STATE OF ALASKA
Department of Administration
Division of Retirement and Benefits

Medical Claims Administrator and Managed Network, Dental Claims Administrator and Network

RFP 190000025

Amendment #4

November 9, 2018

This amendment is being issued to answer questions submitted by potential offerors and to provide additional important information. In addition to adhering to any changes made to the RFP by this amendment, offerors must use Submittal Form 1 – Offeror Information to acknowledge this amendment.

Eric Verrelli
Contracting Officer
Phone: (907) 465-5674
Email: eric.verrelli@alaska.gov

Questions submitted by potential offerors and answers from the State:

Question 15: Regarding the booklets and the summaries of benefits referenced in section 2.06: In the preventive section of 3.5, Covered Medical Expenses, there is a reference to Preventive Task Recommendations A&B. Do the medical benefits comply with all of what is listed in A&B?

Answer: The AlaskaCare employee and Defined Contribution Retiree medical plans both cover most preventive services with an A or B rating on the USPSTF recommendations. The AlaskaCare Defined Benefit medical plan covers only mammograms, pap smears, and prostate specific antigen tests. There are some A or B rated recommendations that are excluded under all medical plans. Some are because the benefit is covered under the pharmacy or dental benefits, others relate to plan exclusions around diet or exercise.

Question 16: Regarding the booklets and the summaries of benefits referenced in section 2.06: In the Medical Exclusions, #37, there is a reference to any treatment, drug, service or supply related to changing sex or sexual characteristics… We are assuming this is meant to exclude all transgender services and surgeries? We are not finding another reference to this under section 3.5 Covered Medical Expenses.

Answer: The AlaskaCare plans covers most treatment of gender dysphoria, including psychological counseling and hormone therapy. However, the AlaskaCare plans do not cover gender reassignment surgery or services and supplies associated with the surgery.

Question 17: Regarding the booklets and the summaries of benefits referenced in section 2.06: In the Medical Exclusions section, #24, there is a reference to root care and orthotics. Does this also apply to routine foot care for the treatment of diabetes? We are not finding this referenced in section 3.5, Covered Medical Expenses.

Answer: The AlaskaCare employee and Defined Contribution Retiree medical plans do not cover routine foot care or orthotics related to treatment of diabetes. The Defined Benefit Retiree medical plan has broader coverage of orthotics, but does not include routine foot care or orthopedic shoes.

Question 18: Regarding the booklets and the summaries of benefits referenced in section 2.06: In the Medical Exclusions we see an exclusion for sleep therapy, but we are not finding anything in Section 3.5 for sleep disorder testing. Should we assume no testing is covered and no cpap machines?

Answer: AlaskaCare plans do cover medically necessary sleep disorder testing and cpap machines.

Question 19: Regarding Section 2.06, Current Medical Plan Features and Coverage, page 12: Are we to assume that the $600/$1000/$4,800 Deductibles listed on the bottom line for Annual Individual Deductible for 1/1/19 are for the Family Deductible?

Answer: Yes, the family plan deductible beginning January 1, 2019 for the standard plan is $600, for the economy plan is $1,000 and the consumer choice plan is $4,800. Individual deductibles are $300, $500, and $2,400 respectively.

Question 20: Regarding Section 2.06, Current Medical Plan Features and Coverage, page 12: Do you have a list of the codes for Episode of Care for SurgeryPlus? Does SurgeryPlus process the claims and forward on the bundled pricing to the carrier?

Answer: SurgeryPlus processes the claims and provides the claim payment information to the carrier only as it relates to the amount collected towards the deductible. In advance of scheduled consultations and procedures, SurgeryPlus shares CPT codes to ensure there is no duplication of coverage. More detailed information will be provided during the clarification process.

Question 21: Regarding Section 2.06, Current Medical Plan Features and Coverage, page 12: How do you identify emergent versus non emergent care in an emergency room for the $100 penalty?

Answer: This is determined by the admission code submitted on the claim.

Question 22: Regarding Section 2.06, Current Medical Plan Features and Coverage, page 12: For Teladoc, the $5 copay for general consult does not apply to the out of pocket maximum (OOPM), but the $75 dermatology copay is subject to deductible and applies to the OOPM. Is it correct to assume the State has a direct relationship with Teladoc and that the carrier does not administer this benefit?

Answer: Teladoc services are currently offered through our agreement with the third party administrator. We do not have a direct contractual relationship with Teladoc.

Question 23: Regarding Section 2.06, Current Medical Plan Features and Coverage, page 12: For the Audio/Hearing benefit, what is the rolling benefit based on? Date of enrollment or date of first use?

Answer: The rolling benefit is based on the date of service.

Question 24: Regarding Section 2.06, Current Medical Plan Features and Coverage, page 12: Please define 'Necessary contact lenses' and 'elective in lieu of lenses and frames'?

Answer: There are certain eye conditions that can only be corrected by contact lenses. Non-elective contact lenses, also called medically necessary contact lenses, are prescribed by an optometrist to correct these types of eye problems, whereas elective contacts are chosen by the patient to correct an eye issue that eyeglasses can also correct.

Question 25: Regarding the Retiree Plan: For the defined contribution plan, what is the contribution?

Answer: For defined "contribution" retirees, the contribution refers to the retirement benefit being based on a defined contribution amount rather than a formula based benefit. However, the defined contribution retirees are also required to pay a percentage of the medical/pharmacy benefit premium. The percentage required is based on the number of years of service. For retirees with at least 10, but less than 15, years of service, the member must pay 30% of the premium and the retirement system pays the remaining 70%. All retirees opting to participate in the dental, vision and audio plan, must pay 100% of the premium regardless if they are defined contribution or defined benefit members.

Question 26: Regarding the Retiree Plan: For the defined benefit plan, is there any contribution?

Answer: Certain defined benefit members are required to pay for the cost of the medical/pharmacy plan premium. These include retirees who first entered the system on or after July 1, 1996 but before July 1, 2006 and have less than 10 years of creditable retirement service. Alternate payees that receive a benefit through a qualified domestic relations order, must also pay the full cost the medical/pharmacy premium. All participants in the optional dental, vision and audio (DVA) benefits must pay the full premium for the DVA coverage.

Question 27: Alternative Proposals (Sec. 1.11): "Offerors may only submit one proposal for evaluation. In accordance with 2 AAC 12.830 alternate proposals

(proposals that offer something different than what is asked for) will be rejected." Can an Offeror submit a proposal for both ASO and separately for TPA services where the ASO Offeror owns the offeror that makes a separate TPA offer?

Answer: Yes, a TPA Offeror that is a subsidiary of the parent ASO Offeror can submit a separate bid. However, the subsidiary must be able to meet the minimum qualifications based on their own capabilities and book of business.

Question 28: Alternative Proposals (Sec. 1.11): "Offerors may only submit one proposal for evaluation. In accordance with 2 AAC 12.830 alternate proposals
(proposals that offer something different than what is asked for) will be rejected." Will a broad network option with no steerage to Alaska Regional Hospital for Actives and DC Retirees be determined to be an Alternative Proposal (Sect. 1.11) and thus rejected?

Answer: Offerors are to provide their broadest network option. If there are any alternative network solutions (narrow networks, direct contracting, ACOs, etc.) that an Offeror feels would be advantageous to the State, those details can be provided in the appropriate sections of the response (e.g. Value Opportunity)

Question 29: Other Major Plan Features (Pg. 21): "2. The State has a preferred hospital arrangement in Anchorage with Alaska Regional Hospital for the active
Members and DC retired members." Does the State require offerors to provide a custom steerage network in Anchorage to match the current steerage network using Alaska Regional Hospital as the only network option for Inpatient and Outpatient services for Active and DC Retiree Plans?

Answer: As stated in Amendment 4, the requirement to support the current Alaska Regional contract is not a requirement of this contract. However, the Offeror must be able to partner with the State in administering these types of programs. If an Offeror has other potential solutions for the State's consideration, those should be presented in the appropriate sections of the response (e.g. Value Opportunity). The re-pricing exercise should be completed using the Offeror's proposed network with no consideration to the steerage provisions currently in place.

Question 30: Replication of Current Benefit Design (Sec. 3.01): "The State requires all bidders to replicate the current plan designs offered to both the active and retiree populations and will not accept any deviations." Does this requirement include network steerage to Alaska Regional Hospital on the Active and DC Retiree Plans, in that, stand-alone Ambulatory Surgical Centers and free-standing Imaging Centers in Anchorage are all currently non-par providers?

Answer: No, the Offerors are to complete the re-pricing exercise using their proposed network solution. Network claims will be re-priced using the contracted discounts and non-network claims will be subject the State's plan provision outlined in section 2.06 of the RFP.

Question 31: Replication of Current Benefit Design (Sec. 3.01): "The State requires all bidders to replicate the current plan designs offered to both the active and retiree populations and will not accept any

deviations." Does this requirement include benefit plan design features (ie. deductibles and coinsurance), medical management (CM/DM) and other medical programs currently being offered?

Answer: The offeror will need to replicate the plan design features as outlined in the plan booklets, including deductible and coinsurance. Case Management must be provided, but not replicated. Other medical management programs and services may be additionally offered and should be outlined or discussed in the value opportunity assessment, service approach submission, and/or the financial workbook.

Question 32: Mandatory Requirements (Sec. 14, #3): "Confirm that your pricing includes your broadest network offering." Does this mandatory requirement conflict with the current steerage network for Actives and DC Retirees which is not the broadest network offering available?

Answer: No, the Offeror is to offer their broadest network available. The terms and pricing associated with the network proposed will be valid regardless of the State's contract with Alaska Regional.

Question 33: Mandatory Requirements (Sec. 14, #3): "Confirm that your pricing includes your broadest network offering." What are the RFP instructions related to TPAs network capabilities, repricing exercise, Geo Access and Disruption that is applicable to the State's steerage network currently offered to the Active and DC Retiree Plans?

Answer: For the GeoAccess and Disruption the Offeror should include all facilities and providers that are in the network proposed without consideration for the plan steerage in place for Anchorage.

Offerors are to complete the claims re-pricing file based on the TPA's contracts within the proposed network. This includes re-pricing claims that are currently impacted by the State's arrangement with Alaska Regional based on the proposed network and not the Alaska Regional contract.

Question 34: Other Major Plan Features (Pg. 21): 6. Determination of recognized charge for the employee plan and the DC retiree plan.
Currently in Anchorage, emergency room, emergency admissions and NICU Level 3 services at a non-par hospital are exceptions and NOT repriced at 185% of Medicare.
There are 3 methods described, based on geography, listed for determining OON recognized charge determination. There is no reference to allowable charge claim hierarchy or voluntary vs. non-voluntary member access rules. What are the RFP instructions for applying the correct plan provision to determine the applied allowable charge for facility expenses and how will this be consistent between all Offerors for the repricing exercise?

Answer: In-network claims should be priced using contracts associated with the proposed network. For claims that fall outside of the proposed network, those should be priced using the State's current determination for facility charges as stated in section 2.06 of the RFP.

Question 35: Other Major Plan Features (Pg. 21): 6. Determination of recognized charge for the employee plan and the DC retiree plan. Currently in Anchorage, emergency room, emergency admissions and NICU Level 3 services at a non-par hospital are exceptions and NOT repriced at 185% of Medicare.

There are 3 methods described, based on geography, listed for determining OON recognized charge determination. There is no reference to allowable charge claim hierarchy or voluntary vs. non-voluntary member access rules. Should Emergency Room, Emergency Admissions and NICU level 3 services at Providence be excluded from the repricing exercise since these claims are repriced by exception and not based on plan provisions?

Answer: Offerors should complete the full repricing file based on the network and contracts that they have in place as of October 1, 2018, including claims that would fall under the Alaska Regional contract. For claims that fall outside of the proposed network, the Offeror should price these based on the determination of recognized charge as defined in section 2.06 of the RFP.

Question 36: Exhibit Instructions to Vendors (Financial Workbook): 6. Repriced Claims
All OON recognized charges are determined by AlaskaCare Plan Provisions for all plans using market-standard methodologies (ie. 90th of FH, % of Medicare or % of Billed) that are consistent with all medical TPAs. One exception is national PPO wrap contract repricing for U65 and involuntary access to services. Will OON re-pricing results be necessary if the allowed amounts are based on AlaskaCare plan provisions using standard, market-based methodologies that are consistently applied by all Medical TPAs?

Answer: Yes, the evaluation committee would like to know the differences in the networks proposed by each Offeror, including the differences in number of claims that would fall to out-of-network providers/facilities. Offerors are to complete the full re-pricing file using their proposed network and discounts associated with that network. Claims that fall outside of the proposed network will need to be subject to the State's current plan provisions defined in section 2.06 of the RFP.

Question 37: Exhibit Instructions to Vendors (Financial Workbook): 6. Repriced Claims Providence Hospital is a broad network contracted provider in Anchorage, but this facility is a non-par provider on the State's Active and DC Retiree Plans by design. Should these non-par claims be repriced based on the AlaskaCare Plan Provisions for OON recognized charges on the Active and DC Retiree plans?

Answer: Offerors are to complete the re-pricing exercise using their proposed network solution. Network claims will be re-priced using the contracted discounts and non-network claims will be subject the State's plan provision outlined in section 2.06 of the RFP.

Question 38: Mandatory Requirements (Sec. 1, #2): "Have Alaska clients in your book of business totaling a minimum of 10,000 lives" Does this mean 10,000 "group medical" lives or any line of business or contract type (ie. dental, vision, life, disability, etc.)?

Answer: The mandatory requirement is specific to group medical lives.

Question 39: Sec. 3.01: Alaska Public Sector Participation:
Would this new offering replace the existing State of Alaska sponsored insured contract for participating political subdivisions, or will it be an offering in addition to?

Answer: This would be an offering in addition to the existing State of Alaska sponsored insurance contract.

Question 40: Sec. 3.01: Alaska Public Sector Participation:
Would there be a minimum size group for each Alaska public entity that could participate in the contract, given the State's contract is self-insured?

Answer: It is the State's intention not to determine a minimum group size, but this provision would be further discussed in the clarification process.

Question 41: Sec. 3.01: Alaska Public Sector Participation:
About mutually-agreed upon requirements, would this mean adopting one or more of the AlaskaCare plans in place, or would it be expected that the offeror would be willing to create new plans to support the other Alaska public entities?

Answer: It is assumed that any plans participating under this section would be self-insured. The state intends to develop mutually agreed-upon mandatory requirements for participation with the offeror during the clarification period.

Question 42: Sec. 3.01: Alaska Public Sector Participation While it requires a separate contract with each entity, would the Division of Retirement & Benefits be coordinating any administration for participating public entities?

Answer: The state and the offeror will outline a mutually agreed-upon process for coordination and administering such contracts during the clarification period.

Question 43: Sec. 2.07: Current Dental Plan Features and Coverage:
Within AK, for out-of-network claims, Delta Dental defines the recognized charge as: 75% of the 80th percentile of the prevailing charge rate as determined by Delta Dental. Delta Dental does not use an industry standard profile for out-of-network claim reimbursement. In order to ensure that all carriers claims repricing exercise are evaluated using the same criteria, what Fair Health profile most closely resembles Delta Dental's out-of-network allowable charge? 80th, 70th, 60th, 50th, 90th, other?

Answer: Offerors are to provide pricing based on the 80th percentile of how they would determine the recognized charge. Offerors should provide additional detail on how the recognized charge is determined within the comments for Section 3.13.4.

Question 44: Regarding MEDICAL SUBMITTAL FORM 7 – Contractual Requirements, Section 4 – Member and Account Service, item 7:

What is the State of Alaska's definition of "concierge level customer service support?" What, specifically, does the State of Alaska require of a concierge level customer service team?

Answer: This is a level of service above that of a typical call center. Concierge representatives will work with members to answer not only the questions they ask, but those they may not know to ask. They will work as a member advocate, outreaching to providers to help resolve balance billing questions or claims coding issues, etc.

Question 45: Please provide an overview of all covered services under the current EAP program?

Answer: EAP currently offers active employees and their dependents 8 visits per member per issue per year. This includes guidance or counseling for stress, depression, marital problems, financial worries, work related issues, balancing work and family, and alcohol or drug abuse. In addition, it offers the employer Critical Incidence Stress Debriefings (CISD) and worksite group trainings.

Question 46: For the current EAP program; How many free sessions are provided per issue?

Answer: 8 visits per member per issue per year.

Question 47: For the current EAP program; How many hours of training and critical incident support are provided?

Answer: 20 hours each year under the base fee.

Question 48: Please provide a copy of your most recent EAP utilization report and/or year-end EAP utilization report from 2017.

Answer: Out of an average of 5,970 covered employees in calendar year 2017, there were 277 face-to-face counseling referrals, 7 work/life referrals, 13 legal referrals, 4 financial referrals, 2 critical incident consultation cases, and 220 general consultations and referrals. Overall utilization rate was 8.8%. 89.1% of members using services were the employee, and 68.5% were female.

Question 49: Does the current EAP program cover both active employees and retirees or does it simply cover active employees?

Answer: The EAP covers only active employees and their dependents.

Question 50: What is the current rate (PEPM) for the EAP program?

Answer: $2.65 PEPM

Question 51: Will the State of Alaska allow the processing of biometrics through claims for this group?

Answer: This question is unclear. However, the state values its members privacy, if the offeror wishes to submit the processing of biometrics, it can be done through the Value Opportunities Section.

Question 52: Would you be able to provide the Registration Code that we will needed to complete the proposal on the ProposalTech platform? Please let me know the next steps in this process.

Answer: No registration code will be required when proposaltech becomes live. A link to the RFP registration will be provided on the State of Alaska Online Public Notice website.

Question 53: Form 12 Document, #11, states an annual PG for Appeal Reviews. Is the state looking for additional PG's that are not listed, or just that we agree with the one that is listed in the document?

Answer: The State encourages vendors to submit any additional PGs. Any deviations from Medical and/or Dental Submittal Form 12 will be discussed during clarification.

Question 54: What are the State of Alaska's current baseline rates for HEDIS preventive screening measures?

Answer: In the employee plan, breast cancer screening is 54.5%, cervical cancer screening is 51.1%, colon cancer screening is 38.1%. In the retiree plan breast cancer screening is 61.9%, and cervical cancer screening is 40.6%. (The retiree plan does not cover colon cancer screening.)

Question 55: Regarding item 25 on page 10 of the RFP (under services provided by the incumbent): What is the State of Alaska's definition of "care consideration outreach?"

Answer: Care consideration compares claims data to clinical guidelines to identify wellness opportunities or safety risks. Recommendations are then sent to an individual and/or their doctor, and the method of contact is determined by the severity level. Some examples of care considerations are: recommending a preventive service, a foot exam for a diabetic, or adding a statin when the member has high cholesterol.

Question 56: Section 4.07 Performance Qualifications in the RFP document states "The survey must be evaluated by the owner. The survey cannot be completed by any third-party representatives/consultants of the owner." Most potential references that have similar requirements to those of the State are either public entities or publicly traded companies. There is no owner or single owner associated with these references. Will you consider modifying the requirement to read "The survey must be evaluated by an authorized representative"?

Answer: Yes.

The language in section 4.07 of the RFP (Performance Qualifications) has been modified to read:
- The survey must be evaluated by the owner or authorized representative. The survey cannot be completed by any third-party representatives/consultants of the owner or authorized representative.

Question 57: Section 3.16 Subcontractors - can you please explain the rationale regarding the requirement for subcontractors to possess a valid Alaska Business License if the contract will be between the State of Alaska and the Offeror?

Answer: See 2 AAC 12.020 (c)

Question 58: Can offeror's bid Additional Services (Attachment 3, Exhibit 4) such as account based plans, direct bill and COBRA Administration if they are not bidding on the medical? These additional services are included in the medical financial workbook and not the dental financial workbook.

Answer: No.

Question 59: Regarding our submitted ITP/NDA, when can we expect to gain access to the census and claims files for the RFP?

Answer: Once all data files are gathered, they will be made available in ProposalTech. To receive the data files you must complete the ITP-NDA form and email it to the Contracting Officer.

Question 60: Are you going to send a link to the files once approved, or will they just be out on ProposalTech?

Answer: The data files will be uploaded to ProposalTech, offerors will be able to download the files from there.

Question 61: Would the State consider/accept the attached NDA with limited (three) changes to Sections 4 and 7?

Answer: Changes will not be accepted.

Changes to the RFP:

Section 1.02 Deadline for Receipt of Proposals

Note the extension to the deadline for receipt of proposals. The RFP Schedule is revised as follows:

Proposals must be received no later than **2:00 p.m.,** Alaska Time, on **December 18, 2018**. See Section 1.07 for further instructions.

Section 1.03 RFP Schedule

Note the extension to the deadline for receipt of proposals. The RFP Schedule is revised as follows:

ACTIVITY	TIME	DATE
Educational Meeting	10:00 am	10/5/18
Issue Date / Draft RFP Released		10/11/18
Draft RFP Period Ends		10/24/18
Pre-Proposal Conference and Second Educational Meeting	9:30 am	10/29/18
Deadline to Submit Questions	4:30 pm	11/13/18
Responses to Questions		11/30/18
Deadline for Receipt of Proposals / Proposal Due Date	2:00 pm	12/18/18
Initial Evaluations and Proposal Analysis Starts		12/12/18
Shortlisting (optional)		1/28/19
Interview Period	TBD	2/7/19 – 2/15/19
Clarification Period Begins		2/19/19
Notice of Intent to Award		5/1/19
Contract Issued		6/3/19
Start Date		1/1/20

Section 4.07 Performance Qualifications

Language has been **modified** to read:

The survey must be evaluated by the owner or authorized representative. The survey cannot be completed by any third-party representatives/consultants of the owner or authorized representative.

Sec. 5.05 Pass/Fail Criteria (d) – Disruption Analysis

Language has been **modified** to read:

Disruption Analysis - shows how disruptive it will be for plan participants to switch to a different network of providers. By looking at the State's claims activity for the prior year, an analysis can match providers (and facilities) used by plan participants to the prospective network. This can help the PEC gauge expected in-network usage with the prospective network.

Network disruption will be analyzed as follows:

- The percentage of providers in the offeror's network that are available to members and are included in the claims data file.
- The percentage of claims in the offeror's network that are included in the claims data file.
- An evaluation of the number of facilities that are available to participants based upon a distribution within the state.
- An offeror's network disruption will be evaluated using the entirety of their proposed network with no consideration for the current Alaska Regional steerage provision in place.

SEC 5.06 Evaluated Criteria (d) - Contract Cost

Language has been **modified** to read:

Costs will not be evaluated/scored by the PEC. Offerors must use the tables in M-11/ D-11– Financial Workbook (Attachments 3 and 4) to display their proposed fees and claims costs. Comment sections have been provided through these form(s) to allow offerors to provide supplemental explanations, if necessary.

Segal will perform a financial analysis of the proposed fees and claims and produce a document similar to RFP Attachment 9. Segal utilizes client specific claims data for the re-pricing analysis to estimate claims cost that is trended to the renewal contract period using annual trend rates of 4% for medical and 3.5% for dental. For the medical repricing exercise, offerors are to complete this using the entirety of their proposed network and contracts in place as of October 1, 2018. Claims associated with the Alaska Regional steerage provisions should also be priced using the offeror's proposed network as either in-network or out-of-network. For any claims that fall outside of the proposed network the offeror is to price these claims using the methodology for recognized charge as provided in section 2.03 of this RFP. These repriced claims costs will be added to the offeror's administrative services organization (ASO) rate to develop an annual total cost. Annual total cost will be summed for each of the five initial contract years to develop the total initial contract cost.

Medical Financial Workbook – Exhibit 5. Repriced Claims

Instructions have been **updated** as follows:

Offerors are to provide the totals from their repricing exercise. Claims are to be separated for in-network and out-of-network claims. After submission of the Non-Disclosure Agreement for this RFP, Offerors will be provided with a file that contains 12 months of claims data. All Offerors will be required to complete a repricing exercise based on the entirety of the proposed network's contracted discount in place as of October 1, 2018. Claims associated with the Alaska Regional steerage provisions should also be priced using the offeror's proposed network as either in-network or out-of-network. For any claims that fall outside of the proposed network the offeror is to price these claims using the methodology for recognized charge as provided in section 2.03 of this RFP. Additionally, Offerors shall not include any assumptions regarding increases in billed charges. The completed claims repricing file must be submitted as part of the Offeror's response. The repricing file should also include explanation detailing the methodology and all adjustments included, and a reconciliation that ties your claims back to the total eligible charges provided. Include a full description of any capitated arrangements that will be utilized.

Medical Financial Workbook – Exhibit 1.

The following information has been **added**:

# of employee, # non-medicare retirees, and medicare retirees has been updated.

Medical Financial Workbook – Exhibit 3 & Exhibit 4

The following information has been **added**:

# of employees updated

Medical Financial Workbook – Exhibit 5

The following information has been **added**:

exhibits have been updated to include the total eligible amount and claim lines for active and non-medicare

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Dental Financial Workbook – Exhibits 1

The following information has been **added**:

# of employee and # retirees has been updated

Dental Financial Workbook – Exhibits 3

The following information has been **added**:

# of employees updated

Dental Financial Workbook – Exhibits 4

The following information has been **added**:

exhibits have been updated to include the total eligible amount and claim lines

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Medical Submittal Form Packet - Minimum Requirements Section 4: Match Current Plan Design

Language has been **modified** to read:

Confirm you can, at a minimum, ~~duplicate and~~ administer the plan features ~~and coverage~~ of the State's current plan design(s) for each benefit plan, outlined in section 2.06 of the RFP, and will not require the State to alter any of the plan benefits in order to accommodate your claims administration system. In addition, the offeror also confirms that it can support a variety of custom strategic initiatives, such as direct provider contracting, value based provider payment initiatives, and additional vendor partners that support specific components to the program (f.g. SurgeryPlus and Alaska Regional).

End of Amendment #4