| Network Access Fee | \$ | \$ |
| Other | \$ | \$ |
| Total Fee PEPM | \$ | \$ |

2. Proposed Plan Option II

| Passive PPO Monthly Fee per Covered Employee | PPO Plan | Premier Plan |
|---|---------------------|-------------------------|
| Administrative Fee | \$ | \$ |
| Network Access Fee | \$ | \$ |
| Other | \$ | \$ |
| Total Fee PEPM | \$ | \$ |

3. Proposed Plan Option III

| Passive PPO Monthly Fee per Covered Employee | PPO Plan | Premier Plan |
|---|-------------|-----------------|
| Administrative Fee | \$ | \$ |
| Network Access Fee | \$ | \$ |
| Other | \$ | \$ |
| Total Fee PEPM | \$ | \$ |

V. Bid Form B – Network Match Instructions

A census of employee dental plan eligibility, enrollment and home zip codes is included in Appendix A. We are requesting a network match based upon the residential zip code of eligible City of Newport News employees. **Only dentists with open practices should be included.**

You are required to provide the full Geo Access report in addition to the above analysis.