

Appendix A

Current Plan Documents

Delta Dental PPO plus Premier Summary of Dental Plan Benefits For Group# 1206-0001, 0099 Wake County Public School System

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of North Carolina

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings includes cleaning of complete and partial dentures, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Harmful Habit Appliance – thumb sucking appliance	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	50%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Dependent children to the end of the month of age 26	Dependent children to the end of the month of age 26	Dependent children to the end of the month of age 26

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Four prophylaxes (cleanings) are payable per calendar year. Full mouth debridement is payable once in any five-year period.
- Fluoride treatments are payable twice per calendar year for people up to age 21.

- Benefits for space maintainers are unlimited for people up to age 19.
- Bitewing X-rays (excluding vertical films) are payable twice per calendar year. Vertical bitewing X-rays are payable once in any three-year period. Full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Extra-oral posterior dental X-rays are a Covered Service.
- Certain laboratory tests are Covered Services once in any 12-month period.
- Sealants are payable once per tooth per two calendar years for the occlusal surface of permanent molars up to age 19. The surface must be free from decay and restorations.
- Veneers are payable on incisors and cuspids once per tooth per five-year period when necessary due to fracture or decay.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on bridges and crowns are Covered Services on posterior teeth.
- Pulpal regeneration is a Covered Service.
- Localized delivery of chemotherapeutic agents is payable two times per quadrant in any two-year period.
- Oroantral fistula closure, tooth transplantation, vestibuloplasty, frenectomy, frenuloplasty, bone replacement graft for ridge preservation, and sinus augmentation are Covered Services. Excision of bone tissue is payable five times per lifetime.
- Full and partial dentures are payable once in any five-year period. Reline and rebase of dentures is payable once in any two-year period. Interim dentures are payable once in any five-year period.
- Implants and implant related services are payable once per tooth in any five-year period.
- Semi-precision attachment abutment, implant or abutment supported connecting bar, and replacement of semi-precision or precision attachment of implant/abutment supported prosthesis are Covered Services once in any five calendar years.
- Antibiotic drug injections are Covered Services. Application of desensitizing medicament (for example, application of adhesive resins) is a Covered Service once in every six-month period. Cleaning and inspection of removable partial and complete dentures is payable four times per calendar year.
- Occlusal guards are not a Covered Service.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – Delta Dental PPO Dentist or Delta Dental Premier Dentist - \$1,250 per person total per Benefit Year on all services except orthodontic services. \$1,000 per person total per lifetime on orthodontic services.

Nonparticipating Dentist - \$1,000 per person total per lifetime on orthodontic services. \$1,000 per person total per Benefit Year on all services except orthodontic services.

These are not separate maximums by type of dentist.

Maximum Carryover – Delta Dental PPO Dentist, Delta Dental Premier Dentist - If at least one Covered Service is applied toward your Maximum Payment in a Benefit Year and the total Benefit paid does not exceed \$500.00 in that Benefit Year, up to \$350.00 will carry over to the next Benefit Years Maximum Payment. This carryover amount will accumulate from one Benefit Year to the next, but will not exceed \$1,000.00. If no Covered Services are paid during a Benefit Year, all accumulated carryover amounts from previous Benefit Years will be forfeited.

Nonparticipating Dentist - If at least one Covered Service is applied toward your Maximum Payment in a Benefit Year and the total Benefit paid does not exceed \$500.00 in that Benefit Year, up to \$250.00 will carry over to the next Benefit Years Maximum Payment. This carryover amount will accumulate from one Benefit Year to the next, but will not exceed \$1,000.00. If no Covered Services are paid during a Benefit Year, all accumulated carryover amounts from previous Benefit Years will be forfeited.

Deductible – \$50 Deductible per person per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, cleaning and inspection of a partial and complete denture, and orthodontic services.

Waiting Period – Employees who are eligible for dental benefits are covered on the first of the month following the date of hire.

Eligible People – All eligible employees enrolled in the Teachers' and State Employees' Retirement System, permanent full-time employees working 30 or more hours per week and employees in a job share position as defined by Wake County Public School System who choose the dental plan.

Also eligible are your legal spouse and your children to the end of the month in which they turn 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled. You and your eligible dependents may only enroll during an open enrollment period or when the enrollment is the result of a qualifying event as defined under Internal Revenue Code Section 125. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your spouse are both eligible for coverage under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Your dependent children may only be enrolled on one application. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Contract.

Benefits will cease on the termination date as defined by Wake County Public School System.

Dental Benefits Summary

Individual Calendar Year Maximum - \$1250 (PPO and Premier), \$1000 (Nonparticipating providers)

Individual Calendar Year Deductible - \$50

Family Calendar Year Deductible - NONE

Preventive Services - 100%, no deductible

Basic Services - 50%, subject to calendar year deductible

Major Services - 50%, subject to calendar year deductible

Orthodontic Services (dependent children to age 26) - 50%

Orthodontic Lifetime Maximum - \$1,000

Premiums

Permanent Full-Time Employee Contribution

	12 Mo Employee Year Round / Modified	11 Mo Employee 11 Deductions	10 Mo Employee 10 Deductions
Employee Only	\$6.00	\$6.55	\$7.20
Employee + Family	\$47.41	\$51.72	\$56.89

Job Share Employee Contribution

Updated 7/1/21

	12 Mo Employee Year Round / Modified	11 Mo Employee 11 Deductions	10 Mo Employee 10 Deductions
Employee Only	\$20.00	\$21.82	\$24.00
Employee + Family	\$61.41	\$66.99	\$73.69

Appendix B Census

Census Summary As of December 31, 2023	
Total Covered Employees and Dependents (Members)	28,636
Female	18,272
% Female	64%
Employees	16,103
Dependents	12,533
Total COBRA Participants (Members)	241
Former Employee	121
Dependents	120

Census Summary As of October 28, 2024	
Total Covered Employees and Dependents (Members)	28,883
Female	18,197
% Female	63%
Employees	16,210
Dependents	12,673
Total COBRA Participants (Members)	233
Former Employee	120
Dependents	113

Additional census data can be viewed via the link below:

[2025 Census Data](#)

Appendix C History of Rates

Calendar Year End	Employee Only	Employee + Family	Employer Portion	Admin Fee	Total ER Cost
2015	\$6.00	\$47.41	\$21.95	\$2.26	\$24.21
2016	\$6.00	\$47.41	\$21.95	\$1.88	\$23.83
2017	\$6.00	\$47.41	\$21.95	\$1.98	\$23.93
2018	\$6.00	\$47.41	\$21.95	\$2.19	\$24.14
2019	\$6.00	\$47.41	\$21.95	\$2.19	\$24.14
2020-25	\$6.00	\$47.41	\$23.81	\$2.19	\$26.00

**Appendix D
Procedure Experience Report**

Service – Claims Paid Jan 2024 – Dec 2024

Type	No. Of Services	Total Claims	Network Savings	Claims Savings	Remaining Charges	Deductible Savings	Coinsurance/ Maximum Savings	Total Paid
Diagnostic	35,998	\$2,916,041	\$964,958	\$48,024	\$1,903,059	\$0	\$48,761	\$1,854,298
Preventive	43,249	\$4,541,022	\$1,403,762	\$97,998	\$3,039,263	(\$100)	\$70,521	\$2,968,842
Bitewing Radiographs	15,665	\$1,353,701	\$445,494	\$7,495	\$900,712	\$0	\$18,173	\$882,539
All Other Radiographs	31,528	\$1,807,594	\$643,629	\$62,090	\$1,101,874	\$0	\$29,226	\$1,072,649
Sealants	2,544	\$205,879	\$73,436	\$10,438	\$122,005	\$0	\$1,402	\$120,603
Minor Restorative	10,862	\$3,261,036	\$1,030,195	\$40,160	\$2,190,681	\$202,992	\$1,068,738	\$918,951
Major Restorative	3,249	\$3,242,801	\$785,288	\$108,689	\$2,348,824	\$51,350	\$1,327,282	\$970,192
Endodontics	773	\$806,226	\$201,805	\$21,218	\$583,203	\$7,828	\$346,454	\$228,921
Periodontics	4,665	\$1,319,726	\$341,842	\$217,750	\$760,134	\$70,601	\$393,390	\$296,144
Relines and Repairs	93	\$33,733	\$11,277	\$1,025	\$21,431	\$2,050	\$11,074	\$8,308
Simple Extractions	1,187	\$309,834	\$118,988	\$3,590	\$187,256	\$18,600	\$94,643	\$74,012
Other Oral Surgery	2,781	\$1,539,777	\$450,745	\$60,300	\$1,028,733	\$25,002	\$552,426	\$451,305
TMD	1	\$625	\$0	\$625	\$0	\$0	\$0	\$0
Other Basic Services	5,195	\$971,489	\$189,163	\$266,024	\$516,302	\$31,867	\$278,056	\$206,379
Prosthodontics	598	\$945,974	\$243,260	\$78,275	\$624,439	\$4,900	\$421,788	\$197,752
Implants	359	\$605,318	\$41,806	\$5,581	\$557,930	\$5,050	\$388,240	\$164,640
Orthodontic Services	5,605	\$2,129,652	\$70,958	\$278,676	\$1,780,018	\$0	\$1,448,678	\$331,340
Overpayment Recovery	0	\$0	\$0	\$0	\$0	\$0	\$15,225	(\$15,225)
Total	164,352	\$25,990,427	\$7,016,605	\$1,307,958	\$17,665,864	\$420,140	\$6,514,076	\$10,731,648

Class – Claims Paid Jan 2024 – Dec 2024

Type	No. Of Services	Total Claims	Network Savings	Claims Savings	Remaining Charges	Deductible Savings	Coinsurance/ Maximum Savings	Total Paid
Class I	128,984	\$10,824,237	\$3,531,278	\$226,045	\$7,066,913	(\$100)	\$168,083	\$6,898,930
Class II	25,557	\$8,242,445	\$2,344,015	\$610,691	\$5,287,739	\$358,940	\$2,744,780	\$2,184,019
Class III	4,206	\$4,794,092	\$1,070,354	\$192,545	\$3,531,193	\$61,300	\$2,137,310	\$1,332,584
Orthodontia	5,605	\$2,129,652	\$70,958	\$278,676	\$1,780,018	\$0	\$1,448,678	\$331,340
Overpayment Recoveries	0	\$0	\$0	\$0	\$0	\$0	\$15,225	(\$15,225)
Total	164,352	\$25,990,427	\$7,016,605	\$1,307,958	\$17,665,864	\$420,140	\$6,514,076	\$10,731,648

Network – Claims Paid Jan 2024 – Dec 2024

Network	No. Of Services	Total Claims	Network Savings	Claims Savings	Remaining Charges	Deductible Savings	Coinsurance/ Maximum Savings	Total Paid
In	135,036	\$21,430,928	\$7,016,375	\$877,826	\$13,536,726	\$346,425	\$5,161,481	\$8,028,821
Out	29,316	\$4,559,499	\$230	\$430,132	\$4,129,137	\$73,715	\$1,352,595	\$2,702,827
Total	164,352	\$25,990,427	\$7,016,605	\$1,307,958	\$17,665,864	\$420,140	\$6,514,076	\$10,731,648

**Appendix E
Experience & Premium Report**

Year	Month	Participants	Employee Only	Family	# Claims	Paid Premiums	Paid Claims	Admin Cost	Loss Ratio
2024	January	29,687	10,659	5,877	6,109	\$710,898.58	\$1,189,778.95	\$37,867.44	172.69%
2024	February	29,668	10,690	5,867	4,639	\$1,446,624.98	\$845,890.02	\$37,915.53	61.09%
2024	March	29,676	10,687	5,872	4,981	\$670,637.52	\$876,646.35	\$37,920.11	136.37%
2024	April	29,639	10,668	5,865	5,766	\$924,736.83	\$1,004,754.89	\$37,860.57	112.75%
2024	May	29,618	10,650	5,866	4,245	\$1,205,262.58	\$765,218.24	\$37,821.64	66.63%
2024	June	29,560	10,620	5,860	4,760	\$745,809.85	\$857,084.59	\$37,739.20	119.98%
2024	July	29,442	10,582	5,838	6,542	\$1,360,822.24	\$1,233,319.75	\$37,601.80	93.39%
2024	August	29,302	10,488	5,832	5,359	\$286,813.73	\$972,114.76	\$37,372.80	351.97%
2024	September	28,857	10,350	5,725	4,337	\$1,232,828.06	\$719,926.15	\$36,811.75	61.38%
2024	October	29,062	10,514	5,744	4,953	\$980,276.83	\$812,721.01	\$37,230.82	86.71%
2024	November	29,110	10,568	5,744	4,299	\$546,168.98	\$705,045.18	\$37,354.48	135.93%
2024	December	29,117	10,577	5,754	4,536	\$705,399.33	\$749,148.19	\$37,397.99	111.50%
Total		352,738	127,053	69,844	60,526	\$10,816,279.51	\$10,731,648.08	\$450,894.13	103.39%

Year	Month	Members	Spouse	Dependents	Employee Only	Employee + Spouse	Family	Employee + Child	Employee + Children
2024	January	29,687	3,584	9,567	10,659	782	2,802	990	1,303
2024	February	29,668	3,581	9,530	10,690	787	2,794	986	1,300
2024	March	29,676	3,576	9,541	10,687	787	2,789	989	1,307
2024	April	29,639	3,571	9,535	10,668	787	2,784	991	1,303
2024	May	29,618	3,577	9,525	10,650	793	2,784	986	1,303
2024	June	29,560	3,574	9,506	10,620	794	2,780	986	1,300
2024	July	29,442	3,554	9,468	10,582	792	2,762	989	1,295
2024	August	29,302	3,552	9,430	10,488	795	2,757	992	1,288
2024	September	28,857	3,460	9,322	10,350	753	2,707	978	1,287
2024	October	29,062	3,466	9,338	10,514	758	2,708	987	1,291
2024	November	29,110	3,465	9,333	10,568	756	2,709	988	1,291
2024	December	29,117	3,470	9,316	10,577	765	2,705	990	1,294
Total		352,738	42,430	113,411	127,053	9,349	33,081	11,852	15,562

**Appendix F
NOTICE OF INTENT TO PROPOSE**

Wake County Public School System
Purchasing Department
Attn: Petra Gooding, Senior Buyer
1551 Rock Quarry Road
Raleigh, NC 27510-4145
TELEPHONE: (919) 588-3456

This form will provide Wake County Public School System written notification of our Intent to Propose Group Dental Insurance.

PROPOSER'S NAME _____

PROPOSER'S F.E.I.D. _____

INSURER NAME (if different than Proposer) _____

INSURED'S F.E.I.D. _____

PROPOSER'S ADDRESS _____

TELEPHONE NUMBER _____

FAX NUMBER _____

CONTACT PERSON _____

EMAIL ADDRESS _____

DATE SUBMITTED _____

**Appendix G
References**

Please use the format below for submitting references as outlined in the RFP.

Organization 1: _____

Point of Contact: _____

Mailing Address: _____

Phone Number: _____ Email Address: _____

Length of Relationship: _____ Type of Insurance Contract _____

No. of covered employees: _____

Insurer Providing Insurance Contract: _____

Agent Name (if applicable): _____

Client Reference Type: Public Sector Private Client

Organization 2: _____

Point of Contact: _____

Mailing Address: _____

Phone Number: _____ Email Address: _____

Length of Relationship: _____ Type of Insurance Contract _____

No. of covered employees: _____

Insurer Providing Insurance Contract: _____

Agent Name (if applicable): _____

Client Reference Type: Public Sector Private Client

Organization 3: _____

Point of Contact: _____

Mailing Address: _____

Phone Number: _____ Email Address: _____

Length of Relationship: _____ Type of Insurance Contract _____

No. of covered employees: _____

Insurer Providing Insurance Contract: _____

Agent Name (if applicable): _____

Client Reference Type: Public Sector Private Client

Appendix H NON-COLLUSION STATEMENT

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 services 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 document for the organization and that the organization is in compliance with all requirements of this Request for Proposal including, but not limited to, certification requirements. In submitting a proposal to the Wake County Public School System, the organization offers and agrees that, upon acceptance, the organization is deemed to have sold, assigned, and transferred to the Wake County Public School System all rights, title and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the State of North Carolina relating to the particular commodities or services which may be purchased or acquired by the Wake County Public School System.

RFP: _____

Proposer: _____

Authorized Officer: _____
Signature Date

Authorized Officer: _____
Printed or typed name

Title or Position: _____

Telephone: _____

**Appendix I
DISCLOSURE INFORMATION**

Upon reasonable inquiry, the organization discloses, on the lines below:

That the following identified owner, officer, director, employee, agent or lobbyist who is/was a current or former member, officer or employee of the Wake County Public School System or any of its units and was, is, or will be significantly involved in preparing or approving this contract, representing the interests of the organization regarding this contract, or doing the work covered under this contract.

That the following identified current or former member or employee of the Wake County Public School System owns, directly or indirectly, an interest of five percent (5%) or more of the total assets or capital stock in the company.

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

If none, check here _____

RFP: _____

Name of Proposer: _____

Authorized
Officer: _____

Signature

Date

Authorized
Officer: _____

Print or type name

Title or Position: _____

Telephone: _____

Appendix J Mandatory Warranties and Requirements

Each Proposer shall warrant that they understand, represent, and acknowledge that it is professionally qualified and possesses the requisite skills, knowledge, qualifications, and experience to provide the

required services. The mandatory requirements included must be verified as follows (if the Proposer cannot so certify to any of following, the Proposer shall submit with its Proposal a written explanation of why it cannot agree and include reasoning for noncompliance. In the following chart please check (√) each item on the featured outline with an appropriate response. Include all supporting verification and documentation.

Name of Proposer: _____

Warranties and Requirements	Agree
The insurer has a minimum of five years' experience in writing, underwriting and servicing Group Dental Insurance. (1.12.1)	
The experience of the insurer's current book of business includes at least two Group Dental Insurance contracts (policies) having a minimum of 1,500-2,000, covered employees. (1.12.2)	
All organizations associated with this RFP or the resultant insurance contract (policy), including the agent or any other organization, has experience with at least two Group Dental Insurance contracts (policies) having a minimum of 1,500-2,000, covered employees. (1.12.3)	
All insurance agents associated with this RFP or the resultant insurance contract (policy) possess a North Carolina resident or nonresident license. (1.12.4)	
All organizations associated with this RFP or the resultant insurance contract (policy) has a minimum of three years' experience in marketing a Group Dental Insurance contract (policy). (1.12.5)	
The Proposer, including the insurer, agent or any other organization associated with this RFP or the resultant insurance contract (policy), is currently or will be registered with the State of North Carolina, prior to the insurance contract (policy) award. (1.12.6)	
The Proposer, including the insurer, agent or any other organization associated with this RFP or the resultant insurance contract (policy), is not currently under suspension or debarment by the State or any other governmental authority. (1.12.7)	
Insurers will submit the most recent years audited financial statement if requested by the Legislature. (1.12.8)	
To the best knowledge of the person signing the Proposal, the Proposer, its affiliates, subsidiaries, directors, officers, employees or any other organization associated with this RFP or the resultant insurance contract (policy) are not currently under investigation by any governmental authority and have not in the last ten years been convicted or found liable for any act prohibited by law in any jurisdiction, involving conspiracy or collusion with respect to bidding on any public contract. (1.12.9)	
To the best knowledge of the person signing the Proposal, the Proposer, its affiliates, subsidiaries, directors, officers or any other organization associated with this RFP or the resultant insurance contract (policy) have no delinquent obligations to the State, including a claim by the State for liquidated damages under any other contract. (1.12.10)	
Warranties and Requirements	Agree
To the best knowledge of the person signing the Proposal, the Proposer, its affiliates, subsidiaries, directors, officers or any other organization associated with this RFP or the resultant insurance contract (policy) have	

<p>not within the preceding three years been convicted of or had a civil judgment rendered against them or is presently indicted for or otherwise criminally or civilly charged for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a federal, state, or local government transaction or public contract; violation of federal or state antitrust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property. (1.12.11)</p>	
<p>To the best knowledge of the person signing the Proposal, the Proposer, its affiliates, subsidiaries, directors, officers or any other organization associated with this RFP or the resultant insurance contract (policy) have not within a three-year period preceding this certification had one or more federal, state, or local government public transactions terminated for cause or default. (1.12.12)</p>	
<p>The proposed Group Dental Insurance contract shall be provided by one insurer; however, insurers may submit proposals through multiple agents and agents may submit proposals through multiple insurers. (1.13.1)</p>	
<p>All commission, if any, should be provided and shall be included in the rate quoted to the WCPSS. (1.13.2)</p>	
<p>The proposed Group Dental Insurance contract (policy) shall meet or exceed all Group Dental Insurance benefits provided in the WCPSS current Group Dental Insurance contract (policy). (1.13.3)</p>	
<p>The person signing the Proposal has the authority to bind the Proposer. (1.13.4)</p>	
<p>The Proposer must have a detailed plan to provide continued service and support of the resultant insurance contract in the event the Proposer's company is no longer the servicing carrier for any reason, including going out of business, merging with another company or is otherwise unable to fulfill its obligation under the insurance contract. (1.13.5)</p>	
<p>The Proposer will satisfactorily provide all services requested as specified in the RFP, and the completion of those services will be the responsibility of the successful Proposer. (1.13.6)</p>	
<p>The Proposer shall at all times during the insurance contract (policy) term remain responsive and responsible. (1.13.7)</p>	
<p>The Contractor shall maintain Commercial General Liability Insurance with limits sufficient to cover losses resulting from, or arising out of, Contractor action or inaction in the performance of the Contract by the Contractor, its agents, employees, or subcontractors, but no less than a Combined Single Limit for Bodily Injury, Property Damage, and Personal and Advertising Injury Liability of \$1,000,000 per occurrence and \$2,000,000 aggregate. (1.13.8)</p>	
<p>The Contractor shall maintain Errors and Omissions/Professional Liability insurance with minimum limits of \$1,000,000 per occurrence. (1.13.9)</p>	
<p>The Contractor shall maintain Automobile and/or Commercial Truck Insurance as appropriate with Liability, Collision, and PIP of \$100,000 per occurrence and \$300,000 aggregate where the vehicle(s) is registered but in no case less than those required by the State of North Carolina. (1.13.10)</p>	
<p>Warranties and Requirements</p>	<p>Agree</p>
<p>The Contractor shall maintain Employee Theft Insurance with minimum limits of \$1,000,000 per occurrence. (1.13.11)</p>	

<p>Within five (5) Business Days of execution of a Contract with the WCPSS, the Contractor shall provide the Contract Monitor with current certificates of insurance, and shall update such certificates from time to time but no less than annually in multi-year contracts, as directed by the Contract Monitor. Such copy of the Contractor's current certificate of insurance shall contain at minimum the following:</p> <ul style="list-style-type: none"> a. Workers' Compensation – The Contractor shall maintain such insurance as necessary and/or as required under Workers' Compensation Acts and the Federal Employers' Liability Act. b. Commercial General Liability as required in Section 1.13.8. c. Errors and Omissions/Professional Liability as required in Section 1.13.9. d. Automobile and/or Commercial Truck Insurance as required in Section 1.13.10. e. Employee Theft Insurance as required in Section 1.13.11. <p>(1.13.12)</p>	
<p>The WCPSS shall be named as an additional named insured on the policies with the exception of Worker's Compensation Insurance and Professional Liability Insurance. Certificates of insurance evidencing coverage shall be provided prior to the commencement of any activities in the Contract. All insurance policies shall be endorsed to include a clause that requires that the insurance carrier provide the WCPSS, by certified mail, not less than 45 days' advance notice of any non-renewal, cancellation, or expiration. In the event the WCPSS receives a notice of non-renewal, the Contractor shall provide the WCPSS with an insurance policy from another carrier at least 30 days prior to the expiration of the insurance policy then in effect. All insurance policies shall be with a company licensed by the State to do business and to provide such policies. (1.13.13)</p>	
<p>The Contractor shall require that any subcontractors providing services under this Contract obtain and maintain similar levels of insurance and shall provide the WCPSS with the same documentation as is required of the Contractor. (1.13.14)</p>	

Name of Proposer: _____

Name of Insurer: _____

Name of Agency or any organization that will assist in the placement, service or any other capacity: _____

List all Agents that will assist in the placement, service, or any other capacity:

Appendix K Technical/Reference Proposal (Questionnaire)

In submitting a Proposal, each Proposer understands, represents, and acknowledges all the conditions of

The Wake County Public School System RFP #251-26-185 - Group Dental Plan: Appendices
the RFP (if the Proposer cannot so certify to any conditions of the RFP, the Proposer shall submit with its Proposal a written explanation of why it cannot do so).

Responses to the questions below will be scored using a scale grading based on minimum to top responses by an evaluation committee and will provide the basis of each Proposer's initial score.

Scores from the Technical/Reference Proposal (Questionnaire) below and scores from the Premium (cost) Proposals will be used to determine the successful Proposer, therefore responses to questions should be complete.

Proposers are encouraged to provide simple, easy to understand terms in lieu of industry jargon.

Answer all questions below. Those questions requiring additional space, information or attachments, should be included with the question, response, information and attachments including a reference to the additional information.

All differences being proposed that conflict with any requirement provided within the RFP should be outlined in the response.

Technical/Reference Evaluation Areas	Available Points
Warranties (Experience)-Section 1.12.1, 1.12.2, 1.12.3, 1.12.5	8
Group Dental Insurance Plan Type 3.3	8
Group Dental Insurance Coverage 3.4	5
Dental Procedures 3.4.2	5
Claims-Section 3.8	5
Customer Service 3.9	5
Reporting Requirement 3.11	6
Usual, Customary & Reasonable 3.12	5
Explanation of Benefits 3.13.6	3
Enhancements-Section 3.15	4
Statement of Compliance 3.16	2
References-Section 5.3.2.1 & 5.3.2.2	2
Maximum Available Technical/Reference Points	60

Technical/Reference Questionnaire	Possible Points
Name of Proposer:	

<p>Warranties (Experience):</p> <ul style="list-style-type: none"> • Number of years' experience in writing, underwriting, and servicing a self-insured Group Dental Insurance? _____ Minimum requirements listed in Section 1.12.1 • Number of insured's having a minimum of 1,500-2,000, covered employees within current book of business. _____ Minimum requirements listed in Section 1.12.2 • What is the average number of employees currently provided by each Group Dental Insurance Policy? _____ Minimum requirements listed in Section 1.12.3 • Size (number of covered employees) of largest policyholder within current book of business _____ Minimum requirements listed in Section 1.12.3 • Number of years' experience in marketing and servicing Group Dental Insurance? _____ Minimum requirements listed in Section 1.12.5 	<p>8</p>
<p>Group Dental Insurance Plan requirements listed in Section 3.3:</p> <ul style="list-style-type: none"> • Passive Preferred Provider Organization Dental Plan Offered? Included? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain below: <hr/> <hr/> <hr/> <ul style="list-style-type: none"> • How often are changes (additions, deletions & corrections) to the directory of participating providers updated? <p>Participating Providers requirements listed in Section 3.3.1: Provide the number of participating providers including general dentist or dental specialist that are within each Zip Code and County:</p> <p>Zip Code: County: No. of General Dentist No. of Dental Specialist</p>	<p>8</p>
<p>Technical/Reference Questionnaire</p>	<p>Possible Points</p>
<p>Name of Proposer:</p>	

<p>Group Dental Insurance Coverage minimum requirements in Section 3.4:</p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><u>SCHEDULE OF BENEFITS</u></th> <th colspan="2" style="text-align: center;"><u>TABLE OF ALLOWANCE</u></th> </tr> <tr> <td></td> <th style="text-align: center;">**PP</th> <th style="text-align: center;">**NPP</th> </tr> </thead> <tbody> <tr> <td colspan="3">*Preventive and Diagnostic Services</td> </tr> <tr> <td style="padding-left: 40px;">Deductible Amount</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding-left: 40px;">Benefit Percentage</td> <td style="text-align: center;">_____ %</td> <td style="text-align: center;">_____ %</td> </tr> <tr> <td colspan="3">*Basic Services</td> </tr> <tr> <td style="padding-left: 40px;">Deductible Amount</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding-left: 40px;">Benefit Percentage</td> <td style="text-align: center;">_____ %</td> <td style="text-align: center;">_____ %</td> </tr> <tr> <td colspan="3">*Major Services</td> </tr> <tr> <td style="padding-left: 40px;">Deductible Amount</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding-left: 40px;">Benefit Percentage</td> <td style="text-align: center;">_____ %</td> <td style="text-align: center;">_____ %</td> </tr> <tr> <td style="padding-left: 40px;">*Maximum Benefit Amount per benefit period</td> <td colspan="2" style="text-align: center;">\$ _____</td> </tr> <tr> <td colspan="3">Orthodontia Services</td> </tr> <tr> <td style="padding-left: 40px;">Deductible Amount</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding-left: 40px;">Benefit Percentage</td> <td style="text-align: center;">_____ %</td> <td style="text-align: center;">_____ %</td> </tr> <tr> <td style="padding-left: 80px;">Maximum Benefit Amount per lifetime</td> <td colspan="2" style="text-align: center;">\$ _____</td> </tr> </tbody> </table> <p>**PP-Participating Provider; NPP Non-Participating Provider</p>	<u>SCHEDULE OF BENEFITS</u>	<u>TABLE OF ALLOWANCE</u>			**PP	**NPP	*Preventive and Diagnostic Services			Deductible Amount	_____	_____	Benefit Percentage	_____ %	_____ %	*Basic Services			Deductible Amount	_____	_____	Benefit Percentage	_____ %	_____ %	*Major Services			Deductible Amount	_____	_____	Benefit Percentage	_____ %	_____ %	*Maximum Benefit Amount per benefit period	\$ _____		Orthodontia Services			Deductible Amount	_____	_____	Benefit Percentage	_____ %	_____ %	Maximum Benefit Amount per lifetime	\$ _____		<p>5</p>
<u>SCHEDULE OF BENEFITS</u>	<u>TABLE OF ALLOWANCE</u>																																																
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Deductible Amount	_____	_____																																															
Benefit Percentage	_____ %	_____ %																																															
Maximum Benefit Amount per lifetime	\$ _____																																																
<p>Dental Procedures: Confirm that all dental procedures currently provided will be provided or identify any dental procedures that will not be covered. Minimum requirements listed in Section 3.4.2</p> <p>_____</p> <p>_____</p> <p>Additional Codes provided:</p> <p>_____</p>	<p>5</p>																																																
<p>Claims: Explain in detail the claims filing process, claims counseling services provided and claims processing guidelines including the review process and monitoring procedures. Minimum requirements listed in Section 3.8</p> <p>_____</p>	<p>5</p>																																																
<p>Technical/Reference Questionnaire</p>	<p>Possible Points</p>																																																

<p>Name of Proposer:</p>	
<p>Customer Service: Explain the customer service provided to insureds and the customer service satisfaction tools used including complaint resolution. Minimum requirements listed in Section 3.9</p>	<p>5</p>
<p>Reporting Requirements: Explain in detail the ability to process weekly and monthly claim reports for the below reports, including any capability for custom reporting.</p> <ul style="list-style-type: none"> • Experience Report that includes date of birth, gender, description of dental procedure and paid claim amount – monthly report • Billing Report that includes benefit type, employee ID number, full name, plan year, date of birth, check number, check date, amount of check paid – weekly report • Fiscal Year-End Report that includes same fields as the billing report but isolated for only claims paid for July and August – annual report due by Sept 1 • COBRA experience and billing report – service must be provided by awarded provider/administrator 	<p>6</p>
<p>Usual, Customary and Reasonable (UCR) Fees: Explain in detail how UCR fees are determined, what reimbursement percentile is used to determine UCR amounts and how often your organization’s UCR fees are updated? Minimum requirements listed in Section 3.12</p>	<p>5</p>
<p>Explanation of Benefits: Provide a sample of the EOB that will be used by your organization. Minimum requirements listed in Section 3.13.6</p>	<p>3</p>
<p>Enhancements: Explain in detail the enhancements offered by your organization, including additional services, comparable services or support services that would better serve the insured and provide broader benefits. Referenced in Section 3.15</p>	<p>4</p>
<p>Statement of Compliance: Provide a statement of compliance that the resultant dental plan will not reduce Group Dental Insurance benefits for insureds or a written explanation of why your organization cannot certify compliance. Referenced in Section 3.16</p>	<p>2</p>
<p>References: Provide references on Appendix G included in the RFP. Requirements in Section 5.3.2.1 & 5.3.2.2.</p>	<p>2</p>
<p>Total Score:</p>	<p>60</p>

Appendix L

Premium (Cost) Proposal Rate Form- Three Year Insurance Contract (Policy) Term

Dental Insurance Rate Form

The Premium (Cost) Proposal must not contain any Technical/Reference information.

L-Insured Person Single Rate	\$	\$	\$
M-Insured Person Family Rate	\$	\$	\$
V-(Proposed Teir) Insured Person Single +1	\$	\$	\$
N-Combined Average Rate (Average of L&M)	\$	\$	\$
O-Total Annual Administrative Cost	\$	\$	\$
P-Projected Percentage of Network Usage	%	%	%
Rate Guarantee per calendar year	2027	2028	2029

Proposers **must** complete the Insured Person Rate and Insured Person Rate w/Dependents above, if proposing a three-year insurance contract (policy) term.

Name of Proposer: _____

Appendix M General Business Information

The Proposer, including the insurance agency, insurer and any other organization associated with this RFP, must indicate the name, address, telephone number, email address, FAX number, and Employer Identification Number (EIN) of the legal entity with which the insurance contract (policy) is to be administered by and written through.

Name of Proposer: _____

Name of Agency: _____

Primary Point of Contact: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____ Employer Identification No.: _____

Agent's Name and License Number: _____

Name of Insurer: _____

Primary Point of Contact: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____ Employer Identification No.: _____

Company Name: _____

(any other organization associated with this RFP)

Primary Point of Contact: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____ Employer Identification No.: _____

Appendix N Drug Free Workplace Certification Form

Preference shall be given to businesses with drug-free workplace programs. Whenever two or more submittals which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a submittal received from a business that certifies that it has implemented a drug-free workplace program shall be given preference in the award process.

In order to have a drug-free workplace program, a business shall:

1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, the penalties that may be imposed upon employees for drug abuse violations.

3) Give each employee engaged in providing the commodities or contractual services that are under contract a copy of the statement specified in subsection (1).

4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under contract, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of Chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5) Impose a sanction on or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available who is so convicted.

6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this respondent complies fully with the above requirements.

I certify that _____ has a drug-free workplace program as noted above.

Corporate Name of Respondent (Typed)

Authorized Officer's Signature

Title

Date

Appendix O Electronic Verification Compliance

E-VERIFY REQUIREMENTS FOR CONTRACTORS

As a requirement and condition of this Agreement, the Contract must use the Department of Homeland Security's E-Verify system when hiring new employees for the term of the contract. E-Verify is an electronic system designed to verify the documentation of job applicants. It is operated by the U.S. Department of Homeland Security. Further information on E-Verify can be found at the following website: <http://www.uscis.gov/e-verify>

- This requirement shall apply to the Contractor and any and all "sub-contractors" that may be hired during the performance of this contract. Subcontractors, if any, shall also be required to sign an Affidavit of Compliance and retain that Affidavit for four (4) years after the end of the contract.
- E-Verify must be used ONLY for newly hired employees during the term of the contract. It is NOT to be used for existing employees.
- E-Verify must be used to verify the documentation of ANY new employee during the term of the contract, not just those directly or indirectly working on deliverables related to this contract.
- Contractor shall retain a copy of the E-Verify Memorandum of Understanding that they execute with the Department of Homeland Security.
- Sign and submit to the WCPSS an Affidavit of Compliance with the executed contract.
- The WCPSS reserves the right to audit the Contractor's compliance with these requirements.

AFFIDAVIT OF COMPLIANCE WITH DEPARTMENT OF HOMELAND SECURITY'S "E-VERIFY" SYSTEM

As the person duly authorized to enter into such commitment for

_____,
(Company or Organization Name)

I hereby certify that the Company or Organization named herein will (Check one box below)

Be in compliance with all of the requirements of E-Verify for the duration of the contract entered into between the WCPSS and the Company or Organization

OR

Hire no employees for the term of the contract between the WCPSS and the Company or Organization

Authorized Officer's Signature

Title

Date

Appendix P PERFORMANCE GUARANTEES

CATEGORY	DEFINE COMMITMENT	MEASURABLE TIME FRAME	PENALTY
Plan Implementation			
Benefit Availability			
Enrollment Assistance			
Claim Turnaround Time			
Claim Savings			
PPO Savings			
Member Satisfaction			
Account Management			
Financial Accuracy			
Reporting Accuracy			
Processing Accuracy			
Call Center – Service Level			
Call Center – Abandonment Rate			
Call Center – Wait Time			

Appendix Q CHECKLIST

Vendor Name: _____

This checklist is provided to assist the Proposer in preparation of its Proposal. **Because this checklist is just a guideline, the Proposer must read and comply with the RFP in its entirety.**

- _____ RFP Cover Sheet Completed and Signed-Page 1.
- _____ Notice of Intent to Propose (Submitted by deadline)–Appendix F.
- _____ References–Appendix G.
- _____ Non-Collusion Statement – Appendix H.
- _____ Disclosure Information – Appendix I.
- _____ Mandatory Warranties and Requirements – Appendix J.
- _____ Technical/Reference Questionnaire – Appendix K.
- _____ Premium (cost) Rating Form– Three Year – Appendix L.
- _____ Copies – 1 original, 6 copies, and 1 flash drive of Technical/Reference & 1 original, 1 copy, and 1 flash drive of Premium (cost)
- _____ General Business Information – Appendix M.
- _____ Drug Free Workplace – Appendix N.
- _____ Electronic Verification Compliance – Appendix O.
- _____ Performance Guarantees – Appendix P.
- _____ Copy of Proposer’s standard Group Dental Insurance Policy.