Florida Healthy Kids Corporation

Invitation to Negotiate 2015-02:
Dental Benefits Coverage
For

THE FLORIDA HEALTHY KIDS CORPORATION

Florida Healthy Kids Corporation
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INVITATION TO NEGOTIATE 2015-02:
Dental Benefits Coverage Underwriting and Services
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I. Introduction

The Florida Healthy Kids Corporation ("FHKC") is a Florida non-profit corporation. It was established by the State of Florida in 1990 to demonstrate the concept of using school systems as a grouping mechanism for the purpose of providing comprehensive health insurance coverage for children. The Florida Healthy Kids Corporation Act can be found in section 624.91, Florida Statutes.

Eligibility and benefits for the program are determined by FHKC in accordance with federal and state law. Families enrolled in the Healthy Kids program contribute towards the cost of their coverage based on their family size, income and other factors. FHKC contracts with a third party administrator ("TPA") to determine eligibility, collect premium payments and provide certain customer service functions.

The Healthy Kids program is one (1) component of Florida's KidCare program which provides health insurance coverage to children through four (4) separate programs: Healthy Kids, MediKids, Children's Medical Services Managed Care Plan ("CMS") and Medicaid for children. Florida KidCare is Florida's Title XXI or state Children's Health Insurance Program ("CHIP") which was created federally in 1997 and re-authorized in 2009, and authorized in state law in sections 409.810 through 409.821, Florida Statutes.

Terms used in this Invitation to Negotiate ("ITN") are defined in the same manner as in the standard Contract included in this ITN and incorporated by reference. References to "Respondents" and "Insurers" refer to those Parties that will respond or intend to respond to this ITN.

II. Scope of Invitation to Negotiate (ITN)

FHKC is soliciting proposals under this ITN from Insurers or any provider of dental care services meeting standards established by FHKC to assume the underwriting risk of the dental benefits coverage provided by FHKC (the "Program"). FHKC encourages all interested parties to respond to this ITN; however, FHKC is not an insurer and cannot assume risk. Only those proposals that offer statewide coverage will be considered.

This procurement document is issued in order to secure comprehensive dental services for Enrollees only in the Healthy Kids component of the Florida KidCare program. Current Dental Benefit Contracts in Florida's 67 counties will reach their termination date on June 30, 2016. The proposed effective date for implementation of awards under this ITN is July 1, 2016. All existing dental plan contracts have then reached their final renewal period and cannot be extended. Separate health plan contracts are not affected by this ITN. Existing contractors are

eligible to participate in this ITN, and new and qualified plans are encouraged to submit proposals.

The Insurer should understand that current and future enrollment is contingent upon the continued availability of funding from multiple sources. Therefore future enrollment levels cannot be assured. Insurers are not guaranteed any minimum level of enrollment. Currently, FHKC contracts on a statewide basis with three (3) Insurers that are dental managed care companies.

The award of any Contracts under this ITN or any future renewals is contingent upon the availability of funds for the Program.

III. Procurement Process

A. Evaluation of Proposals

Proposals will be evaluated in a two (2) step process. First, proposals that do not offer an insured product, fail to meet the minimum benefit package specifications or change the program's objectives will be disqualified in FHKC's sole discretion.

Proposals meeting these minimum qualifications will then be evaluated consistent with state law which requires FHKC to competitively bid for health (and dental) services, and to purchase services in a cost effective manner consistent with the delivery of quality health (and dental) care.

Factors that are taken into consideration during this process include, but may not be limited to:

1) Respondent's compliance status with requirements of other regulatory agencies in Florida (for example: Agency for Health Care Administration ("AHCA"), Office of Insurance Regulation ("OIR") and Department of Financial Services ("DFS");
2) Respondent's status as an incumbent Insurer with FHKC;
3) Respondent's compliance and performance status with FHKC if a current contractor or if a previous contractor;
4) Existing or previous litigation or regulatory action by or against the State of Florida, United States Government or FHKC;
5) Respondent and its subsidiaries, subcontractors or agents that would be engaged under this Contract are not de-barred or otherwise prohibited from

contracting with FHKC, the State of Florida or from receiving federal or state funds;

6) Reference checks conducted on Respondent's performance as a vendor for comparable Contracts;
7) Respondent's current and recent financial status;
8) Sufficiency of the proposed provider network (including, but may not be limited to primary dental care and specialty dental care services);
9) Geographic representation of provider network within the County;
10) Member Services functions;
11) Quality Assurance and medical case management services;
12) Ability to meet access and appointment standards within the County;
13) Compliance with all Reporting Requirements (Incumbents are evaluated based on current compliance status; non-incumbents will be evaluated based on testing results and reference check results); and,
14) Competitiveness of premium rate.

Proposals are evaluated under the supervision of the Purchasing and Contracting Committee, which may establish a special evaluation committee to review the ITN responses. The Purchasing and Contracting Committee is established by the FHKC Board of Directors. Personal interviews may be requested with any or all Respondents, in FHKC's sole discretion. All interviews are conducted in or from Tallahassee, Florida by the Purchasing and Contracting Committee or its special evaluation workgroup and are scheduled by FHKC.

The scope and length of any such Personal Interviews will be set by FHKC. Any materials presented by Respondents at the Personal Interviews will be considered public records. Respondents should also be aware that submissions received during this ITN process, selection criteria, scoring system and results from this ITN will be available for inspection upon request after the ITN process has been concluded in accordance with Florida law.

Respondents are responsible for ensuring that all elements of the proposals are provided in an organized and concise fashion. FHKC is not obligated to interpret any elements not clearly labeled or described. FHKC reserves the right to review and evaluate proposals as submitted without further input or clarification from the Respondent.

Respondents may request that certain documents or elements of their submissions be deemed as "trade secrets" during this process. Such

documents, as noted above, may be deemed to be public records at the conclusion of the procurement process. In order to properly assert that a document provided to FHKC constitutes a "trade secret," Respondent must meet the following requirements:

1) Each page of such document or specific portion of the document claimed to be a trade secret must be clearly marked as "trade secret";
2) All material marked as "trade secret" must be separated from all non-trade secret material, such as being submitted in a separate envelope clearly marked as "trade secret" and provided at the end of the section where the material was required to be submitted; and,
3) When submitting "trade secret" material to FHKC under this ITN, Respondent must include the affidavit included with this ITN as Appendix VIII, certifying under oath concerning the documents claimed to be "trade secrets."

If FHKC receives a request from a third party for a document or information that is marked and certified as a "trade secret", FHKC will first promptly notify the requesting entity or person that the document has been identified as a "trade secret." FHKC will then inform the Respondent claiming trade secret status that the company has thirty (30) days following receipt of such notice to file an action in Circuit Court in Leon County, Florida, seeking a determination whether the document or information or in question contains trade secrets, and to obtain an order barring FHKC from disclosing the document. If such action is commenced within the (30) thirty day period, FHKC will not release the documents pending the final outcome of the legal action(s). The failure to file an action within the (30) thirty days constitutes a waiver of any claim of confidentiality of the documents in question.

FHKC may disclose a trade secret, together with the claim that it is a trade secret, to an officer or employee of any governmental agency, state or federal, whose use of the trade secret is within the scope of his or her employment.

Respondents may not mark the entirety of its response as a "trade secret," and FHKC will not attempt to discern which elements a Respondent was attempting to mark as "trade secrets" in any such wide-ranging efforts.

B. Calendar of Events

A proposed Calendar of Events has been established for this ITN process. This Calendar is subject to change by FHKC. Any changes to the timeline will be posted to the FHKC website at www.healthykids.org.

Event	Date (All Times are Eastern)
Draft ITN Release Date	September 1, 2015
Question and Answer Period, with responses posted to website	September 1, 2015 – September 18, 2015
Final ITN Release Date	October 26, 2015
Bidders' Conference – Tallahassee, FL	November 6, 2015 10:00 A.M. – Noon
Letters of Intent Due to Issuing Officer *Mandatory* *(After this date, official notifications and communications regarding this ITN process will only be sent to those parties that submit a LOI.)*	November 2, 2015
Proposal Deadline	November 20, 2015 12:00 NOON EST
Personal Interview Period (*Only if requested by FHKC*)	TBD
Anticipated Award Date	January 27, 2016 FHKC Board Meeting
Implementation Date	July 1, 2016

A recommendation on the selection of an Insurer or Insurers will be made to the FHKC Board of Directors following the conclusion of the evaluation process. The FHKC Board of Directors shall determine the final award of any

Contract or Contracts. Award announcements are anticipated by the January, 2016 Board meeting, but the date is subject to change.

Any of the deadlines or dates in this ITN may be modified in FHKC's sole discretion.

C. Single Point of Contact

Respondents to this ITN and their agents may only contact the Issuing Officer, Steven Malono, Corporate Counsel, at malonos@healthykids.org during this procurement process. If Respondents or their agents contact any other employee of FHKC, an FHKC Board Member or Workgroup member, including ad-hoc Board members or Committee members, regarding this ITN or this procurement process before the final Contract awards have been made by the FHKC Board of Directors, Respondent's proposal may be disqualified in the sole discretion of FHKC.

D. Questions Regarding the ITN

Any explanation desired by Respondents regarding the meaning or interpretation of the ITN must be submitted in writing to the Issuing Officer electronically at malonos@healthykids.org. No phone calls or faxes will be accepted. Only those questions received in writing will receive a response. All questions will be posted to the website for all Respondents to view.

Questions on the draft ITN were accepted through September 18, 2015. Questions received after that date were also considered on a case-by-case basis by FHKC for a determination as to whether or not all potential bidders would benefit from a response. All responses were posted to the FHKC website.

E. Bidder's Conference

A bidders' conference for all interested parties will be held in Tallahassee, Florida on November 6, 2015, at 10:A.M. – Noon, at the FHKC offices in Tallahassee.

The final ITN document will be reviewed at the bidders' conference and attendees will have an opportunity to ask questions and may receive

preliminary verbal responses to those questions. Final written answers will also be posted to FHKC's website following the bidders' conference.

F. Requests for Supplemental Information

Written requests for any information not included with this ITN will be considered by FHKC. All attempts to satisfy reasonable requests for information will be made by FHKC. If FHKC determines that such information would be beneficial to all Respondents, the information will be posted on FHKC's website.

Once an ITN has been issued, individual public records requests for information relating to prior procurement processes and bid responses will be honored through the scheduling of a public viewing of such records. Grading tools and procurement files from prior processes are no indication of future processes.

Any information or responses received by interested parties verbally or through other representatives during this ITN process are not binding on FHKC, and Respondents should not rely on such information.

In accordance with state law, proposals received under this ITN, the grading tools and other materials developed as part of this process are not available to the public until the process has concluded. Information about marking items submitted by Respondents as "trade secret" has been addressed under Section II.

G. Amendment of the ITN

FHKC reserves the right to amend any portion of the ITN at any time prior to the announcement of Contract awards. In any such event, all Respondents will be afforded an opportunity to revise their proposals to address ONLY the amendment, if in FHKC's sole discretion, it determines such an amendment is necessary.

H. Special Note – Disclosure Statement

FHKC is a private, Florida non-profit corporation, and not subject to the bid requirements of the State of Florida. FHKC may elect to consider or reject any or all responses. Information contained in any proposals received under this ITN is not available to any other respondents until the ITN process has been concluded. FHKC intends to award Contracts to more than one (1) Respondent. A Respondent's response to this ITN and the submission of any subsequent formal proposal or bid indicates its agreement to this statement.

IV. Other Terms and Conditions

A. Most Favorable Terms

FHKC reserves the right to award a Contract without any further discussion with the Respondents regarding the proposals received. FHKC reserves the right to contact individual Respondents to clarify any point regarding their proposals or to correct minor discrepancies. FHKC is not obligated to accept any proposal modification or revision after the bid submission date.

B. Withdrawal of Proposals

Respondents may withdraw any or all proposals at any time prior to execution of a Contract by submitting a written statement to the Issuing Officer.

C. Conditions

Any conditions, caveats or contingencies included in a proposal for acceptance will not be considered part of the proposal and may be disqualified without further consideration, opportunity for modification or clarification by the Respondent.

D. Competitive Negotiation Process

In the final phase of the ITN, FHKC may elect to enter into negotiations with selected Respondents in order to purchase comprehensive insurance coverage consistent with the delivery of quality dental care. State law requires FHKC to select its dental plans through a competitive bid process.

FHKC also may elect to execute a Contract or Contracts with a selected Respondent or Respondents without any further negotiation. Therefore, proposals should be submitted in complete form, and pursuant to all terms and conditions as required in this ITN.

FHKC is the sole judge of which proposals provide the best solutions in terms of technical merit and price.

E. Limitations

Respondents may not submit proposals under multiple plans that are affiliated and linked by shared ownership or controlling interests. FHKC shall make the final determination of such, will notify Respondents of any such situations and request that Respondent withdraw all but one (1) of the affiliated proposals, or all of the Respondents' proposals from all affiliated entities may risk disqualification from the ITN process.

F. Announcements and Press Releases

Any announcements or press releases regarding Contracts awarded under this ITN must be approved by FHKC prior to release.

V. Submission Requirements

A. Submission Address and Deadlines

To be considered, all proposals must be submitted to the Issuing Officer at the address listed below in the manner prescribed under this ITN:

Steven Malono
Corporate Counsel
Florida Healthy Kids Corporation
661 East Jefferson Street
Florida Bar Annex Building, 2nd Floor
Tallahassee, Florida 32301
(850) 701-6108

Respondents should thoroughly address all of the stated components for each designated lettered Tab. The Respondent should consult the ITN and

associated documents, the designated statutes and the proposed Contract for additional information or guidance on each of the proposal components.

Proposals must be received by 12:00 noon (Eastern) on November 20, 2015. Proposals received after this date and time will NOT be considered.

B. Specific Contents

Each proposal must be separated into three (3) distinct volumes and presented in both hard copy and electronic format (searchable CD or flash drive) in the following manner:

Volume One (1) (Administrative):
1 hard copy, 8½" by 11"contained in a 3 ring binder
5 CDs or flash drives

Volume Two (2) (Networks):
1 hard copy, 81/2" by 11" contained in a 3 ring binder
5 CDs or flash drives

Volume Three (3) (Rate Proposals):
1 hard copy, 81/2" by 11" contained in a 3 ring binder
5 CDs or flash drives

Each CD or flash drives must be clearly marked with the Respondent's legal name, address and contact information on each CD cover. Individual flash drives should be sealed in an envelope with the outside envelope clearly labeled with the required information.

Information contained on the CD or flash drive must be in WORD, EXCEL or PDF format (only scanned documents may be in PDF format) as specified in each Tab and easily searchable. Provider directories must be in Excel format, searchable by any search parameters (name, specialty, etc.)

Within each volume, the contents should be organized by lettered and numbered tabs as designated below.

Any proposal element that does not receive a response from the bidder (or that appears out of the requested order as stated below) will result in a "zero" score for that component.

Respondents must use 11 point font and 1" Margins.

Special Notes:

CDs and flash drives that have been encrypted or password protected will be rejected.

No information received under this ITN should be password protected. Any such submissions may result in the rejection of the overall proposal in FHKC's sole discretion, and may not receive further consideration.

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VOLUME ONE: ADMINISTRATIVE RESPONSE

PROPOSAL COVER PAGE

Respondent should insert Appendix IX as the Proposal Cover page fully executed by an Executive Officer of the Respondent's Organization. An Executive Officer is defined as an officer that can legally bind the Respondent's organization.

Tab A: Profile of Respondent

Tab 1:
Background information and corporate profile of Respondent, including any experience Respondent may have with providing comprehensive dental or health insurance coverage to children.

Tab 2:
Respondent must provide documentation of the financial solvency of the organization, including audited financial statements for the organization's two (2) most recent fiscal years. If the organization's two (2) most recent fiscal years ended within 120 days prior to the proposal due date (in accordance with the ITN Calendar) and the last audited financial statement is not yet available, FHKC will consider the two (2) immediately prior fiscal years as the most recent.

Tab 3:
Respondent must provide information about any pending litigation with which Respondent is involved and in which Respondent's potential liability would exceed $500,000 or 10% of the Respondent's reserves, whichever is greater.

Tab 4:
Information regarding the location from where services will be provided if Respondent is awarded Contract, and what percentage of the total Contract such services represent. For example, if customer service functions are located in Florida (10% of total Contract) and claims payment is located in Georgia (2% of total Contract), those categories and percentages should be identified.

Respondent must provide an affirmative statement that no services under this Contract would be provided outside of the United States.

Tab 5:
Respondent's Corporate Organizational Chart with identification of key staff members who would have responsibilities if awarded this Contract.

Tab 6:
Conflict of Interest Statement and Disclosure

FHKC has a Code of Ethics which is included in the ITN. The Respondent must review that Code of Ethics and disclose any relationships with any members of FHKC's Board of Directors or its employees (a list of FHKC Board members can be found at www.healthykids.org).

Tab 7:
Affirmation attesting agreement to all terms and conditions as proposed under this ITN and proposed Contract or Amendment. This attestation also must affirm that the Respondent is not de-barred or otherwise prohibited or ineligible to receive federal or state funds.

This attestation must be signed and dated by an executive officer of the Respondent.

Tab 8:
References
Respondent must provide at least three (3) references from current or recent (within the past two (2) years) contracts of comparable population, size or annual premium volume utilizing the form included in the Appendix to this ITN. FHKC shall not be listed as one of the references.

Tab B: Copy of Letter of Intent

A copy of Respondent's Letter of Intent (the "LOI") must be included under Tab B.

Only those Respondents who have filed a written LOI with the Issuing Officer by 5:00 p.m. (Eastern) on Monday, November 2, 2015 will have their proposals considered.

The LOI should clearly identify the responding organization, a contact name and contact information, including mailing address, email address, telephone number and fax number, alternate contact name and corresponding

information. The LOI must affirm that the Respondent will submit a statewide response to this ITN. The LOI must be signed by an executive officer of the Respondent's organization.

The LOI is non-binding and may be withdrawn or modified at any time by the Respondent.

Tab C: Evidence of Regulatory Authority

Respondent must submit evidence of its regulatory authority to operate as proposed in Florida. Appropriate regulatory evidence will be based on the insurance model being proposed by the Respondent. FHKC will determine whether or not the evidence provided by the Respondent is sufficient.

As an example, an Insurer's Certificate of Authority in the State of Florida from the OIR is one type of evidence of regulatory authority.

If licensure has not yet been obtained, the Respondent should provide evidence of its submission status, the type of licensure or authority being sought and Respondent's arguments and assurances that such licensure or authority meets this mandatory component of the ITN, and a timeline for successful completion of this requirement.

Preference will be given to those Respondents who are fully authorized to conduct business in the manner proposed in its response as of the submission date of its proposal to FHKC.

If Respondent is not yet authorized to conduct business in the State of Florida in the manner proposed in its response, the Respondent must detail the timeline for compliance with this requirement. Respondent's regulatory status will be a graded component and will be taken into consideration when awarding points.

Tab D: Evidence of Accreditation

If Respondent is accredited, a copy of both the award certificate and award letter should be included behind this Tab. Such documentation should clearly indicate the accrediting body, the type of accreditation achieved and the length of accreditation.

Example: NCQA, 2 Year Accreditation
AAAHC, 1 Year Accreditation

If the accreditation award letter or certification lists any deficiencies, Respondent must address how and when those deficiencies were cured.

While accreditation may not be required, FHKC reserves the right to award points based on Respondent's type and level of accreditation, in FHKC's sole discretion. Preference may be given based on the type of accreditation achieved and the level of years of accreditation attained by the Respondent.

Tab E: Eligibility and Enrollment Process

For background information on the eligibility and enrollment process, please review the Appendix. For Respondent's proposal, however, FHKC is seeking Respondent's affirmation of the following:

1) FHKC shall determine eligibility for its Applicants and Enrollees.
2) Respondent may request that eligibility be reviewed for any Enrollee in accordance with the Contract but may not deny coverage or benefits to any Enrollee once FHKC has determined that a child is eligible for the Program.
3) Respondent understands that other state agencies also may play a role in the determination of eligibility under the Florida KidCare program, and FHKC cannot require another state agency or program to enroll an Applicant or Enrollee in a particular Program.
4) Respondent shall accept at least two (2) eligibility files from FHKC on a monthly basis. FHKC also may request that Respondent accept manual adjustments to the enrollment file after the first of the month which are effective back to the first (1st) of the coverage month. Payment for manual adjustments will be made in the following month's coverage payment.

5) Respondent must agree to accept payments through electronic mechanisms.
6) Respondent should affirm its understanding of this process and detail how it will ensure that these enrollments will be handled on a timely basis. Under this process, all enrollments, including those received via a supplemental file or "manual request" after the first of the month, are effective on the first (1st) of the month.

Tab F: Benefits and Cost Sharing

The benefit package for the Healthy Kids program is prescribed by state law and is subject to change during the Contract term. The co-payment structure is established pursuant to federal and state laws and regulations. Such statutory and regulatory legal requirements are set forth in the standard Contract included in this ITN.

Under this Tab, the Respondent must:

1) Affirm its understanding of the benefits package by re-stating the benefits package and co-payment schedule;
2) If any enhancements to the benefits package are offered, provide actuarial evidence that those enhancements do not impact the proposed cost of the program;
3) Any limitations or conditions relating to benefits not prescribed in state law or in the Contract must be included in the response under this Tab and Insurer must affirm that these conditions do not conflict or otherwise unlawfully restrict the benefits required by federal or state law;
4) Respondent must affirm its understanding that certain Enrollees may be prohibited from participation in cost sharing (if costs exceed 5% of family income or if an American Indian or Alaskan Native Enrollee) and explain how Respondent would implement measures to ensure that Enrollees would be protected from cost sharing requirements;
5) Describe how Respondent's network providers will be made aware that certain Enrollees may have different cost sharing requirements under the Program;
6) Respondent must address how benefits will be coordinated with an Enrollee's medical providers, specifically situations involving injuries

to the mouth and jaw; dental procedures requiring inpatient hospitalization (for sedation/behavior management); and addressing how Respondent will ensure coverage of any prescriptions written by the Enrollee's medical provider; and

7) Coordination of benefits with other insurers that may be responsible for benefits for Enrollees such as auto insurance coverage should be detailed.

Areas of Special Emphasis for ITN 2015-02 under Tab F:

Tab F-1 – Third Party Payor Coordination of Benefits

Respondent should specifically address how its organization addresses the coordination of benefits with other insurers that may be responsible for benefits for Enrollees, such as auto insurance coverage.

This response should also re-assure the Corporation that Respondent does not deny coverage for services to enrollees who may have access to third party coverage, such as auto insurance coverage, or that may offer coverage only for certain benefits in limited situations.

Tab F-2 – Coordination of Benefits with Health Plan

Respondent must address how the limited dental benefits provided under a FHKC health plan contract for injuries to the mouth and jaw will be coordinated with its dental plan. Of specific interest are those situations involving injuries to the mouth and jaw where coordination of benefits with the Enrollee's Healthy Kids' health and dental plan is essential. The focus should be on addressing the complete medical and dental needs of the Enrollee.

The Respondent should address how it will ensure that the Enrollee receives the benefits covered by law, and that the family is not required to coordinate the benefits and services between the two plans and its providers.
Respondent should describe how its plan will provide the least burdensome process to its Enrollees while ensuring access to all of the covered health and dental benefits and services in a timely manner.

Tab G: Program Management

Respondent's Tab should fully address each of the components detailed below as it specifically relates to the Healthy Kids program. If there are any differences in how the program would be managed in one (1) region or county as compared to another, these differences should be highlighted and a rationale provided for each of those differences.

Additional information about each of these components may be found in the Appendix.

Tab G-1:

Member Services

Proposal should address, at a minimum:

a) Member education and sample member materials;
b) New member orientations or welcome strategies;
c) How members will access services;
d) Referral process and any prior authorization processes;
e) Grievance and Resolutions Processes, including requests for expedited or emergency reviews;
f) How requests for Second Opinions Are Handled;
g) Member Services Hours of Operations (Minimum 9-5 EST, M-F);
h) Extended Member Services (Additional Staffed Hours, After Hours, Automated Phone or Internet Options)
i) Availability of Bilingual Customer Service Representatives (Spanish and Creole);
j) Availability of an on-demand Language Line During Operational Hours To Serve All Languages;
k) Availability of Materials in languages other than English;
l) Availability of Materials in Braille and other alternate formats;
m) Provision for Out-of-Network Services when necessary;
n) Urgent Care and Emergency Services;
o) Out-of-the Area Services (Child injured or in need or urgent dental care when out of the service area); and
p) Retention Efforts for Renewing Enrollees.

Respondent's proposal should detail any activities the Respondent would undertake to educate Enrollees about their benefits, how to access services and the importance of preventive care. The proposal also should address the Respondent's referral or pre-authorization process, if any, for Enrollees.

A sample member handbook, either currently approved by FHKC or proposed, should be included with the Respondent's response. The Respondent must agree to distribute new member materials, including a member handbook and identification card within five (5) business days of the receipt of an enrollment file or notice of enrollment in the case of manual additions. These member materials and member correspondence must be pre-approved in writing by FHKC prior to distribution, be available in languages other than English and must comply with federal Title XXI regulations.

The Respondent's proposal should briefly detail the member services offered by the Respondent, including the number of member services representatives that will be available to Healthy Kids Enrollees, the hours of operation of the member services call center, whether or not a toll-free number is utilized, the availability of representatives who speak languages other than English or provide services for hearing impaired Applicants or Enrollees, how assistance during after hours or holidays is provided and whether written materials are available in languages other than English. Member services days and hours of operation should be conducive to the needs of the Enrollees.

The Respondent's response must include a copy of the Respondent's current grievance process. The grievance process must conform to all applicable state and federal laws and regulations. Any subsequent changes to the process must be reviewed and approved by FHKC prior to implementation. Insurers must be able to generate quarterly reports of grievances received from Healthy Kids' Enrollees.

The Respondent should also address under Member Services how the Insurer will address new Enrollees transitioning to their plan from another Insurer. An outreach plan to ensure that Enrollees maintain any existing provider relationships that the Enrollee wants to continue, as well as to ensure continuity of care with specialty providers, prior authorizations or other dental needs should also be addressed.

Tab G-2:
Provider Network Management

Proposal should address and include, at a minimum:

a) A two-paragraph narrative describing Respondent's Provider contracting policies;
b) Description of Respondent's compensation methodology. FHKC reserves the right to request specific compensation schedules.
c) Description of any Provider education programs, including the structure, content and frequency of provider visits or other education activities;
d) Description of how Provider network changes are handled

Respondents should be aware that FHKC has prior approval over all subcontracts, excluding provider contracts, including those previously approved for all incumbent plans. All such contracts and subcontracts are subject to re-review and approval.

Tab G-3:
Quality Assurance

Respondent should describe its quality assurance programs with a particular emphasis on any pediatric and adolescent programs.

Respondents must affirm their understanding that FHKC will conduct its own quality audits and research efforts during the Contract term and Respondent will cooperate fully with any and all such efforts.

Tab G-4:
Case Management

Respondent will be responsible for the management of dental situations of its Enrollees on an ongoing basis. The Respondent should highlight in its submission any specialized pediatric or adolescent programs that would be available to Healthy Kids Enrollees, and how these programs would be beneficial to its Enrollees and to the program overall.

Tab G-5:
Confidentiality and Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA") Compliance

Describe Respondent's activities to ensure confidentiality and compliance with HIPAA.

Describe Respondent's compliance activities related to the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Tab G-6:
Disaster Recovery and Business Continuity and Recovery Plans

Describe Respondent's approach to Disaster Recovery and its Business Continuity and Contingency plan including alternative locations for services should catastrophic events occur where primary services are conducted.

Tab H: Implementation Period and Transition Process

Respondents must include a detailed time-line that would ensure the successful implementation of the Contract by July 1, 2016.

The time-line should include specific dates and events beginning with the Contract award date shown in the ITN and continue through the end of the first contract year, June 30, 2017.

Specific emphasis should be placed on how the Respondent would ensure a smooth transition or delivery of the following:

1) Implementation of necessary infrastructure and systems, if not a current Insurer with FHKC, or expansion of existing system if an incumbent Insurer;
2) Development of member materials and education of member services and plan staff on the Program, if a new Insurer;
3) Coverage and maintenance of enrollee's existing dental relationships;
4) Transition of coverage for Enrollees being treated by specialists at the time of transition;

5) Identification of any pre-existing authorizations and hospitalizations;
6) Transition of members being followed by case management teams or other providers; and,
7) Compliance with all contractual requirements (reporting, access, appointment, credentialing, etc.).

Those awarded Contracts under this ITN will be required to submit a more detailed transition plan for FHKC approval within ten (10) business days of Contract execution. Respondents must affirm their understanding of this requirement in their response.

Tab I: Reporting Requirements

Respondent must meet all of the reporting requirements described in the proposed Contract and shall bear the financial responsibility for all costs incurred in order to comply with these reporting requirements.

Existing Contractors with FHKC will be evaluated based on their current compliance status with all reporting requirements, including the quarterly submission of claims data with FHKC's Contractor, the Institute for Child Health Policy (the "ICHP") and to FHKC. FHKC solely will determine each Contractor's compliance status and provide notice of each Contractor's status prior to the ITN submission deadline.

If the Respondent is not a current Contractor, the Respondent must initiate a testing phase with FHKC's Contractor, ICHP, with regard to the quarterly submission of claims data by initiating at least one successful exchange of files with the ICHP by December 4, 2015. The definition of a successful exchange of files will be determined by ICHP. Respondent should contact ICHP by no later than November 13, 2015, to establish an account that will be used for the file exchange.

Successful completion of this testing phase is a required component of this ITN and is a graded component. An incumbent Insurer who is delinquent or non-compliant with any existing reporting requirements will have points deducted and may be disqualified from further consideration at FHKC's sole discretion.

Non-incumbent Respondents should successfully complete the testing process with the ICHP no later than December 4, 2015. Points will be deducted if the testing process has not been successful during the evaluation process and Respondent may be disqualified from further consideration at FHKC's sole discretion, if by the date of the Purchasing and Contracting Committee Meeting at which final grades are presented, the testing requirements have not been completed to FHKC's satisfaction. It is Respondent's sole responsibility to ensure that the necessary steps have been taken to complete these requirements.

A copy of the required data layout for such transmissions will posted to the Healthy Kids website.

Non-incumbent Respondents should also present evidence that they are prepared to submit quarterly data for the "Insure Kids Now" data upload that FHKC conducts each quarter.

A copy of the required data layout for such transmissions will be posted to the Healthy Kids website. Non-incumbent Respondents should submit a file that complies with the IKN layout, for FHKC staff/evaluator review, by December 4, 2015. The test file must be deemed compliant by December 11, 2015. The definition of "compliance" will be determined by FHKC.

All Respondents must affirm their understanding of those requirements under this Tab and agree to meet those requirements.

Tab J: Contract

A contract for services will be executed between FHKC and the successful Respondent or Respondents. The proposed Contract will be provided no later than the Bidder's Conference. This ITN, and the Respondent's submission in response to this ITN, will be incorporated by reference to the final Contract.

Conflicts

Any conflicts between the proposed Contract, this ITN and the Respondent's proposal will be resolved by FHKC and included in the final Contract that is executed between the Parties.

Revisions

Revisions to FHKC's standard Contract are not generally accepted; however, the Respondent may include in its response any requested changes. Requested changes are reviewed and evaluated and points may be deducted for substantive changes.

Excessive or unreasonable changes or changes that modify the program's objectives, amend substantive requirements or impair FHKC's fiduciary or other contractual responsibilities may result in points being deducted or the Respondent's proposal being removed from further consideration. FHKC reserves the right to reject any or all requested changes in its sole discretion.

If the Respondent anticipates requesting revisions, the specific revisions must be requested in writing in a strikethrough and underline format of the original document and submitted with the response to the ITN.

If no changes are requested, the Respondent must state explicitly its acceptance of the Contract.

FHKC may make awards with no contractual revisions accepted.

VOLUME TWO: PROVIDER NETWORKS, BY COUNTY

The proposed network must be sufficient to provide adequate appointment access and geographic distribution in accordance with contractual standards. Additionally, the proposal must provide evidence of a network of specialists, facilities or other providers that will adequately address the needs of a pediatric and adolescent population and support the entire dental benefit package.

1. Appointment Standards

A. Definitions

For the purposes of this Section, the following definitions shall apply:

1. "Emergency care" means the level of care required for the treatment of an injury or acute illness that, if not treated immediately, could reasonably result in serious or permanent damage to the Enrollee's health.

2. "Urgently needed care" or "Urgent Care" means the level of care that is required within a twenty-four (24) hour period to prevent a condition from requiring emergency care.
3. "Routine care" means the level of care can be delayed without anticipated deterioration in the Enrollee's condition for a period of seven (7) calendar days.
4. "Routine Dental Examinations" means the semi-annual preventive office visit including a dental cleaning and examination of an Enrollee where no specific condition has been identified.

B. Appointment Access

INSURER shall provide timely treatment for Enrollees in accordance with the following standards:

1. Emergency care shall be provided immediately.
2. Urgently needed care shall be provided within twenty-four (24) hours.
3. Routine care of Enrollees who do not require emergency or urgent care shall be provided within seven (7) calendar days of the Enrollee's request for services.
4. Routine preventive dental examinations shall be provided within four (4) weeks of the Enrollee's request.
5. Follow-up care shall be provided as medically appropriate.

By utilization of the foregoing standards, FHKC does not intend to create standards of care or access to care different than those deemed acceptable within INSURER's service area. Rather, FHKC intends that INSURER and its Providers timely and appropriately respond to Enrollee needs, as they are presented, in accordance with standards of care existing within the service area. In applying these standards, INSURER and Provider shall give due regard to the level of discomfort and anxiety of the Enrollees and their families.

In addition to the standards provided above, the INSURER must also meet the standards developed in compliance with the requirements of section 409.820, Florida Statutes, (see below).

The Respondent should review Administrative Rule 64C-10 – Florida KidCare Quality Assurance and Access Standards - and acknowledge that these standards as proposed and as they may be amended over the contract term are the minimum requirements. The Corporation may enhance these requirements and to the extent that the requirements stated above exceed those in the proposed rule, the higher standards would be applicable to the Program.

409.820 Quality assurance and access standards. Except for Medicaid, the Department of Health, in consultation with the agency and the Florida Healthy Kids Corporation, shall develop a minimum set of quality assurance and access standards for all program components. The standards must include a process for granting exceptions to specific requirements for quality assurance and access. Compliance with the standards shall be a condition of program participation by health benefits coverage providers. These standards shall comply with the provisions of this chapter and chapter 641 and Title XXI of the Social Security Act.

Respondent shall include only licensed dentists and specialists acting within the scope of their professional licensure to serve as providers. Additionally, Respondent's dental primary care network shall include only those providers that Enrollees may access without prior authorization or referrals from either the Insurer or another provider. If prior authorization or a referral is required prior to an Enrollee utilizing such a provider, the provider must be listed as a specialist.

An exception process for individual providers that do not meet these standards has been established by FHKC. Providers previously granted exemptions by FHKC may be included in Respondent's proposal and the date of the exemption noted. Exemptions are valid only for the plans that received the original exemption. Except for these exemptions, non-conforming providers will not be counted in determining the adequacy of a Respondent's provider network.

Contracted dental plans may request that exemptions be granted for non-conforming primary care dental providers by making a written request to FHKC for consideration through the FHKC Quality Committee, a Committee of the FHKC Board of Directors. The Committee meets at least quarterly

The Committee reviews requests at any regularly scheduled meeting. These requests are considered on a case by case, taking into account the provider's education and background, dental specialty (if applicable), other dental training and expertise, any exemption that has been or previously granted through the Department of Health's Children's Medical Services Managed Care Plan, the need for providers in the area, special needs or populations served by the provider and other factors unique to that provider or the county. Exemptions are generally

valid for three (3) years but can be granted for shorter periods of time depending on the situation and can also be granted with conditions.

Information regarding Provider Networks should be provided under the following Tabs in alphabetical order, by county, as detailed below, based on where the provider is located. Providers can be included from any Florida county so long as those providers can meet the access, appointment and credentialing standards established under this ITN for the area of expertise.

Providers from outside of Florida are not generally accepted; however, the Respondent may include out of state providers if a rationale for their inclusion is also incorporated into Respondent's submission. The narrative should be included under the specific Tab where such providers are utilized.

FHKC will make a case by case determination as to whether or not to include the provider or facility in the network adequacy review process of this ITN. If selected as an Insurer, FHKC will have a prior approval process for the use of out of state providers and approval of out of state primary care or specialty providers will continue to be reviewed by FHKC under the existing process.

Providers that have multiple offices may be listed more than once; however, the office hours cannot overlap. For example, a provider cannot be shown to be present in both offices from 8 a.m. to 5 p.m., Monday through Friday in both locations. If Respondent is not able to discern the provider's specific hours in each location then the Respondent must list the provider only once or FHKC will disqualify the provider in its review of the Respondent's network.

In front of designated Tabs for this Volume, a summary sheet which provides a count of unique providers under each Tab is required. The summary sheets are provided in the Appendix. The summary sheet should be the first page behind each Tab followed by an EXCEL listing of providers as detailed for each Tab and then Geo-Access Maps, as appropriate.

Except for Tab A, Geo-Access Maps are not required, but Respondents are strongly encouraged to include such maps for each Tab.

Facilities used for Enrollees shall meet applicable accreditation and licensure requirements and meet facility regulations specified by the Agency for Health Care Administration (AHCA).

SPECIAL NOTES:

Respondent should list those providers and facilities that the Respondent already has under contract and that have already agreed to specifically participate with Respondent for Healthy Kids through executed contracts, amendments to existing contracts, or executed letters of agreement on the EXCEL lists under each of the Tabs being described below.

If the Respondent has a contract with the provider but it is not specific to Healthy Kids, the contracting has not been completed or the provider, dentist or facility has not yet agreed to extend their contracting to include Healthy Kids through one of these identified mechanisms, the provider listing must be shaded to indicate that the contracting status had not been completed.

To be an un-shaded provider or facility, the contracting process must be fully completed. Fully completed is defined as the provider, dentist or facility has executed a contract specifically for the Healthy Kids product line and is ready to see a Healthy Kids Enrollee.

Respondents may not imply to any provider, dentist or facility during the ITN process that the Insurer is already a Healthy Kids provider, has a contract or is about to receive a Healthy Kids contract unless they are an incumbent in that specific county. Respondents may not also imply that Healthy Kids requires a specific reimbursement schedule.

While not required for Respondent's submission, FHKC may request evidence of such contracts, amendments and letter of agreements during the ITN process.

Additional information about the contracting process can be found in the Appendix and should be covered by the Respondent under Volume I, Tab 2 – Provider Network Management and not covered under this Tab.

Tab A: Primary Care Dental Providers

Geographical access to primary care dental providers experienced in child dental health are to be available within twenty (20) minutes driving time from Enrollee's residence to Provider. The driving time limitation may be reasonably extended in those areas where such limitation with respect to rural residences is unreasonable. In such instances, Respondent shall provide access for urgent care through contracts with the closest available Providers.

For Primary Care Dental Providers, Respondent may only include those providers to whom Enrollees have access to without a prior authorization or referral. Primary care dentists that are available only through a referral or prior authorization process shall be listed as specialty providers and Respondent may not receive full credit for that Provider's participation under the network review process for access to primary care dentists.

Any age restrictions as well as the contracting status for each Provider must also be included.

Respondent must provide evidence of the status of its proposed network. The response must clearly indicate whether these providers have already committed to provide services to Healthy Kids' Enrollees, and have executed a contract to specifically serve Healthy Kids Enrollees. (unshaded), or if these providers must still complete a contracting process once the Respondent is awarded this Contract (shaded). If a contracting process must still occur, the response should identify those dentists and include a description of the contracting process and a time frame for completion. The contracting status of the entire provider network will be considered in determining the adequacy of the Respondent's proposed network. The Respondent's recruitment process must articulate clearly that the Respondent has not been awarded a contract.

A Geo-Access map is required for each county which shows current Healthy Kids enrollment in relation to available primary care dentists.

Respondent should provide the following minimum information about each primary care provider in the EXCEL Spreadsheet format provided below. In alphabetical order BY COUNTY, with each county presented as a separate sub-Tab and with its own EXCEL list, and then listed within each county alphabetically by dentist type, and then alphabetically by last name within each dentist type. Information not provided in the format prescribed below may be rejected.

EXAMPLE:
COUNTY: ALACHUA

County	LNAME	FNAME	Suffix (DS, DMD)	Address	Type of Practice	Office Hours	Age Restrictions	Panel Capacity	Panel Status
Alachua	Brown	John	DDS	12 Main St., Gainesville, FL 33333	General Dentistry	9-5 M,T,R,F 9-12 W	3-99	250	OPEN
Alachua	Jones	Melissa	DDS	10 US 1, Alachua, FL 22222	Pediatric Dentistry	9-12 M-F	5-99	50	CLOSED
Alachua	Smith	Susie	DDS	14 Main St., Gainesville, FL 3333	General Dentistry	9-5 M-F	0-18	100	Existing Only

If dentists from surrounding counties that meet the geographic access standards of this ITN, including the rural exceptions, are also available to Enrollees in this county they may also be included in this chart. These dentists should be listed AFTER the county-based dentists. In the example above, dentists for Alachua should be listed first and then any surrounding counties may follow in county alphabetical order.

If including primary care providers from surrounding counties:

County	LNAME	FNAME	Suffix (DDS, DMD)	Address	Type of Practice	Office Hours	Age Restrictions	Panel Capacity	Panel Status
Alachua	Brown	John	DDS	12 Main St., Gainesville, FL 33333	General Dentistry	9-5 M,T,R,F 9-12 W	3-99	250	OPEN
Alachua	Jones	Melissa	DDS	10 US 1, Alachua, FL 22222	General Dentistry	9-12 M-F	5-99	50	CLOSED
Alachua	Smith	Susie	DDS	14 Main St., Gainesville, FL 3333	Pediatric Dentistry	9-5 M-F	0-18	100	Existing Only
Bradford	Lloyd	Sara	DDS	50 US 1 North Starke, FL 3333	General Dentistry	8-5 M-F	5-99	100	OPEN
Gilchrist	Floyd	Lyle	DDS	440 Crest Avenue, Trenton, FL 33345	General Dentistry	9-5 M-F	12-99	250	Existing Only

Tab B: Specialist Dental Providers

Specialty dental care services, ancillary services and hospital services are to be available within sixty (60) minutes driving time from Enrollee's residence to provider. The driving time may be reasonably extended or waived in those areas where such limitation with respect to rural residences is unreasonable.

All non-primary care dentists shall be included under a separate tab utilizing the same format and required information as for Tab A.

Respondent should provide the following information about each specialist in EXCEL Spreadsheet format. In alphabetical order by county, with each county proposal presented as a separate sub-Tab under Tab B and its own separate EXCEL list, and then listed alphabetical by specialty in that county, then alphabetically by provider last name within each specialty.

PROPOSAL FOR COUNTY: ALACHUA

County	Specialty	LNAME	FNAME	Suffix	Address	Office Hours	Age Restrictions	Pediatric Specialist?
Alachua	Orthodontics	Smith	John	DDS	10 Main Street, Gainesville, FL 12345	9-12 M-F 8-5 W	10-99	No
Alachua	Pedodontics	Jones	Mary	DDS	20 Main Street, Gainesville, FL 12334	9-12 M-F 8-5 W	10-99	No
Alachua	Maxillofacial Surgery	Moore	Harry	DDS	15 Main Street, Gainesville, FL 12334	M-Th 8-5	15-99	No
Bradford	Orthodontics	Moore	Harry	DDS	1010 Main Street, Starke, FL 12334	8-12 F	15-99	No
Gilchrist	Orthodontics	Montana	Hannah	DDS	445 Crest Avenue, Trenton, FL 33345	8-5 M, W	12-99	No

Providers from surrounding areas may be included if those providers are available to Enrollees and can meet the access, appointment and credentialing standards established in this ITN. Surrounding county providers should be presented in the same manner and format as shown under Tab A: Primary Care Dental Providers.

A Geo-Access map indicating the location of each specialty care dental provider for each county is not required but is strongly encouraged.

NOTES:

Specialists should be listed based on the location of their practice office. Credit is provided only for specialists that meet the access standards of this ITN unless the Respondent can provide a rationale for why a certain specialist should be included outside of those standards. The narrative supporting that request should be included under this Tab behind the EXCEL spreadsheets.

Tab C: Public Providers

For each county tab, presented as its own EXCEL list, and then alphabetical by name of the facility, provide a list of any contracted relationships with any public providers, such as County Health Departments, federally qualified health centers, and rural health clinics by county, using the format shown below.

If these providers would be included in your network, please list these locations, providers and hours of operations and affirm that these providers meet the access, appointment and credentialing standards established by this ITN.

If there are no public providers in Respondent's proposal, please respond accordingly in the submission under this Tab.

Proposal for County _____:

For Facilities:

County	Facility Name	Types of Services Provided	Address	Hours of Operation	Reimbursement Equivalent to Medicaid PPS?	Type of Facility (CHD, FQHC, RHC)

For Individual Providers (Not Included under other Tabs):

County	Specialty	LNAME	FNAME	Suffix	Address	Office Hours	Age Restrictions	Pediatric or Adolescent?	Type of Practice

Respondents should describe through narrative following the EXCEL listing under each County Tab the Respondent's relationships with Public Providers, including how contracted, the

reimbursement mechanism and how Enrollees are seen in such facilities (appointment process, reimbursement, co-payments, etc.). Federal law requires that if an Enrollee utilizes services from a contracted Federally Qualified Health Centers ("FQHC") or Rural Health Center ("RHC"), these entities shall receive reimbursement that is no less than an amount equivalent to the Medicaid Prospective Payment System ("PPS") amount.

Under this Tab, all Respondents should provide an affirmative statement that they understand this federal requirement whether or not they currently contract with these providers now or plan to under this ITN proposal.

Tab D: Any Other Sub-Contracted Services

Please describe any other services not listed already, provided directly by Respondent or through contracts or other vendors. A separate tab for each county is not necessary so long as the information is provided on a county-specific basis, as appropriate.

Any contracts, other than provider contracts, utilized for these sub-contracted services must be included in the response. Respondent must affirmatively state its understanding that FHKC must provide prior approval of these subcontracted relationships, and receive notification of any changes to these relationships during the Contract term in accordance with the Contract provisions.

If there are no other subcontracted relationships, please respond accordingly to this Tab in the submission.

Tab E: Affiliated Entities

Under this Tab, Respondent must identify and disclose any providers or facilities included in any of the Tabs A through H which is affiliated, owned or operated by the Respondent or a parent or affiliate of the Respondent.

If this section does not apply to Respondent, an affirmative statement attesting that no such relationships exist between the Respondent and any providers or facilities included in this response must be provided.

VOLUME THREE: PREMIUM RATE PROPOSALS

State law provides for the coverage of dental services for Healthy Kids Enrollees, and that such benefits may be the same benefits as provided under Medicaid for children. Proviso language in the state's General Appropriations Act prohibits FHKC from paying more than an annually determined weighted average dollar amount per member per month. Since July 1, 2010, the Healthy Kids dental benefit for both the Title XXI and full pay populations has included all dental services provided under Medicaid for children, with no benefit cap.

Effective Dates

1. The Contract shall begin on July 1, 2016 ("Commencement Date").

2. The Contract shall end on June 30, 2018.

The Contract may be extended at FHKC's discretion for a maximum of two (2) one (1) year additional periods beyond the term indicated above. FHKC agrees to notify INSURER by, April 1, 2018, if FHKC does not intend to exercise the first option; and by April 1, 2019 if FHKC has exercised the earlier extension and FKHC does not intend to an additional one (1) year extension. In no event shall the contract extend beyond June 30, 2020.

FHKC may exercise the renewal options of the Contract either in whole or in part.

Upon the expiration of the Contract, should FHKC choose to use another INSURER, INSURER shall ensure a smooth transition.

The following conditions apply for each rate proposal:

a) Any proposed premium rate that includes conditions for acceptance or contingencies will be disqualified.
b) Each rate proposal must include a breakdown of the rate using the form provided in Appendix VI with the designated categories. Rates submitted not using this form and the designated categories will be disqualified from further consideration. Respondent may be given one (1) opportunity, in FHKC's sole discretion, to correct the discrepancy before disqualification. If a particular service category is $0.00, Respondent's proposal should indicate $0.00.
c) Every rate proposal must be supported by an actuarial memorandum.

Rate Presentation Options

Premium rate proposals should be presented as independent rate proposals in one three-ring notebook and 5 CDs or flash drives labeled as Volume Three (3): Premium Rate Proposals.

Respondent should include in its submission an affirmation attesting its understanding of the three (3) conditions listed above, as well as the requirements in the proposed Contract regarding Premium Rates.

Single Statewide Rate

The Respondent must offer a single rate that covers all sixty-seven (67) Florida counties.

The trade secret provisions of this ITN do not apply to Respondent's Volume III submissions.

SPECIAL NOTICE

The FHKC Board of Directors has authorized any Respondent submitting a bid under the traditional "combined" FHKC dental program (Title XXI and full pay, at the same statewide rate) to also submit a proposal for a "stand alone" dental option, available to FHKC's full pay eligible Enrollees only. These Enrollees would not have FHKC health coverage, and may or may not have other health insurance. Respondents should submit such proposals within the response to the "combined" ITN response as a separate attachment. Respondents may not submit a response to the "stand alone" option only without also bidding on the "combined" program, but there is no requirement to bid on the "stand-alone" option. The rate for the "stand alone" option must also be a single, statewide rate, and should be separately and clearly identified using the form found in Appendix VI. Respondent may include in the "stand alone" program submission any waiting periods, co-pays or other provisions it deems reasonable and necessary. However, benefits must mirror the combined program benefits. Each such submission must be accompanied by a separate "stand alone" program actuarial memorandum. The FHKC Board reserves the right to award a "stand alone" contract to several Respondents, one Respondent, or to make no award at all.

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APPENDIX DOCUMENTS

APPENDIX I: BACKGROUND INFORMATION

I. Program Eligibility

Generally, to be eligible for the Healthy Kids program, an applicant must be uninsured at the time of application and be between the ages of 5 (five) and 19 (nineteen) years. Age eligibility is based on the child's age on the first day of the month. For example, if a child reaches the age of nineteen on the first day of the month, the coverage would cancel that month; however, if the child turns nineteen on the tenth of the month, the coverage would end on the last day of the month in which the child turned age nineteen.

Other eligibility criteria may be utilized to determine whether a child is eligible for subsidized coverage in accordance with federal and state laws and regulations. Program eligibility and premium assistance calculations are not the responsibility of the Insurer.

Most families with household incomes at or below 200% of the federal poverty level ("FPL") pay a monthly premium of $15 or $20 per family per month to participate in the Program. While there is no income limit for the Healthy Kids program, a family's household size and income, or any voluntary cancellation of employer sponsored coverage for the Enrollee during the prior sixty (60) day period will determine whether subsidized coverage is available. FHKC shall make these determinations in accordance with federal and state laws and regulations. There are state statutory exceptions to these requirements. FHKC will not identify subsidy levels of its Enrollees to Insurers.

Citizenship status is another factor that may impact a child's ability to qualify for subsidized coverage.

To be eligible for Title XXI federally subsidized coverage, a child must be a United States citizen or meet the definition of a qualified alien. Enrollment of non-qualified non-citizen children was closed several years ago; however, some children were grandfathered-in and remain enrolled in the program.

New enrollees who are not eligible for subsidy are offered the opportunity to participate in the program at a non-subsidized rate. Respondents to this ITN must agree to cover these "full pay" Enrollees, and may not submit a response to the ITN that excludes full pay Enrollees.

Once a child has been determined eligible, the child is eligible for coverage for twelve (12) months, without re-determination or re-verification of eligibility. Enrollees are required to renew their coverage once every twelve (12) months based on the month of their initial enrollment in

the Program or the last renewal completion date. Each Enrollee's renewal date also will be provided to the Insurer in the enrollment files. Insurers are encouraged to implement their own initiatives to encourage families to complete the renewal process. All such efforts must be approved in writing by FHKC prior to implementation.

Eligibility for the program is determined by FHKC. The Insurer must accept all Enrollees deemed eligible by FHKC. The eligibility criteria for the Healthy Kids program are subject to change during the Contract term.

Additionally, the Insurer should be aware and acknowledge that eligibility for the Medicaid Program is determined by the Department of Children and Families ("DCF") and not Healthy Kids. Applicants and Enrollees eligible for the CMS program must be both financially eligible through either Title XXI (CHIP) or Title XIX ("Medicaid") of the Social Security Act, and meet clinical eligibility requirements that are established by the Florida Department of Health ("DOH"). Applicants and Enrollees who meet the eligibility criteria described above for Medicaid or CMS, as determined by the responsible state agency, are not eligible for the Healthy Kids program.

Effective July 1, 2009, revisions to the Florida KidCare Act were implemented which permitted Enrollees who were both financially and clinically eligible for the CMS program to elect to opt out of the CMS program and enroll in the Healthy Kids program. Insurers should be aware that some Enrollees in the Healthy Kids program may meet the financial and clinical requirements for the CMS program but have elected to enroll in the Healthy Kids program instead.

II. Enrollment

The current enrollment process is handled by FHKC and its Third Party Administrator ("TPA"). FHKC's current TPA is PSI Services Holdings, Inc., a wholly owned subsidiary of Maximus.

Families may complete the Family Related Medical Assistance Application or an on-line application. Documentation of income is first attempted electronically and then if not able to be determined electronically, the family is asked to submit evidence of family income. Whether or not a child is currently insured is also part of the eligibility process; however, good cause exceptions do exist in state law.

Choice is provided to Healthy Kids enrollees in all counties. New Enrollees are auto-assigned among the plans available in the county, keeping family members together in the same plan. Beginning in the second contract year, auto assignment may be made to available plans in each Region on other than a one to one basis, depending upon a plan's past HEDIS scores, or based upon any other reasonable factor as determined by FHKC in its sole discretion. A copy

of FHKC's policy on *Enrollee Protections Relating to Managed Care Assignments* is provided later in this Appendix for reference. New Enrollees are provided a ninety (90) day free look period to change plans before a lock-in period begins. Plan changes may occur after this free look period under one of the good cause exceptions as provided in the policy.

Once approved for enrollment by FHKC, the Insurer will be responsible for the distribution of member materials, including identification cards, member handbooks and provider information to Enrollees. Enrollee information is transmitted to the Insurer in the monthly eligibility files.

An on-line portal permits Insurers to look-up the eligibility status of its Enrollees.

Program eligibility is determined by FHKC. Should the Insurer believe that a child is no longer eligible for the Program or has other comprehensive health insurance coverage; the Insurer may contact FHKC for review of the child's eligibility in accordance with the Contract. Only FHKC may dis-enroll or cancel a child's coverage. If FHKC determines that coverage should be cancelled, the cancellation would take effect only at the end of the month, and would not be retroactive.

The Insurer will receive two (2) enrollment files each month from FHKC's TPA. The first enrollment file will be sent to the Insurer approximately seven (7) business days before the end of the month. A second (2nd) supplemental eligibility file will be sent to the Insurer after the third (3rd) business day of each month and will contain a listing of eligible participants who are eligible back to the first (1st) of the month. The second (2nd) eligibility file includes primarily Enrollees whose prior coverage has been reinstated, but also may include a small number of Enrollees who are eligible for the first (1st) time and some cancellations back to the first of the month. A single monthly premium payment is forwarded to the Insurer for the total new enrollment from both enrollment files. All payments to the Insurers are currently performed electronically.

Manual additions after the supplemental file must also be acceptable to the Insurer. Additional information about the enrollment file transmissions are contained in the standard Contract.

On occasion, FHKC may request that Insurer also accept second (2nd) supplemental files of Enrollees retroactive to the first (1st) of the coverage month. Such requests shall be limited to those circumstances where an error by FHKC or its TPA resulted in cancellation of coverage for eligible Enrollees.

The Insurer also must be willing to accept other authorizations from FHKC indicating that an Enrollee will be on a supplemental eligibility file prior to the Insurer's receipt of that file. It is the

Insurer's responsibility to load and implement the enrollment files in a timely manner to ensure that Enrollees have access to coverage the first (1st) of each month.

EXAMPLE:

Coverage Month:	November 2016	
Effective Date:	November 1, 2016	
File	Due to Insurers	Payment To Insurer
Regular Enrollment	October 21, 2016	By November 10, 2016
Supplemental Enrollment	November 3, 2016	By November 10, 2016
Manual Adds/Deletes	Throughout November	By December 10, 2016

III. Benefits

Comprehensive dental benefits pursuant to section 409.815(2(q), Florida Statutes, are currently being provided to Enrollees under contracts that are separate from the comprehensive health services contracts. Any Respondent selected under this ITN must agree to work with Healthy Kids' contracted health services plans to coordinate dental benefits. (Health services plans are responsible for coverage for prescriptions written by an Enrollee's dental provider and coverage for oral surgeries or other dental related procedures on the mouth or jaw due to accident or injury.

The Healthy Kids program provides a comprehensive health services package. The minimum benefit level for this program is specified by state law, section 409.815, Florida Statutes, and cannot be modified.

The appendix provides a detailed description of the required benefit plan.

IV. Delivery of Services

Insurers must provide benefits through a network of designated plan providers. Provisions must also be made for out-of-area (including out-of-state and out-of-the-country services) emergency services and tertiary care. Providers should include pediatric specialists and facilities that specialize in pediatric services. Networks will be reviewed closely to determine

whether sufficient access to primary care providers and specialists is available and that access and appointment standards can be met both at Contract inception and throughout the Contract term.

FHKC does not contract directly for services and does not intervene in contract disputes between its contracted Insurers and individual providers. FHKC expects its contracted providers to settle its disputes with its providers in accordance with any contract between the entities and any controlling federal and state laws or regulations. FHKC will not intervene in any such disputes.

It is the Insurers' responsibility to ensure an adequate service network is established and maintained that meets or exceeds contractual requirements and ensures that Enrollees' access to care is not compromised. If the Insurer does not meet the service network contractual requirements, FHKC will direct its Enrollees to seek care from any willing provider and the Insurer will be responsible for the cost of any such services that are covered under the Contract.

APPENDIX II: UTILIZATION DATA

Utilization information is posted as separate links on the Healthy Kids website with the ITN materials.

APPENDIX III: ENROLLEE DEMOGRAPHIC INFORMATION

Table I: Current Enrollment by County – August 2015

This information is posted as a separate link to the ITN as an EXCEL spreadsheet.

Table II: Enrollment by Zip Code, by County – August 2015

This information is posted as a separate link to the ITN as an EXCEL spreadsheet.

Table III: Enrollment by Age and Gender, by County – August 2015

This information is posted as a separate link to the ITN as an EXCEL spreadsheet.

APPENDIX IV: REFERENCE FORM

Provide at least three (3) contract references where Respondent has provided comprehensive dental services to a similar population, comparable demographic or equivalent premium volume. Contracts should either be current or have concluded within the last two (2) years. FHKC should not be utilized as a reference.

	1	2	3
Contract Name:			
State:			
Type of Program (i.e., Medicaid, CHIP, Commercial)?			
Contract Begin Date:			
Contract End Date:			
Area of Contract: (Statewide, County, Regional)			
Benefits Provided:			
How Compensated Under Contract: (Pre-Paid, Capitated, Fee-For Service, Other, Explain)			
Average Annual Member Months			
Co-Payments Charged?			
Met Performance Standards?			
Any Penalties or Liquidated Damages or Withheld Levied During Contract Term?			
If Yes, Explain.			
Claims or Encounter Data Level Reporting Requirements?			
Annual Premium Volume			
Contract Manager:			
Contact Information:			

APPENDIX V: VOLUME TWO SUMMARY SHEETS

A summary sheet must accompany each Tab in Volume II as set forward under this Appendix V unless otherwise indicated. Failure to provide the designated summary tab may result in points being deducted from Respondent's proposal or the disqualification of the proposal from further consideration.

Summary Sheets for each required Tab follow in sequential order.

Volume Two

Tab A: Primary Care Dental Providers (PCP) Summary Sheet

Instructions: Each County that has a provider should have its own summary sheet. Providers whose age restrictions are severely limited (example: see children age 15 and up only) or are outside of the Healthy Kids age range (5 through 18) will be excluded.

County: _____

*Only those Primary Care Dental Providers physically located in the County

Total Primary Care Dental Provider Network

(Fully Contracted to provide services to Healthy Kids population, with Open Panels):

Total Unique Primary Care Dental Providers in Network:	
Of those Primary Care Dental Providers, # of Pediatric Dentists:	
Of those Primary Care Dental Providers, # of General Dentists:	
Total Unique Primary Care Dental Provider Locations:	
Of those locations, # with Pediatric Dentists:	
Of those locations, # with General Dentists:	

Total Primary Care Dental Provider Network

(All Primary Care Dental Providers, Pending Contracts, Any Panel status):

Total Unique Primary Care Dental Providers in Network:	
Of those Primary Care Dental Providers, # of Pediatric Dentists:	
Of those Primary Care Dental Providers, # of General Dentists:	

Total Unique Primary Care Dental Provider Locations:	
Of those locations, # with Pediatric Dentists:	
Of those locations, # with General Dentists:	
Total Unique Primary Care Dental Providers in Network:	

Definitions:

Contracted means the provider is already under contract with the Respondent and is ready to see Healthy Kids enrollees.

Unique means the primary care dental provider is counted once. The provider may have multiple practice locations but can be counted as only one provider.

Primary Care Dental Provider can only be a licensed pediatric dentist or general dentist. For the purposes of this summary sheet, no other provider may be counted.

Contract Pending means that the provider is under contract with Insurer for another product line but not for Healthy Kids and additional contracting must still be completed.

Volume Two
Tab B: Specialty Dental Care Providers Summary Sheet

Instructions: Each County that has a provider, should have its own summary sheet.

**Only those dental specialists that see Enrollees within the Healthy Kids age range (anywhere within the ages of 5 through 18) should be listed on the summary sheet and on the EXCEL worksheet that follows the summary sheet.*

Providers whose age restrictions are severely limited (example: see children age 15 and up only) or are outside of the Healthy Kids age range (5 through 18) will be excluded.

County: _____

*Must be physically located in the County

Specialty Dentist	TOTAL UNIQUE NUMBER WHO SEE CHILDREN	THOSE IDENTIFIED AS PEDIATRIC SPECIALISTS	Locations List City of Each Provider's Office represented in the count
Endodontist			
Oral/Maxillofacial Surgeon			
Orthodontist			
Periodontist			
Prosthodontist			

Respondents may add other dental specialists not included on this summary sheet to the bottom of this sheet. Please add any names in alphabetical order.

APPENDIX VI:	Volume Three– Required Cover Sheet Premium Rate Proposal Form

All rate proposals in Volume Three must be presented utilizing this form. Use this same form for any "stand-alone" rate submissions, clearly identifying it as such.

Rates not presented using this form may be disqualified from further consideration.

Rate Component	Per Member Per Month Cost
Dental Services	$
Reinsurance Costs:	$
ACA Insurer Fee	$
Subtotal of Costs Above:	$
Subtotal of Costs Above:	$
Administration:	$
Grand Total:	$
Expected Medical Loss Ratio:	

APPENDIX VII:	Enrollee Protections Relating to Managed Care Assignments

Florida Healthy Kids Corporation

Date Proposed: October 21, 2010 Board of Directors Meeting
Policy Name: Enrollee Protections Relating to Managed Care Assignments
Revisions to original policy shown as ~~strikethroughs~~ (deletes) and underlines (adds)

Effective Date: January 1, 2011

Original Policy

Date Proposed: March 26, 2009 Board of Directors Meeting
Date Approved: June 18, 2009 Board of Directors Meeting
Effective Date: October 1, 2009

Policy

1. New applicants to the Healthy Kids program who reside in a county with multiple health and dental plan choices will be assigned to one of the available plans. Siblings will be assigned to the same health plan. Assignment ratios among the plans may vary by county based on factors determined by the Board.

2. Upon receipt of an application and identification of a potential Healthy Kids enrollee under that application, applicants will receive written correspondence that informs them of their choice options, the free look period and the disenrollment process described under this policy.

3. The enrollee shall have a 90 calendar day "free look" period beginning on the first day of the first month of coverage. During this free look period, the enrollee may change to another available plan without having to provide a reason for such a change. The change will become effective the first of the following month, if enrollment for that month has not already been processed. If enrollment has already been processed for the following month, the change will be effective the first of the second month.

Examples: *Request received on March 10th for a plan change.*
The change will be effective with April 1st coverage month.
Request received on March 30th for a plan change.
The change will be effective with May 1st coverage.

4. The Corporation may make available on its website the option for parents to request a plan change during the free look period.

5. After the "free look" period, the enrollee will be locked into that health or dental plan until the enrollee's renewal period, unless the enrollee meets one of the exceptions provided in this policy.

6. The Corporation will recognize and extend the time allotted for making plan-related choices if the Corporation's Third Party Administrator is under corrective action that includes access to the call center or delays in the review and processing of documents submitted by applicants or enrollees.

7. A request for disenrollment from a health or dental plan outside of the free look period will be granted if one of the following conditions is met:

    A. The enrollee moves out of the area.
    B. The plan does not, because of moral or religious objections, provide the service the enrollee seeks.
    C. The enrollee needs related services to be performed at same time; not all related services are available within the network; and the enrollee's primary care medical or dental provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
    D. Other reasons, including but not limited to: poor quality of care, lack of access to services or lack of access to providers experienced in providing care needed by enrollee.
    E. The enrollee has an active relationship with a health or dental care provider who is not on the health or dental plan's network but is in the network of another participating health plan that is open to new enrollees.
    F. The health or dental plan no longer participates in the county in which the participant resides.
    G. The enrollee's health or dental plan is under a quality improvement plan or corrective action plan relating to quality of care with the Corporation.

8. A request for disenrollment must be received by a parent or guardian listed on the account or in the case of an enrollee who is no longer a minor, from the enrollee. Requests may be received via telephone, fax or mail. Requests received via unsecured email will be reviewed and a confirmation phone call will be made to the parent or guardian to affirm the request.

9. Requests will be reviewed and processed within three (3) business days of receipt of the request.

10. Staff may request additional information from the requesting parent or guardian should the information provided not meet the conditions for one of the exceptions. If additional information is necessary, the review period clock will re-start for an additional three (3) day period upon receipt of the requested information.

11. If a request is denied as not meeting one of the exceptions, the parent or guardian may request that their request be reviewed through the Corporation's Dispute Resolution Process.

12. The Corporation may also refer the enrollee to the plan's grievance process should the reason provided for disenrollment include dissatisfaction with access to care or access to providers before considering the enrollee's plan change request. In such cases, the parent or guardian must complete the grievance process for the ~~health~~ plan before submitting a second request to the Corporation.

13. Any action taken, approval, denial or referral to the plan's grievance process, will be communicated in writing to the family within five (5) calendar days of the date of the Corporation's decision.

14. Renewal correspondence will be sent out at least sixty (60) days in advance of the renewal period and will inform the family of the following items:

    1) Their ability to change health and dental plans, if available;
    2) The good cause exceptions that are available under this policy for changes outside of their renewal period; and,
    3) How to initiate the disenrollment process outside of the renewal period opportunity.

15. All such correspondence shall be written in a manner and format that is easily understood by applicants and potential applicants and enrollees.

16. The effective date of this revised policy is January 1, 2011.

APPENDIX VIII: Trade Secrets Affidavit

AFFIDAVIT OF _____

STATE OF _____
COUNTY OF _____

Affiant, (*Name of Officer*), after having been duly sworn, deposes and states as follows:

1. I am at least 18 years of age, a United States citizen and resident of the State of _____. The matters stated herein are based upon my personal knowledge.

2. I am the (*Office held*) of (*Name of Company*), ("Company"), located in located in _____.

3. The Florida Healthy Kids Corporation ("FHKC") has requested a copy of the Company's (*description of document or documents considered a trade secret*).

4. The Company considers this information a trade secret that has value and provides an advantage or an opportunity to obtain an advantage over those who do not know or use it.

5. The Company has taken measures to prevent the disclosure of the information to anyone other than those who have been selected to have access for limited purposes, and the Company intends to continue to take such measures.

6. The information is not, and has not been, reasonably obtainable without our consent by other persons by use of legitimate means, and the information is not publically available elsewhere.

FURTHER AFFIANT SAYETH NOT.

_____
(*Officer/Affiant*)

STATE OF _____
COUNTY OF _____

Sworn to and subscribed before me this _____ day of _____, 20__, by (*Officer/Affiant*), who is personally known to me or who has produced _____ as identification.

_____
NOTARY PUBLIC
My Commission Expires:

APPENDIX IX

PROPOSAL COVER SHEET

THE FLORIDA HEALTHY KIDS CORPORATION

Invitation to Negotiate 2015-02

Page 1 of 67 pages

RELEASE DATE:
October 26, 2015

SUBMIT PROPOSAL TO:

Steven Malono
Florida Healthy Kids Corporation
661 East Jefferson Street, 2nd Floor
Tallahassee, Florida 32301
(850) 701-6108
malonos@healthykids.org
www.healthykids.org

SOLICITATION TITLE:

Invitation to Negotiate 2015-02

PROPOSALS WILL BE OPENED: November 20, 2015 "Stand – Alone" Option Included? ___ yes ___ No

RESPONDENT NAME:	
RESPONDENT MAILING ADDRESS:	
CITY – STATE – ZIP:	
PHONE NUMBER:	
TOLL FREE NUMBER:	
FAX NUMBER:	
EMAIL ADDRESS:	
FEID NO.:	

*AUTHORIZED SIGNATURE (MANUAL)

*AUTHORIZED SIGNATURE (TYPED), TITLE

*This individual must have the authority to bind the Respondent.

TYPE OF BUSINESS RESPONDENT (Corporation, LLC, partnership, etc.):	

I certify that this Proposal is made without prior understanding, agreement, or connection with any corporation, firm, or person submitting a proposal for the same materials, supplies or equipment, and is in all respects fair and without collusion or fraud. I agree to abide by all conditions of this proposal and certify that I am authorized to sign this proposal for the Respondent and that the Respondent is in compliance with all requirements of the Invitation to Negotiate, including but not limited to, certification requirements.

RESPONDENT CONTACTS: Please provide the name, title, address, telephone number and e-mail address of the official contact and an alternate, if available. These individuals shall be available to be contacted by telephone or attend meetings as may be appropriate regarding the solicitation schedule.			
PRIMARY CONTACT:		SECONDARY CONTACT:	
NAME, TITLE:		NAME, TITLE:	
ADDRESS:		ADDRESS:	
PHONE NUMBER:		PHONE NUMBER:	
FAX NUMBER:		FAX NUMBER:	
EMAIL ADDRESS:		EMAIL ADDRESS:	

APPENDIX X – ENROLLEE BENEFIT SCHEDULE

I. Minimum Dental Benefits

The minimum benefits are those benefits covered under the dental program for children enrolled in Florida Medicaid and provided for under section 409.906, F.S.

Services to be covered include diagnostic services, preventive treatment, restorative, endodontic, periodontal, surgical procedures and extractions, orthodontic treatment and complete and partial dentures in the same manner is provided for in the Florida Medicaid Dental Services Coverage and Limitation Handbook, or any successor document, which is hereby incorporated by reference.

To the extent that there is a conflict between the dental benefits for children listed below and the Florida Medicaid Dental Services Coverage and Limitation Handbook, or any successor document, the handbook shall prevail.

Benefits are to be covered to the extent medically necessary for the Enrollee and which do not duplicate another Provider's services. The services rendered to each Enrollee must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment. The services cannot be experimental or investigational.

Treatment for temporomandibular joint (TMJ) disease is specifically excluded.

No Co-Payments shall be imposed for any services or office visits covered under this Contract.

All requirements for prior authorizations must conform to federal and state regulations and must be completed within fourteen (14) days of request by the Enrollee. Extensions to this process may be granted in accordance with federal or state regulations.

	Benefit	Definition of Services	Limitations
I.	Preventive Services Covered services include office visits for oral prophylaxis, topical fluoride application, oral hygiene instruction, sealants and space maintainers.	Oral Prophylaxis to remove coronal plaque, calculus and stains and includes scaling and polishing procedures. Topical fluoride application includes application fluoride gel or liquid to a tooth. Sealants are applications to pits and fissures of permanent teeth. Space maintainers are covered for necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth.	Limited to once every six months Limited to one application in a six month period. Application of fluoride to a tooth prior to restoration is not covered. Limited to one application per tooth every three years. Space maintainers are limited to fixed appliances, must be passive in nature and where the space must be maintained for at least six months.
II.	Oral Examinations Covered services include office visits for a comprehensive visual diagnostic examination of the oral cavity, teeth and support structures.	A comprehensive oral exam includes: ☐ history recording ☐ caries detection ☐ pulp testing when indicated ☐ radiographic studies ☐ written treatment plans A limited oral examination for a specific problem is also covered when palliative treatment is provided on an episodic basis to relieve pain or suffering.	Following the initial examination, coverage is limited to a periodic exam once every six months.
III.	Analgesia Covered services include the administration of a drug or agent to temporarily arrest the feeling of pain in a conscious individual.		Limited to enrollees who have a severe physical or mental disability or is difficult to manage. Service is limited to three times per twelve month period.

	Benefit	Definition of Services	Limitations
IV.	Injectable Medications Covered services include the injection of medicine by a dentist in the treatment of an illness or disease.		
V.	Sedation Covered services include the intravenous and non-intravenous administration of drugs or agents.		Non-intravenous sedation is limited to three times per 366 day period.
VI.	Oral Surgery Services Covered services include extractions, biopsies, surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial areas.	Coverage includes local anesthesia and routine post-operative care. Biopsies are the removal of tissue, hard or soft, from the recipient for microscopic examination for the purpose of diagnosis, prognosis and treatment planning.	
VII.	Palliative Treatment Covered services are those services necessary to relieve pain and discomfort on an emergency basis.		Limited to those instances where circumstances contraindicate more definitive treatment or services.

	Benefit	Definition of Services	Limitations
VIII.	Endodontic Services Covered services include office visits and treatment for pulp capping, therapeutic pulpotomies, root canal therapy, apexification and acpicoetomies.	Root canal therapy on primary teeth with succedaneous teeth must include the placement of a resorbable filling. Root canal therapy on permanent teeth and primary teeth without succedaneous teeth includes the placement of non-resorbable filling. Apexification is the clinical treatment involving the necrossi of the pulp of incompletely formed deciduous and permanent teeth subsequent to trauma or dental caries. Apicoectomy is defined as surgery involving the root surface.	Root canal therapy is limited to those situations where the teeth have a restorable crown; the prognosis of the tooth is not questionable and the exfoliation of the deciduous tooth is not anticipated within eighteen months. Covered only when one of the following conditions exist: -overfilled canal or canal cannot be filled due to excess root curvature; -fractured root tip is not reachable; -broken instrument in canal; -perforation of the root in the apical one-third of the canal; -root canal filling material lying free in periapical tissues and acting as an irritant; -root canal therapy is a failure; or, -periapical pathology not resolved by root canal therapy.

	Benefit	Definition of Services	Limitations
IX.	Periodontal Services Covered services include gingivectomy, gingival curettage, gingival flap procedure, scaling and root planing. Services also include any necessary postoperative care.	Gingival curettage is the surgical procedure of debriding the soft tissue wall of the periodontal pocket by curettage. This service is performed under local anesthesia in conjunction with root instrumentation. Gingival flap procedure is the surgical debridement of the root surface and the removal of granulation tissue following resection of the soft tissue flap and include root planing. Scaling and root planing involves instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus and stains.	
X.	Restorative Services Covered services include those services necessary to eliminate carious or post traumatic lesions from teeth and to restore the anatomic shape, function and esthetics of teeth.	Services include the following: amalgam restorations; resin restorations, including composite and glassionomers; prefabricated stainless steel crowns for both deciduous and permanent teeth; and specified crown types.	Services are limited to: Essential services necessary to restore and maintain dental health; one restoration per tooth surface except for the occlusal surface of permanent maxillary 1st and 2nd molars; one restoration for a mesial or distal lesion; and, one posterior one-surface resin restoration every three years per tooth number/letter surface. Restoration is not covered on primary teeth if loss is expected within six months. Sealants applied in conjunction with preventive resin are not covered. Crowns provided solely for aesthetic reasons are not covered.

	Benefit	Definition of Services	Limitations
			Fixed bridges or fixed partial dentures are not covered.
XI.	Consultation Services Covered services include examination of the enrollee, evaluation of condition, recommendation for treatment, documentation in enrollee's dental records and a written report to the requesting dentist or physician.	Consultation must be provided by an accredited dental specialist whose opinion or advice regarding the evaluation or management of the specific problem is requested by another dentist.	
XII.	Orthodontic Services Covered services include fixed appliance therapy and monthly maintenance visits.	Orthodontic services must be provided by specialty trained orthodontists and pediatric dentists.	Services are limited to those circumstances where the enrollee's condition creates a disability and is an impairment to their physical development. Monthly maintenance visits are limited to a maximum of 24 units or 36 months, whichever occurs first. Services will not be covered if services are for: -Limited or interceptive treatment; -primarily cosmetic purposes; or, -split phase treatment with the exception of cleft palate cases
XIII.	Hospitalization for Dental Treatment		Enrollee's health must be so jeopardized that the procedures cannot be safely performed in the office; and/or, The enrollee is so

	Benefit	Definition of Services	Limitations
			uncontrollable due to emotional instability or developmental disability and sedation has been ineffective.
XIV.	Radiographic Examination Covered services include intraoral, extraoral and panoramic radiographs necessary to make a diagnosis of dental disease or trauma.	Radiographs must determine the presence of caries, retained roots, unerupted teeth, foreign bodies or periapical and other pathology.	Limited to radiographs of intraoral periapical, bitewing, occlusal and panoramic radiographs necessary to make a diagnosis and to develop a treatment plan. Complete set of introral radiographs is limited to once in a three year period. Bitewings are limited to once in six month period. A panoramic radiograph is limited to once in a ~~per~~three (3) year period.
XV.	Removable Prosthodontics Covered services include the fabrication, repairing, relining and adjusting of an appliance for the replacement of extracted teeth under the direction of a dentist.	All dentures, whether seated immediately after extractions or following alveolar healing, must be fully functional.	Complete dentures may be provided once for an upper, a lower or a complete set per the lifetime of the enrollee. Exceptions may be granted if the dentures are no longer functional because of the enrollee's physical condition or the condition of the denture. Partial dentures are not covered if the enrollee has at least eight posterior teeth in occlusion.

APPENDIX XI – LIST OF REQUIRED REPORTS

The following chart summarizes the reports required under this Contract according to the frequency of submission. Monthly reports are due on the fifteenth (15th) of each month for the prior month; quarterly reports are due by the fifteenth (15th) of each month following the end of each quarter and annual reports are due by July 1st (first) unless otherwise noted.

This chart is provided for reference purposes only; the provisions of the Contract and any reporting requirements included herein will control.

At Contract Execution	Immediately	Monthly	Quarterly	Annually
Insurance Coverages (Section 3-16)	Section 3-20 Requirements (Section 3-20)	Provider Network Changes (Section 3-20)	Statistical Claims Data Reporting (Section 3-28)	Grievance Process (Section 3-14)
Lobbying Disclosures (Section 3-17)	Grievances before the Subscriber Assistance Panel (Section 3-14)		Reports of filed Grievances (Section 3-14)	Lobbying Certification (Section 3-17)
Quality Assurance Plan (Section 3-24)	Termination of subcontractors or affiliates (Section 3-31)		Attestation of Medicaid PPS compliance re FQHC/RHC	Experience Adjustment – April 1st (Section 3-21-3)
Conflicts of Interest Disclosure Form (Section 4-8) (Section3-23-3) Attach. F	Changes of ownership or controlling interest (Section 4-6)		Network Adequacy Attestations (Section 3-31)	Audited financial statements (Section 3-24)
Fraud and Abuse Preventions (Section 3-13)	Changes of Notice and Contract Contact (Section 4-15)			Listing of Subcontractors and affiliates (Section 3-31)
Quality Improvement Plan (Section 3-24)	Changes to Conflicts of Interest Disclosure Form (Section 4-8) (Section 3-23-			Member materials (Section 3-19)

At Contract Execution	Immediately	Monthly	Quarterly	Annually
	3) Attachment F			
Cultural Competency Plan (Section 3-19)	Regulatory Filings (Section 3-27)			Proof of insurance coverage (3-16)
				Fraud and Abuse Preventions (Section 3-13)
				Quality Improvement Plan (Section 3-24-1)
				Cultural Competency Plan (Section 3-19)
				Updated Conflict of Interest Form Attachment F (Section 3-23-3)
HIPAA Compliance/BAA				Attestation of HIPAA compliance