



# Dental Plan New Entrant Application for Plan Year 2015

DRAFT

February 3, 2014

This page intentionally left blank.

Table of Contents

- I. General Information and Background..... 5
  - A. Purpose..... 5
  - B. Background..... 5
    - 1. Principles of Evaluation of Issuer Dental Plan Bids ..... 6
  - C. Availability ..... 8
  - D. Clarification Questions ..... **Error! Bookmark not defined.**
  - E. Intention to Submit a Response..... 8
  - F. Solicitation Addenda ..... **Error! Bookmark not defined.**
  - G. Key Action Dates..... 9
  - H. Solicitation Official..... **Error! Bookmark not defined.**
- II. Technical Requirements ..... 9
  - A. Licensed and In Good Standing and Regulatory Filings..... **Error! Bookmark not defined.**
    - 1. Licensed and In Good Standing..... 9
    - 2. New Application or Material Modification of an Existing License or Certificate of Authority .. **Error! Bookmark not defined.**
    - 3. Dental Plan Regulatory Filings..... **Error! Bookmark not defined.**
  - B. California Health Benefit Exchange Dental Plan Questions ..... **Error! Bookmark not defined.**
    - 1. Plan Network Design Issues ..... **Error! Bookmark not defined.**
    - 2. Contracting with Dental Providers Who Serve the Low Income and Uninsured Populations..... 10
    - 3. Quality Improvement Strategy - Promoting - Better Care, Better Health, and Lower Cost ..... 11
  - C. Technical Specifications ..... 11
    - 1. General ..... 11
    - 2. Account Management Support ..... 11
    - 3. Implementation..... 11
    - 4. Account Administration ..... 11
    - 5. Member Services ..... 11
    - 6. Care Management ..... 11
    - 7. Communications & Education..... 11
    - 8. Provider Network..... 11
    - 9. Systems and Data Reporting Management ..... 11
  - D. Performance Measures (Quality) ..... 11
  - E. Documentation ..... 12
  - F. Additional Questions and/or Requirements ..... 13
    - 1. Agent Relations, Fees, and Commissions ..... 13
    - 2. Marketing and Outreach Activities ..... 13
    - 3. Operational Reporting Requirements and Interfaces ..... 13
- III. Cost Proposal..... 13
  - A. Requirements..... **Error! Bookmark not defined.**
  - B. Instructions..... **Error! Bookmark not defined.**
- IV. Proposal Preparation & Submission Instructions..... **Error! Bookmark not defined.**
  - A. Introduction ..... **Error! Bookmark not defined.**
  - B. Final Response Format and Contents ..... **Error! Bookmark not defined.**
    - 1. General Instructions ..... **Error! Bookmark not defined.**
  - C. Proposal Submission ..... **Error! Bookmark not defined.**
- V. Evaluation ..... **Error! Bookmark not defined.**
  - A. Introduction ..... **Error! Bookmark not defined.**
  - B. Receipt..... **Error! Bookmark not defined.**
  - C. Proposal Evaluation Matrix ..... **Error! Bookmark not defined.**
- VI. Attachments ..... 14
  - 1. Intent to Bid Form..... 14
  - 2. Bidder Checklist ..... 14
  - 3. Confirmation..... 14
  - 4. Licenses ..... 14

Covered California

5.	Product Filings .....	14
6.	Plan/Product Bids by Rating Region.....	14
7.	Licensed Geographic Service Arrest .....	14
8.	Premium Tables (EHB) .....	14
9.	Premium Tables (Supplemental Individual) .....	14
10.	Premium Tables (Supplemental SHOP) .....	14
11.	Technical Specifications .....	14
12.	Performance Measures.....	14
13.	Confirmations of Provided Documentation .....	14
14.	Additional Questions and requirements.....	14
15.	EHB Benefit Plan Design .....	14
16.	Proposed Supplemental Benefit Plan Design.....	14

# 1. GENERAL INFORMATION AND BACKGROUND

## PURPOSE

The California Health Benefit Exchange (Exchange) is accepting applications from dental issuers<sup>1</sup> (Applicants) to submit proposals to offer, market, and sell dental plans through the Exchange beginning in 2015. The Exchange will exercise its statutory authority as an “active purchaser<sup>2</sup> in reviewing submitted proposals and reserves the right to select or reject any Applicant or to cancel this Application at any time. This Application invites responses from vendors for both the Standalone Dental Plans (SADP) that will be considered for coverage of the Pediatric Dental Essential Health Benefits (EHB), and for Family Dental Plans<sup>3</sup> that combine coverage of the Pediatric Dental EHB and supplemental coverage and may be purchased on a voluntary basis. The Exchange seeks to award a limited number of contracts related to the SADP and to the Family Dental Plan for each geographic region, while ensuring that statewide coverage is available.

Applications will be accepted from any dental issuer that is licensed to sell dental plans regulated by the California Department of Managed Health Care or a dental insurance product licensed by the California Department of Insurance, including dental plans and health plans that offer dental coverage separate from medical coverage.

The Exchange welcomes dental issuers to submit proposals for both SADP and Family Dental Plan products. Applicants licensed in both the Individual and SHOP markets are encouraged to submit proposals for both market segments.

This Application may be amended by addenda at any time. Issuers who have responded to the Notice of Intent to Apply will be notified of posted changes to the Application; all interested applicants may obtain information and updates from the Exchange's web site.

The matter contained in this document is strictly related to the 2015 year Issuer Dental Plan Application.

## BACKGROUND

Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California became the first state to enact legislation to establish a qualified health benefit exchange. (California Government Code § 100500 et seq.; Chapter 655, Statutes of 2010-Perez and Chapter 659, Statutes of 2010-Alquist.) The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).

Effective January 1, 2014, the California Health Benefit Exchange offers a statewide health insurance exchange to make it easier for individuals and small businesses to compare plans and buy health insurance in the private market. Although the focus of the Exchange is on individuals and small businesses who qualify for tax credits and subsidies under the ACA, the Exchange's goal is to make insurance available to all qualified individuals and to all California businesses with fewer than 50 employees.

The vision of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

The California Health Benefit Exchange is guided by the following values:

---

<sup>1</sup> The term “dental issuer” used in this document refers to dental plans regulated by the California Department of Managed Health Care or the California Department of Insurance. It also refers to the company issuing dental coverage.

<sup>2</sup> California GC §100505 per AB 1602 §9

<sup>3</sup> Family Dental Plan means an approved specialized health plan that covers specified adult dental services and specified pediatric dental services which include, at a minimum, the pediatric dental Essential Health Benefit as outlined in California Health and Safety Code Section 1367.005 and California Insurance Code 10112.27

- **Consumer-Focused:** At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.
- **Affordability:** The Exchange will provide affordable health insurances while assuring quality and access.
- **Catalyst:** The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable healthcare, promoting prevention and wellness, and reducing health disparities.
- **Integrity:** The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Partnership:** The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.
- **Results:** The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.

In addition to being guided by its mission and values, the Exchange's policies are derived from the Federal Affordable Care Act which calls upon Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The California Health Benefit Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability, and prevention. The Exchange needs to address these issues for the millions of Californians who will enroll through it to get coverage, but also must be part of broader efforts to improve care, improve health, and control health care costs.

The California Health Benefit Exchange must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small group health insurance will operate in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, the Exchange has the responsibility to "certify" the Qualified Plans that will be offered in the Exchange for Essential Health Benefits.

The state legislation to establish the California Health Benefit Exchange directed it to "selectively contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service" and to establish and use a competitive process to select the participating health plan Issuers.

These concepts, and the inherent trade-offs among the California Health Benefit Exchange values, must be balanced in the evaluation and selection of the Qualified Health Plans that will be offered on the Individual and the SHOP Exchanges.

As outlined in the Board Options and Recommendations Briefs for Qualified Health Plan Policies and Strategies, the plan selection will influence how competitive the market will be, the cost of coverage, and strategies to add value through health care delivery system improvement.

## APPLICATION EVALUATION AND SELECTION

While evaluating the dental plan proposals, the Exchange will consider the mix of dental plans that best meet the Exchange's goals of providing an appropriate range of high quality choice to participants at the best

available price, while promoting the broad goals described above. In consideration of the mission and values of the Exchange, there are a number of evaluation principles that will be applied. These include the following:

- Promote affordability for the consumer and small employer – both in terms of premium and at point of care

The Exchange seeks to offer health and dental plans, plan designs and provider networks that are as affordable as possible to consumers in terms of premiums and at the point of care, while fostering competition and stable premiums. The Exchange will seek to offer health and dental plans, plan designs and provider networks that will attract maximum enrollment as part of the Exchange's effort to lower costs by spreading risk as broadly as possible.

- Encourage "Value" Competition Based upon Quality, Service, and Price

While premium price and out-of-pocket costs will be a key consideration, contracts will be awarded based on determination of "best value" to the Exchange and its participants. The evaluation of issuer dental plan proposals will also focus on quality and service components, including past history of performance, reported quality and satisfaction metrics, and commitment to serve the Exchange population through cooperation with the Exchange operations, provider network adequacy, and cultural and linguistic competency. We expect that some necessary regulatory and rate filings may need to be completed after the due date for this dental plan application. The application responses, in conjunction with the approved filings, will be evaluated by Covered California and used as part of the selection criteria to offer issuers' products on the Exchange for the 2015 plan year.

- Encourage Competition Based upon Meaningful Dental Plan Choice and Product Differentiation: Standard Benefit Plan Designs<sup>4</sup>

The Exchange is committed to fostering competition by offering dental plans with features that present clear choice and product differentiation. Dental plan applicants are required to propose at least one of the Exchange's adopted standardized benefit plan designs (DPPO, DHMO or DEPO), in each region for which they submit a proposal. Issuers must propose both SADP and Family Dental Plan products. To the extent possible, both DHMO and DPPO products will be offered. Within a given product design, the Exchange will look for differences in network providers. Under such criteria, the Exchange may choose not to contract with two plans with overlapping networks within a rating region.

- Encourage Competition throughout the State

The Exchange must be statewide. Issuers are required to submit dental plan proposals in all geographic service areas in which they are licensed and have adequate networks, and preference will be given to issuers that develop dental plan bids that meet quality and service criteria while offering coverage options that provide reasonable access to the geographically underserved areas of the state as well as the more densely populated areas.

- Encourage Alignment with Providers and Delivery Systems that Serve the Low Income Population

Central to the Exchange's mission is its performing effective outreach, enrolment and retention of the low income and culturally diverse population that will be eligible for premium tax credits and cost sharing subsidies through the Exchange. Responses that demonstrate an ongoing commitment or the development of the capacity to serve the cultural, linguistic and dental care needs of the low income and uninsured populations, beyond the minimum requirements adopted by the Exchange, will receive additional consideration. Examples of demonstrated commitment may include contracting with Federally Qualified Health Centers, and support or investment in providers and networks that have historically served these populations in order to improve service delivery and integration.

## Encourage Long Term Partnerships with Health Plan Issuers

---

<sup>4</sup> The 2015 Standard Benefit Designs are expected to be finalized in March 2014.  
Dental Plan New Entrant Application – DRAFT 2-3-2014

A goal of the Exchange is to reward early participation in the Exchange with contract features that offer a potential for market share and program stability. The Exchange encourages Issuer interest in multi-year contracts (plan year 2015 and 2016) and submitting rates at the most competitive position possible, fosters rate and plan stability and encourages SADP and Family Dental Plan investments in product design, network development, and quality improvement programs. Application responses that demonstrate an interest and commitment to the long-term success of the Exchange's mission are strongly encouraged, particularly those that include underserved service areas, and that leverage Issuer efforts to provide better care, improve health, and lower cost.

#### AVAILABILITY

The dental plan issuer must be available immediately upon certification as a dental plan to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems, and to provide additional information necessary for the Exchange to market, enroll members, and provide dental plan services effective January 1, 2015. Successful applicants will also be required to adhere to certain provisions through their contracts with the Exchange including but not limited to meeting data interface requirements with CalHEERS<sup>5</sup>. The Exchange expects to negotiate and sign contracts prior to September 1, 2014. The successful applicants must be ready and able to accept enrollment as of October 15, 2014.

#### INTENTION TO SUBMIT A RESPONSE

Applicants interested in responding to this application should submit the completed Intent to Apply form by March 17, provided in Attachment 1, indicating their interest in applying and their proposed products, service areas and the like and to ensure receipt of additional information. Only those bidders acknowledging interest in this solicitation by submitting a notification of intention to submit a bid will continue to receive application-related correspondence throughout the application process.

The Applicant's notification letter will identify the contact person for the application process, along with contact information that includes an email address and a telephone number. Receipt of the non-binding letter of intent will be used to issue instructions and login and password information to gain access to the online portion of the Applicant submission of response to the Application.

An issuer's submission of an Intent to Apply will be considered confidential information and not available to the public; the Exchange reserves the right to release aggregate information about issuers' responses. Final Applicant information is not expected to be released until selected issuers and Dental Plan issuers are announced in late June 2014. Confidentiality is to be held by the Exchange; Applicant information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between the Exchange and the regulators.

The Exchange will correspond with only one (1) contact person per Applicant. It shall be the Applicant's responsibility to immediately notify the Contact Person identified in this section, in writing, regarding any revision to the contact information. The Exchange shall not be responsible for application correspondence not received by the Applicant if the Applicant fails to notify the Exchange, in writing, of any changes pertaining to the designated contact person.

#### **Application Contact:**

Pamela Power

Pamela.power@covered.ca.gov

(916) 228-8374

---

<sup>5</sup> California Healthcare Eligibility, Enrollments and Retention System -- The Exchange's eligibility and enrollment system  
Dental Plan New Entrant Application – DRAFT 2-3-2014



## APPLICATION LIBRARY

Applicants may access the Application Library at: [\[link here\]](#)

Applicants may access documents and information here that may be useful for developing their responses. As further documentation related to the application becomes available it will be posted here. Amendments to this Application will not be issued when new information is posted to The Exchange's website. Applicants are encouraged to continuously monitor The Exchange's website.

## KEY ACTION DATES

Listed below is a series of key actions related to this solicitation, along with the corresponding dates and times by which each key action must be taken or completed. If the Exchange finds it necessary to change any of these dates, such changes will be accomplished through addenda to this solicitation. All dates subsequent to the final response submission deadline are approximate and may be adjusted as conditions warrant, without addenda to this solicitation.

Action	Date/Time
Release of Draft Application	February 3, 2014
Release of Revised Draft Application	February 20, 2014
Release of Final Application	March 10, 2014
Intent to Apply notifications due to Exchange	March 17, 2014
Completed New Entrant Applications Due (include 2015 Proposed Rates and Networks)	May 1, 2014
Negotiations between New Entrants and Covered California	June 2014
Contingent New Entrant Dental Plan Certification	June 30, 2014
Final Dental Plan Recertification/Decertification/New Entrant Certification Decisions	August 30, 2014
New Entrant Dental Plan Contract Execution	September 1, 2014

## 2. TECHNICAL REQUIREMENTS

Applicants are required to provide the information requested below. The responses must be provided through completion of the accompanying attachments.

### LICENSED AND IN GOOD STANDING

2.1 In addition to holding all of the proper and required licenses<sup>6</sup> to operate as a dental plan issuer as defined herein, the Applicant must demonstrate that it is in good standing with all appropriate local, state, and federal licensing authorities. Good standing means that the Applicant has had no material fines, penalties levied, citations, or ongoing disputes with applicable licensing authorities in the last two years.

Please refer to Attachment 3 to provide your confirmation.

2.2 The Applicant must acknowledge any ongoing labor disputes, penalties, fines, or corrective action citations for federal or state workplace safety issues.

Please refer to Attachment 3 to provide your acknowledgement.

<sup>6</sup> The Exchange reserves the right to require licenses to be in place at the time of dental plan selection in the case of new applicants for licenses. Bidders who are not yet licensed should indicate anticipated date of licensure.  
Dental Plan New Entrant Application – DRAFT 2-3-2014

- 2.3 The Applicant must acknowledge whether it is seeking a certificate of authority or an amendment to an existing certificate of authority from the relevant regulatory agency in order to meet the requirements of individual and small group products to be offered on the California Health Benefit Exchange.

Please refer to Attachment 3 to provide your acknowledgement. If such a certificate or amendment is sought, refer to Attachment 4 to provide the requested details.

- 2.4 Separate from the Applicant's response to this solicitation, an Applicant is responsible for submitting all required material to the California regulatory agency necessary to obtain approval of products/plans that are to be submitted in response to this application. Applicant must acknowledge that all such product filings have been submitted for regulatory review.

Please refer to Attachment 3 to provide your acknowledgement. Refer to Attachment 5 to provide the requested details associated with such product filings

The California Department of Managed Care (DMHC) and the California Department of Insurance (CDI) have primary responsibility for regulatory review and issuing preliminary recommendations to the Exchange of certain selection criteria listed below in the definition of good standing in addition to applying the minimum licensure requirements. The Issuer is expected to be responsive to questions raised by the agencies in their review.

Please refer to Attachment 3, to provide your confirmation.

See Appendix A Definition of Good Standing.

### 3. PLAN OR POLICY SUBMISSION REQUIREMENTS

Applicant must certify that for each rating region in which it submits a dental plan proposal it is submitting proposals for the required Standard Plan Designs for SADP and for Family Dental Plans. Applicants must adhere to the 2015 Standard Plan Designs. The Exchange will provide draft Standard Plan Designs in Attachment 15 (SADP) and Attachment 16 (Family Dental Plan). Final 2015 Standard Plan Designs are expected in March 2014.

1. Applicants must submit a proposal for both the SADP and Family Dental Plan products.

Please refer to Attachment 3 to provide your confirmation. Please refer to Attachment 6 to indicate the rating regions and number of plans for which you are submitting a dental plan proposal.

2. Applicants may submit DPPO, DHMO and/or DEPO plan product proposals, but must adhere to the 2015 Standard Plan Designs for both the SADP and Family Dental Plan products.
3. Applicants are required to submit product proposals that cover their entire licensed service area, and must certify that they have done so. Applicants may choose to propose for only their Individual or Small Group licensed area, or may offer coverage in both markets. Applicants licensed in both the Individual and SHOP markets are encouraged to propose both market segments.

Please refer to Attachment 3 to provide your confirmation. Please refer to Attachment 7 to complete the crosswalk of licensed service area zip codes and rating region for each dental plan product.

#### 3.1 CONTRACTING WITH DENTAL PROVIDERS WHO SERVE THE LOW INCOME AND UNINSURED POPULATIONS

For SADPs, Applicants should demonstrate the extent to which their proposal includes participation of dental providers with a history of serving low-income and uninsured populations. Preference will be given to those Applicants that include providers with a history of serving the low income and uninsured population.

Applicants shall use the county low income population data to submit the following geo-maps of each county within the proposed geographic service area (county maps may be aggregated for the service area).

- a. FQHC providers plotted on a low-income population map, by county.
- b. Other providers that serve the low-income population, defined as those providers for whom at least 20% of patients served are low income, by county. Note that a proxy for low-income patients may be Medi-Cal or Healthy Families enrollees or individuals eligible for income-based fee consideration.

County data on distribution of the California Low-Income Population is available within the Application Library on the Exchange website. Low-income is defined as a family at or below 200% of Federal Poverty Level. The data supplied will allow Applicants to plot contracted FQHC locations on county maps which display the low-income population. Issuers will be responsible for mapping other low-income providers.

### 3.2 QUALITY IMPROVEMENT STRATEGY - PROMOTING - BETTER CARE, BETTER HEALTH, AND LOWER COST

Consistent with the Exchange's mission to promote better care, better health and lower cost as part of a Quality Improvement Strategy, please refer to Attachment 3 to provide statements confirming your organization will:

- a). Implement a quality assurance program in accordance with Title 2, CCR, Section 1300.70, for evaluating the appropriateness and quality of the covered services provide to members
- b). Maintain a system of accountability for quality improvement in accordance with all applicable statutes and regulations, monitoring, evaluating and taking effective action to address any needed improvements, as identified by The Exchange, in the quality of care delivered to members.

## 4. TECHNICAL SPECIFICATIONS

Please refer to Attachment 11 to respond to Technical Specification questions, confirmations and requests for information. These requests are organized into the following categories:

### 4.1 GENERAL

### 4.2 ACCOUNT MANAGEMENT SUPPORT

### 4.3 IMPLEMENTATION

### 4.4 ACCOUNT ADMINISTRATION

### 4.5 MEMBER SERVICES

### 4.6 CARE MANAGEMENT

### 4.7 COMMUNICATIONS & EDUCATION

### 4.8 PROVIDER NETWORK

### 4.9 SYSTEMS AND DATA REPORTING MANAGEMENT

## 5. PERFORMANCE MEASURES (QUALITY)

Please refer to Attachment 12 to provide your organization's performance measures relevant to the rating regions for which you are applying. If you are applying for a region for which you do not have recent experience, provide your experience for California and note the reason that region specific experience is not available. If you do not have recent California experience provide your national experience and note the reason that California experience is not available.

## 6. DOCUMENTATION

Please confirm in Attachment 13 that you have provided the following documentation for the Exchange's review.

- 6.1 An organizational chart of your California operations, including individual and small group line(s) of business
- 6.2 An organizational chart for the team proposed to staff the Exchange account. Show lines of authority up to and including the executive management level. Include all functions such as account management, claims, member services, billing, individual and small group sales and marketing department etc.
- 6.3 A listing of the individual(s) who will have primary responsibility for staffing the Exchange account. Please indicate where these individuals fit into the organizational chart requested above. Please include the following information and repeat as necessary.
  - Name
  - Title
  - Department
  - Primary responsibilities
  - Phone
  - Fax
  - E-mail
- 6.4 An implementation project plan and timeline including all necessary steps and events (including testing), required to achieve full implementation by January 1, 2015
- 6.5 Audited financial statements for the past two (2) available years, or in their absence, provide documentation that allows for the assessment of your organizations financial stability.
- 6.6 A sample ID card.
- 6.7 Samples of the following standard member communications materials:
  - Introductory pre-open enrollment
  - Welcome package
  - Summary plan description (SPD)
  - Preventive reminders
  - Explanation of benefits (EOB)
- 6.8 An excerpt of your provider network directory for a zip code, or access to your online directory.
- 6.9 A standard claims form and the associated claim submission instructions.
- 6.10 A sample customer satisfaction survey

- 6.11 The most recent customer service survey results
- 6.12 The web address to access your online provider directory

## 7. ADDITIONAL QUESTIONS AND/OR REQUIREMENTS

Please refer to Attachment 14 to respond to all Additional Questions and/or Requirements. These requests are organized into the following categories:

### 7.1 AGENT RELATIONS, FEES, AND COMMISSIONS<sup>7</sup>

### 7.2 MARKETING AND OUTREACH ACTIVITIES

### 7.3 OPERATIONAL REPORTING REQUIREMENTS AND INTERFACES

Reporting requirements will be developed to allow the Issuer to maintain interfaces with the Exchange portal and for the Exchange to monitor Issuer operational performance. For example, dental plans will be required to provide provider network data to allow the Exchange to create a centralized provider directory. Required provider data elements will be provided soon.

New Entrant dental plans will be required to build data interfaces with the Exchange's eligibility and enrollment systems and to report on transactions.

## 8. COST PROPOSAL

Final negotiated and accepted premium proposals shall be in effect for the first full year of operation of the Exchange, effective January 1, 2015, or for the SHOP plan year. Premium proposals are considered preliminary and may be subject to negotiation as part of dental plan certification and selection.

Complete Attachments 8, 9 and 10 to provide your premium bids for the SADP, Family Dental Plan - Individual and Family Dental Plan - SHOP plans and market segments. For each dental plan product, enter preliminary premium for dental plan products to be offered in the Exchange. Premium may vary only by geography (rating region) by coverage tier, and by actuarial value level.

---

<sup>7</sup> For SHOP Exchange Applicants only  
Dental Plan New Entrant Application – DRAFT 2-3-2014

9. ATTACHMENTS

1. INTENT TO APPLY FORM
2. APPLICANT CHECKLIST
3. CONFIRMATION
4. LICENSES
5. PRODUCT FILINGS
6. PLAN/PRODUCT PROPOSALS BY RATING REGION
7. LICENSED GEOGRAPHIC SERVICE AREA
8. PREMIUM TABLES (SADP)
9. PREMIUM TABLES (FAMILY DENTAL PLAN INDIVIDUAL)
10. PREMIUM TABLES (FAMILY DENTAL PLAN SHOP)
11. TECHNICAL SPECIFICATIONS
12. PERFORMANCE MEASURES
13. CONFIRMATIONS OF PROVIDED DOCUMENTATION
14. ADDITIONAL QUESTIONS AND REQUIREMENTS
15. SADP BENEFIT PLAN DESIGN
16. PROPOSED FAMILY DENTAL PLAN BENEFIT DESIGN

Appendix A Definition of Good Standing

Definition of Good Standing	Agency	Relevant To EHB	Relevant to Supplemental
<u>Verification that issuer holds a state health care service plan license or insurance certificate of authority.</u>			
<ul style="list-style-type: none"> <li>Approved for what lines of business (e.g. commercial, small group, individual)</li> </ul>	DMHC	X	X
<ul style="list-style-type: none"> <li>Approved to operate in what geographic service areas</li> </ul>	DMHC	X	X
<ul style="list-style-type: none"> <li>Most recent financial exam and medical survey report</li> </ul>	DMHC	X	X
<ul style="list-style-type: none"> <li>Most recent market conduct exam</li> </ul>	CDI	X	X
<u>Affirmation of no material<sup>8</sup> statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable:</u>			
<ul style="list-style-type: none"> <li>Financial solvency and reserves reviewed</li> </ul>	DMHC and CDI	X	X
<ul style="list-style-type: none"> <li>Administrative and organizational capacity</li> </ul>	DMHC	X	X
<ul style="list-style-type: none"> <li>Benefit Design                             <ul style="list-style-type: none"> <li>State mandates (to cover and to offer)</li> </ul> </li> </ul>	DMHC and CDI	X	
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>Essential health benefits<sup>9</sup> Pediatric Dental only</li> </ul> </li> </ul>	DMHC and CDI	X	
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>Basic health care services</li> </ul> </li> </ul>	CDI	X	
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>Copayments, deductibles, out-of-pocket maximums</li> </ul> </li> </ul>	DMHC and CDI	X	
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>Actuarial value confirmation (using 2015 Actuarial Value Calculator)</li> </ul> </li> </ul>	DMHC and CDI	X	
Network adequacy and accessibility standards	DMHC and CDI	X	
Provider contracts	DMHC and CDI	X	
Uniform disclosure (summary of benefits and coverage)	DMHC and CDI	X	
Claims payment policies and practices	DMHC and CDI	X	X
Provider complaints	DMHC and CDI	X	X
Utilization review policies and practices	DMHC and CDI	X	X
Quality assurance/management policies and practices	DMHC	X	
Enrollee/Member grievances/complaints and appeals policies and practices	DMHC and CDI	X	X
Independent medical review	DMHC and CDI	X	
Marketing and advertising	DMHC and CDI	X	
Guaranteed issue individual and small group	DMHC and CDI	X	X

<sup>8</sup> Covered California will, at its sole discretion, determine what constitutes a material violation for this purpose.