Albuquerque Bernalillo County
Water Utility Authority

Agenda Item No. 8g

Meeting Date: December 4, 2018
Staff Contact: Judy Bentley, Human Resources Manager

TITLE: C-18-43 - Contract with Delta Dental for Fully Insured Group Dental Insurance

ACTION: Recommend Approval

Summary:
The Water Authority Human Resources department is requesting approval to enter into an agreement with Delta Dental Plan of New Mexico, Inc. (Delta) pursuant to the City of Albuquerque CCN number 201800909 and RFP number P2018000015, to provide group dental insurance to employees through the issuance of a purchase order.

If approved by the Board, a purchase order will be issued by the Water Authority to enable the recommended dental insurance provider, Delta, to provide dental benefits to employees.

By entering into this agreement, the Water Authority will be able to provide fully insured group dental insurance to Water Authority employees and their dependents. The City of Albuquerque agreement may be extended for up to five additional one-year periods.

FISCAL IMPACT:
$500,000 excluding NM GRT for FY19, for which appropriations have already been made in the FY19 Operating Budget.

AGREEMENT

THIS AGREEMENT is made and entered into this 1st day of July, 2018, by and between the City of Albuquerque, New Mexico, a municipal corporation (hereinafter referred to as the "City"), and Delta Dental of New Mexico, Inc. 2500 Louisiana Blvd. NE, Suite 600 Albuquerque, NM 87110 (hereinafter referred to as the "The Contractor").

RECITALS

WHEREAS, the City provides group dental insurance for the benefit of its employees; and

WHEREAS, the City has issued Request for Proposal ("RFP") P2018000015 entitled "Group Dental Insurance" attached hereto and incorporated herein as **Exhibit 1**, to solicit competitive bids to provide group benefits to employees; and

WHEREAS, The Contractor submitted its response dated December 21, 2017 to RFP P2018000015 which is attached hereto and incorporated herein as Exhibit 2; and

WHEREAS, The Contractor has been selected by the City to provide dental insurance to employees; and

WHEREAS, the Parties wish to provide for participation by other Governmental Entities; and

WHEREAS, the City desires to engage the Contractor to render certain services in connection therewith and the Contractor is willing to provide such services.

NOW THEREFORE, in consideration of the premises and mutual obligations herein, the parties hereto do mutually agree as follows:

1. **Scope of Services.** The Contractor shall perform the following services (hereinafter referred to as the 'Services') in a satisfactory and proper manner and in accordance with the terms set forth in the Agreement in accordance with the following documents: RFP P2018000015 (Exhibit 1); the proposal submitted by the Contractor in response to the RFP (Exhibit 2); the Delta Dental Group Summary of Benefits attached hereto and incorporated as Exhibit 3; the list of Other Governmental Entities attached hereto and incorporated as Exhibit 4; City of Albuquerque Participation Guidelines attached hereto and incorporated as Exhibit 5; the Delta Dental Group Member Handbook attached hereto and incorporated as Exhibit 6; and the Performance Guarantees attached hereto and incorporated as Exhibit 7.

The Contractor agrees that Other Governmental Entities included in Exhibit 4 shall be allowed to participate in this Agreement through execution of an agreement of participation. The City shall not be responsible for the obligations of the Other Governmental Entities'. All Other Governmental Entities' receiving benefits under this

agreement shall be bound by the terms and conditions contained herein. The City's participation agreement with the Other Governmental Entities' shall require all Other Governmental Entities' who accept benefits under this Agreement, to agree that all terms and conditions contained herein shall be directly enforceable by Contractor against such Other Governmental Entities'.

2. **Time of Performance.** Services of the Contractor shall commence on July 1, 2018, and shall be undertaken and completed in such sequence as to assure their expeditious completion in light of the purposes of this Agreement; provided, however, that in any event, all of the Services required hereunder shall be completed by June 30, 2019. This Agreement may be extended for five (5) additional one (1)-year periods by mutual written agreement between the City and the Contractor.

3. **Compensation and Method of Payment.**

A. **Compensation.** For performing the Services specified in Section 1 hereof, the City and/or Other Governmental Entities agree to pay the Contractor monthly fees based on the rates listed in subsection C. of this Section 3 ("Rates") for participating employees and dependents, which amounts do not include any applicable taxes. Any taxes applicable to the City or Other Government Entities shall be paid by the City and/or Other Governmental Entities accordingly. The Rates excluding applicable taxes that are the responsibility of the City and/or Other Governmental Entities, constitute full and complete compensation for the Contractor's Services under this Agreement, and include all expenditures made and expenses incurred by the Contractor in performing such Services. Under no circumstances shall the Contractor be responsible for any new or existing taxes that are the responsibility of the City and/or Other Governmental Entities.

B. **Method of Payment.** The City and/or Other Governmental Entities understands that the Contractor is offering a prepaid dental insurance plan and the City and/or Other Governmental Entities will therefore issue an initial prepayment of one (1) month's premium for all covered employees and dependents upon identifying the new plan year enrollment level, followed by monthly payment for actual covered employees and dependents. The final payment of the contract period will be adjusted to recover the initial prepayment. Payment of the total amount of monthly prepayments due hereunder shall be made by the City and/or Other Governmental Entities in advance of each month that the City and/or Other Governmental Entities employees and dependents are enrolled with the Contractor. If payment is not received by the Payment Due Date (Defined below), the City and/or Other Governmental Entities shall have a grace period of forty-five (45) calendar days within which to make payment in full ("Grace Period"). The Contractor may, subsequent to the Grace Period, suspend its performance and represent to providers and other third parties that the Defaulting Agency(ies)' employees and dependents are "not eligible" for coverage with the Contractor. The Contractor can continue to show such Defaulting Agency(ies)' employees and dependents as "not eligible" until such time as payment in full is made by Defaulting Agency(ies). The Contractor shall cover claims during such period if the premium for the suspension period has been paid in full within forty-five (45) calendar days of the Grace Period. Acceptance

of late or partial payments by the Contractor shall not constitute a waiver of any present or future rights the Contractor would otherwise have under this Agreement. The City and each Other Governmental Entity agrees to pay as mutually agreed, in accordance with subsection 1 (Pay As Billed) or subsection 2 (Self Billed).

1. **Pay As Billed**. The Contractor shall bill the City and/or Other Governmental Entities on or before the 25th calendar day of each month for the subsequent month's coverage ("Payment Bill Date"). The delivery date of the billing will be defined as the date the detailed billing is posted on the Delta Dental Benefit Manager Toolkit (a secure online tool for Plan Administrators). Payment in the amount of the Contractor's bill must be received in full by the Contractor on or before the first day of the month of coverage ("Payment Due Date").

2. **Self-Billed**. Following the initial prepayment, City and Other Governmental Entities will initiate payment of the aggregate prepayment fee. The aggregate prepayment fee is due on or before the first day of the month of coverage based on enrollment lists generated by the City and/or Other Governmental Entities on the 25th calendar day of the month prior to the month for which payment is due. The list will be financially adjusted to reflect enrollments and terminations which have occurred during the ninety (90) day period immediately preceding issuance of the lists. The lists will also be updated to reflect adjustments resulting from City and/or Other Governmental Entities reconciliation action.

C. Premium Rates. In consideration of the enrollment by the Contractor of eligible employees and dependents, the City and/or Other Governmental Entities agree to pay to the Contractor the following monthly prepayment for each employee and dependent enrolled, based on the coverage selected by such employee. The Contractor and the City and/or Other Governmental Entities agree that prepayment for Cobra subscribers are managed by a COBRA Administrator of the City and/or Other Governmental Entities choice, and the City and/or Other Governmental Entities are responsible to ensure the Contractor's receipt of payment in accordance with this section. The monthly premium payments for this Agreement only (July 1, 2018 to June 30, 2019) are as follows for each of the contract types listed herein:

(1) **FY/19 Rates**

Employee	$31.64
Employee and Spouse	$63.98
Employee and Child(ren)	$70.29
Employee and Family	$95.16

(2) Except as otherwise provided herein, the above Rates are guaranteed for the full fiscal year commencing on the effective dates reflected above.

(3) The "15-day rule" will apply to new enrollments and terminations that occur during the plan year. The 15-day rule affects monthly payments as follows:

a. Enrollment. The City and/or Other Governmental Entities will pay a full monthly prepayment fee for covered employees and dependents who enroll on or before the 15th calendar day of the month of enrollment but will not pay a monthly prepayment fee for employees and dependents who enroll on or after the 16th calendar day of the month of enrollment.

b. Termination. The City and /or Other Governmental Entities will not pay a monthly prepayment fee for covered employees and/or dependents who terminate coverage on or before the 15th calendar day of the month of termination but will pay a monthly prepayment fee for employees and/or dependents who terminate coverage on or after the 16th calendar day of the month of termination.

(4) On each monthly prepayment, the City and/or Other Governmental Entities will include adjustments for prior month new enrollments and terminations, applying the 15-day rule. The City and/or Other Governmental Entities, by identifying a covered employee and dependents on the payment document as terminated or by failing to list a covered employee and dependents on the payment document, authorizes the Contractor to immediately discontinue (terminate) Services to the employee and dependents pending resolution of the non-payment problem. In cases where an employee fails to notify the City Insurance Office of termination of employment or other loss of eligibility and the City has continued to issue a prepayment fee on behalf of the employee and dependents, the City will be entitled to a premium refund for the overpayment, not to exceed a ninety (90) day refund from the date of preparation and submittal of a termination form to the Contractor, provided that the City and/or Other Governmental Entities explicitly understand and agree that the exercise of this right shall then result in the Contractor retroactively terminating coverage for the applicable employee and dependents (as of the last effective date for which premium was paid) and recoup from providers of care all claim payments and other amounts incurred on behalf of such employee and dependents after the retroactive date of termination. The City and/or Other Governmental Entities understand and agree that the terminated employee and dependents shall be solely responsible for the payment of all such claims. If through administrative error, the City and/or Other Governmental Entities continue to pay a prepayment fee for a terminated employee and dependents after submittal of termination forms to the Contractor, the City and/or its Other Governmental Entities will be entitled to a refund of all payments made after submittal of termination forms. The City and/or Other Governmental Entities will make such adjustments on the monthly prepayment report.

D. **Reconciliation of Payment Discrepancies.**

(1) **834 Electronic Full File Transmission.** As mutually agreed, a standard 834 electronic full file will be transmitted to the Contractor. The Contractor will load the file and report questionable discrepancies to the City and/ or

applicable Other Governmental Entities within two (2) business days. The City and/ or applicable Other Governmental Entities will respond to the Contractor on discrepancies within three business days of receipt of report.

(2) **The City and/or Other Governmental Entities.** Monthly prepayments shall be subject to reconciliation by the Contractor. The Contractor shall compare information on the payment schedule with Contractor information to identify discrepancies in covered employees and dependents, prepayment fees, contract types or other discrepancies. Upon identifying discrepancies, the Contractor will first research its own files to account for enrollments, terminations, changes in contract types (e.g., single, couple, single parent or family) which have recently been received by the Contractor.

(3) After completing an internal accounting of discrepancies, the Contractor will transmit to the City and/or applicable Other Governmental Entities a list of covered employees and dependents for whom names or status do not match. The list transmitted to the City and/or applicable Other Governmental Entities for a specific week or month shall be the basis for all further reconciliation of discrepancies and financial adjustment for the week or month reconciled. The City and/or applicable Other Governmental Entities will research discrepancies, make a determination as to the financial amounts identified by the Contractor, make the appropriate adjustment on the subsequent monthly payment and provide the Contractor with an explanation and supporting documentation for any disputed amounts. Adjustments for any amounts payable or refundable to either party will be made only for a ninety (90)-day period from the first day of the month reconciled or employees and dependents for whom a premium payment has not been made will be terminated back to the last day for which payment was made by the City and/or applicable Other Governmental Entities and Contractor shall have the right to suspend the City and/or applicable Other Governmental Entities right to self-bill. If applicable Other Governmental Entities utilizing the Self-Billed options do not respond to Contractor regarding reconciliation discrepancies as described above, Contractor shall have the authorization under this Agreement to suspend such applicable Other Governmental Entities right to self-bill.

E. **Communication of Member Eligibility.** Member eligibility will be communicated by the City to the Contractor by mailing, faxing, or emailing the form to the Contractor, manually entering data through the Contractor's website or by sending a standard 834 electronic file. The City and/or other Governmental Entity will be responsible for submitting timely and accurate eligibility files to Contractor. The Contractor shall not be responsible for any claims processing errors resulting from the City's and/or other Governmental Entity's failure to comply with this subparagraph.

4. **Appropriations.** Notwithstanding any provision in this Agreement to the contrary, the terms of this Agreement are contingent upon the City Council of the City of Albuquerque making the appropriations necessary for the performance of this Agreement. If sufficient appropriations and authorizations are not made by the City Council, this Agreement may be terminated at the end of the City's then current Fiscal Year upon

written notice given by the City to the Contractor. Such event shall not constitute an event of default. All payment obligations of the City and all of its interest in this Agreement will cease upon the date of termination. The City's decision as to whether sufficient appropriations are available shall be accepted by Contractor and shall be final.

5. **Mid-Year Plan Changes.** The plan of benefits shall be guaranteed for FY19, subject to any legally required changes. Any mid-year plan changes initiated by the Contractor without prior agreement by the City, provided such changes are not legally required, shall entitle the City to allow employees and dependents affected by the plan change to an immediate mid-year switch enrollment period.

6. **Intergovernmental Agreement.** The City has entered into Intergovernmental Agreements with governmental entities which exist in the New Mexico area. For purposes of this agreement, the "City" shall mean the City of Albuquerque, New Mexico, a municipal corporation, and "Other Governmental Entity" shall mean the other organizations or employing benefits which have executed an Intergovernmental Agreement with the City to arrange for participation of group benefit plans. These Other Governmental Entities shall be entitled to all dental care services, benefits, and rates accorded to the City employees under this Agreement subject to its provisions.

7. **Independent Contractor.** Neither the Contractor nor its employees are considered to be employees of the City of Albuquerque for any purpose whatsoever. The Contractor is considered as an independent contractor at all times in the performance of the Services described in Section 1. The Contractor further agrees that neither it nor its employees are entitled to any benefits from the City under the provisions of the Workers' Compensation Act of the State of New Mexico, or to any of the benefits granted to employees of the City under the provisions of the Merit System Ordinance as now enacted or hereafter amended.

8. **Personnel.**

A. The Contractor represents that it has, or will secure at its own expense, all personnel required in performing all of the Services required under this Agreement. Such personnel shall not be employees of or have any contractual relationships with the City.

B. All the Services required hereunder will be performed by the Contractor or under its supervision and all personnel engaged in the work shall be fully qualified and shall be authorized or permitted under state and local law to perform such Services.

C. Except for Services performed by an affiliated entity, all Services subcontracted by Contractor must be approved in writing by the City. Any work or Services subcontracted hereunder shall be specified by written contract or Agreement and shall be subject to each provision of this Agreement.

9. **Indemnity.** The Contractor agrees to defend, indemnify and hold harmless the City and its officials, agents and employees from and against any and all claims, actions, suits or proceedings of any kind brought against said parties because of any injury or damage received or sustained by any person, persons or property arising out of or resulting from the negligent acts, omissions or misconduct of the Contractor or Contractor's agents or employees or any subcontractor or its agents or employees. The indemnity required hereunder shall not be limited by reason of the specification of any particular insurance coverage in this Agreement.

10. **Insurance.** The Contractor shall procure and maintain at its expense until final payment by the City for Services covered by this Agreement, insurance in the kinds and amounts hereinafter provided with insurance companies authorized to do business in the State of New Mexico, covering all operations under this Agreement, whether performed by it or its agents. Before commencing the Services and on the renewal of all coverages, the Contractor shall furnish to the City a certificate or certificates in form satisfactory to the City showing that it has complied with this Section. All certificates of insurance shall provide that thirty (30) days' written notice be given to the Risk Manager, Department of Finance and Administrative Services, City of Albuquerque, P.O. Box 470, Albuquerque, New Mexico 87103, before a policy is canceled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. With respect to all coverages required other than professional liability or workers' compensation, the City shall be named an additional insured. All coverages afforded shall be primary with respect to operations provided. Kinds and amounts of insurance required are as follows:

A. **Commercial General Liability Insurance.** A commercial general liability insurance policy with combined limits of liability for bodily injury or property damage as follows:

$1,000,000	Per Occurrence
$1,000,000	Policy Aggregate
$1,000,000	Products Liability/Completed Operations
$1,000,000	Personal and Advertising Injury
$ 50,000	Fire - Legal
$ 5,000	Medical Payments

Said policy of insurance must include coverage for all operations performed for the City by the Contractor, and contractual liability coverage shall specifically insure the hold harmless provisions of this Agreement.

B. **Automobile Liability Insurance.** An automobile liability policy with liability limits in amounts not less than $1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. Said policy of insurance must include coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment both on and off work.

C. **Workers' Compensation Insurance.** Workers' Compensation Insurance for its employees in accordance with the provisions of the Workers' Compensations Act of the State of New Mexico.

D. **Professional Liability (Errors and Omissions) Insurance.** Professional liability (errors and omissions) insurance in an amount not less than $1,000,000 combined single limit of liability per occurrence with a general aggregate of $1,000,000.

E. **Cyber Liability Insurance**. Cyber liability insurance, including but not limited to liability arising out of or associated with Internet activities and the use or operation of computers and computer networks not less than $2,000,000.

11. **Discrimination Prohibited.** In performing the Services required hereunder, the Contractor shall not discriminate against any person on the basis of race, color, religion, gender, sexual preference, sexual orientation, national origin or ancestry, age, physical handicap, or disability as defined in the Americans With Disabilities Act of 1990, as now enacted or hereafter amended.

12. **ADA Compliance.** In performing the Services required hereunder, the Contractor agrees to meet all the requirements of the Americans With Disabilities Act of 1990, and all applicable rules and regulations (the 'ADA'), which are imposed directly on the Contractor or which would be imposed on the City as a public entity. The Contractor agrees to be responsible for knowing all applicable requirements of the ADA and to defend, indemnify and hold harmless the City, its officials, agents and employees from and against any and all claims, actions, suits or proceedings of any kind brought against said parties as a result of any acts or omissions of the Contractor or its agents in violation of the ADA.

13. **Reports and Information.** At such times and in such forms as the City may require, there shall be furnished to the City such statements, records, reports, data and information, as the City may request pertaining to matters covered by this Agreement. Unless otherwise authorized by the City, the Contractor will not release any information concerning the work product including any reports or other documents prepared pursuant to this Agreement until the final product is submitted to the City.

14. **Open Meetings Requirements.** Any nonprofit organization in the City which receives funds appropriated by the City, or which has as a member of its governing body an elected official, or appointed administrative official, as a representative of the City, is subject to the requirements of § 2-5-1 et seq., R.O.A. 1994, Public Interest Organizations. The Contractor agrees to comply with all such requirements, if applicable.

15. **Establishment and Maintenance of Records.** Records shall be maintained by the Contractor in accordance with applicable law and requirements prescribed by the City with respect to all matters covered by this Agreement. Except as

otherwise authorized by the City, such records shall be maintained for a period of three (3) years after receipt of final payment under this Agreement.

16. **Audits and Inspections.**

A. Notwithstanding anything in this Agreement to the contrary, nothing herein, shall obligate The Contractor to disclose any information in violation of any State or Federal Law, Rule or Regulation, including specifically HIPAA. For purposes of this Agreement HIPAA is defined as the Health Insurance Portability and Accountability Act of 1996, and any regulations promulgated thereunder. In the event that the Contractor is required to provide any information or Services herein that requires a Business Associate Agreement because Contractor is considered a business associate pursuant to HIPAA, such information or Services shall not be provided until the applicable parties sign a Business Associate Agreement compliant with HIPAA.

B. At any time during normal business hours and as often as the City may deem necessary, there shall be made available to the City for examination all of the Contractor's records with respect to all matters covered by this Agreement. The Contractor shall permit the City to audit, examine, and make excerpts or transcripts from such records, and to make audits of all contracts, invoices, materials, payrolls, records of personnel, conditions of employment and other data relating to all matters covered by this Agreement. The Contractor understands and will comply with the City's Accountability in Government Ordinance, §2-10-1 et seq. R.O.A. 1994 and Inspector General Ordinance, §2-17-1 et seq. R.O.A. 1994, and also agrees to provide requested information and records and appear as a witness in hearings for the City's Board of Ethics and Campaign Practices pursuant to Article XII, Section 8 of the Albuquerque City Charter.

17. **Publication, Reproduction and Use of Material.** No material produced in whole or in part under this Agreement shall be subject to copyright in the United States or in any other country. The City shall have the right to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data or other materials prepared under this Agreement for purposes of administering its dental benefit plan. Within the limits of the New Mexico Inspection of Public Records Act, each Party shall hold in strict confidence and trust the other Party's ("Disclosing Party") Confidential Information and shall not disclose, sell, rent or otherwise provide or transfer, directly or indirectly, any Confidential Information or anything related to the Confidential Information to any person or entity without the prior written consent of the Disclosing Party. Notwithstanding the preceding sentence, the Party receiving Confidential Information ("Receiving Party") may disclose Confidential Information to its representatives, counsel, shareholders, directors, officers, employees, agents or consultants ("Representatives") who need to know such information in order to enable the Receiving Party to perform its obligations hereunder. The Receiving Party and its Representatives shall use the Disclosing Party's Confidential Information only in connection with the performance of the Receiving Party's obligations hereunder. The Receiving Party shall require any of its Representatives who obtain the Disclosing Party's Confidential Information to comply with this Agreement and shall be responsible for any breach of this Agreement by such Representatives.

18. **Compliance With Laws.** In performing the Services required hereunder, the Contractor shall comply with all applicable laws, ordinances, and codes of the federal, state and local governments.

19. **Changes.** The City may, from time to time, request changes in the Services to be performed under this Agreement. Such change requests must be submitted in writing at least thirty (30) days prior to the requested effective date. Upon mutual agreement, any changes and corresponding premium adjustments will become effective on the subsequent Fiscal Year and shall be incorporated in written amendments to this Agreement.

20. **Assignability.** The Contractor shall not assign any interest in this Agreement and shall not transfer any interest in this Agreement (whether by assignment or novation), without the prior written consent of the City thereto.

21. **Termination for Cause.** If, through any cause, the Contractor shall fail to fulfill in a timely and proper manner its obligations under this Agreement or if the Contractor shall violate any of the covenants, agreements, or stipulations of this Agreement, the City shall thereupon have the right to terminate this Agreement by giving written notice to the Contractor of such termination and specifying the effective date thereof at least thirty (30) days before the effective date of such termination. In such event, all finished or unfinished documents, data, maps, studies, surveys, drawings, models, photographs and reports prepared by the Contractor under this Agreement shall, at the option of the City, become its property, and the Contractor shall be entitled to receive just and equitable compensation for any work satisfactorily completed hereunder.

Notwithstanding the above, the Contractor shall not be relieved of liability to the City for damages sustained by the City by virtue of any breach of this Agreement by the Contractor, and the City may withhold any payments to the Contractor for the purposes of set-off until such time as the exact amount of damages due the City from the Contractor is determined.

22. **Termination for Convenience of City.** The City may terminate this Agreement at any time by giving at least thirty (30) days' notice in writing to the Contractor. If the Contractor is terminated by the City as provided herein, the Contractor will be paid an amount which bears the same ratio to the total compensation as the Services actually performed bear to the total Services of the Contractor covered by this Agreement, less payments of compensation previously made. If this Agreement is terminated due to the fault of the Contractor, the preceding Section hereof relative to termination shall apply.

23. **Termination of Benefits for the City's Failure to Pay Premium or Material Breach.** The Contractor will only pay claims submitted by Enrolled Persons as long as the City/and Other Governmental Entities has paid the premium to the Contractor for the period for which the services were performed. In the event that the City and/or Other Governmental Entity fails to timely pay premiums as set forth in this Agreement, Contractor reserves the right to put all Services, including claims processing Services with

respect to the City and/or any applicable Other Governmental Entities, on hold until such time that all payments due and owing are made. In the event that premiums remain outstanding for more than Forty-Five (45) days past the date they were due, Contractor shall have the right to terminate this Agreement with respect to the City and/or any applicable Other Governmental Entities upon written notice. Upon such written notice, the City and/or Other governmental Entity shall have thirty (30) days to cure such late payment.

In addition, Contractor shall have the right to terminate this Agreement with respect to the City and/or any Other Governmental Entities upon ninety (90) days written notice in the event of the City's and/or Other Governmental Entity's material breach of the terms of this Agreement. Upon such written notice, City and/or Other governmental Entity shall have thirty (30) days to cure such late payment.

24. Construction and Severability. If any part of this Agreement is held to be invalid or unenforceable, such holding will not affect the validity or enforceability of any other part of this Agreement so long as the remainder of the Agreement is reasonably capable of completion.

25. Enforcement. The Contractor agrees to pay to the City all costs and expenses including reasonable attorney's fees incurred by the City in exercising any of its rights or remedies in connection with the enforcement of this Agreement.

26. Entire Agreement. This Agreement contains the entire agreement of the parties and supersedes any and all other agreements or understandings, oral or written, whether previous to the execution hereof or contemporaneous herewith. This Agreement consists of the following documents and the order of precedence of these documents shall be as follows: The Agreement; the proposal submitted by the Contractor in response to the RFP (Exhibit 2); the Delta Dental Group Summary of Benefits (Exhibit 3); City of Albuquerque Participation Guidelines (Exhibit 5); the Delta Dental Group Member Handbook (Exhibit 6); the list of participating entities (Exhibit 4); the Performance Guarantees (Exhibit 7); RFP P2018000018 (Exhibit 1). All Exhibits and Appendices referenced in this Agreement are attached hereto and incorporated herein as though set forth in full.

27. Applicable Law. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of New Mexico, and the laws, rules and regulations of the City of Albuquerque.

28. Approval Required. This Agreement shall not become binding upon the City until approved by the highest approval authority of the City required under this Agreement.

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IN WITNESS WHEREOF, the City and the Contractor have executed this Agreement as of the date first above written.

CITY OF ALBUQUERQUE

Approved By:

Sarita Nair,
Chief Administrative Officer

Date: 7/24/18

Mary L. Scott, Director
Human Resources Department

Date: 7/11/18

B. Jesse Muñiz, MBA
Acting Chief Procurement Officer

Date: 7/19/18

CONTRACTOR: Delta Dental

By: Lou J. Ottino 7/16/18

Title: VP, Sales, Marketing + Customer Admi

EXHIBIT 1

City of Albuquerque

Request for Proposals

Solicitation Number: P2018000015

Fully Insured Group Dental Insurance

November 17, 2017

Deadline for Receipt of Proposals: December 21, 2017 no later than 4:00 p.m. (Mountain Time)
The City eProcurement System will not allow Proposals to be submitted after this date and time.

City of Albuquerque
Department of Finance and Administrative Services
Purchasing Division

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INTRODUCTION

City of Albuquerque
Fully Insured Group Dental Insurance
Request for Proposals ("RFP")

City Background

The City of Albuquerque ("City") is the largest city in New Mexico with a population of over 560,000.

The City employs a Mayoral-Council form of government. The City Council is comprised of nine (9) Councilors who serve staggered four (4) year terms. The City has over 6,400 employees in twenty-four (24) municipal departments located in both the City Hall complex and throughout the City limits.

For more information about the City, please visit our web site at http://www.cabq.gov/

In addition, the City has intergovernmental agreements with seventeen (17) government agencies within the State of New Mexico. These entities range in size from three (3) to 606 employees. The agreements allow the entities ("Participating Entities") to offer the same employee benefit options to their employees for the same rates that the City has contracted for its employees. Total covered lives for the City and all Participating Entities are approximately 16,800. The Village of Jemez Springs is a new entity effective September 1, 2017. They have three eligible employees and all three enrolled in dental insurance. Their data is not included in the census since the census is as of August 2017.

Purpose

The City is seeking to offer a fully insured dental benefit program(s) to the employees of the City and their dependents, and to the Participating Entities who choose to participate with the City. For the remainder of this solicitation, any reference to City includes the Participating Entities. The proposed dental benefit program should promote cost effective, value based directions and patient-oriented care to lower collective health risks by improving individual lifestyles.

The coverage will be available for employees of the City during the fiscal year, which begins July 1, 2018. The City will contribute eighty percent (80%) of the premium for all tiers of coverage regardless of differences in premium price. Participating Entities may elect different employer contribution percentages than the City.

The City is the contracting entity. Upon award, contracted rates shall be firm for the entire contract period. The Participating Entities affiliated with RFP are:

Albuquerque Bernalillo County Water Utility Authority
Albuquerque Housing Authority
City of Belen
Middle Rio Grande Conservancy District
Sandoval County
Southern Sandoval County Arroyo Flood Control Authority
Town of Bernalillo
Town of Cochiti Lake

Town of Edgewood
Town of Mountainair
Village of Bosque Farms
Village of Corrales
Village of Cuba
Village of Jemez Springs
Village of Los Ranchos de Albuquerque
Village of San Ysidro
Village of Tijeras

Offerors shall assume participation by all Participating Entities for proposal purposes. See Appendix A for details. Participation in any of the benefits the City offers is not mandatory for any Participating Entities, however, participation in dental insurance has been constant.

Additional government entities located in reasonable proximity to the Albuquerque service area may request to participate in the City's plans. The City reviews such requests based on available experience data to make a determination that such requests are not expected to negatively impact the City's rates in the future.

The Census Data, (Appendix C) is available on the Sicomm.net site under the attachment section. The workbook is password protected. Please request password referencing: P2018000015 via email: primary contact: kray@cabq.gov, or secondary contact: vcunningham@cabq.gov.

Additionally, it is important to note that at annual renewal, Participating Entities have the option to add additional lines of coverage, or drop lines of coverage. The City requires the entities to provide a ninety (90)-day notice before making any such changes.

Current Dental Insurance Plans

The City currently offers Delta Dental's PPO and Premier plans to employees and Participating Entities on a fully insured basis. The current vendor, Delta Dental, has been under contract with the City for a total of 19 years, with the last four (4) years as the sole vendor providing a competitive benefits package. As of August 1, 2017, the total covered by the City and the Participating Entities cover 6,738 employees in the City's group dental insurance.

There are four tiers of coverage:

Employee only
Couple (two (2) adults)
Single parent (one (1) adult plus one or more children)
Family (two (2) adults plus one (1) or more children)

In considering carrier(s), the City is seeking a plan of demonstrated size and service capability with management systems and procedures capable of providing benefits to a major employer of the magnitude encompassed by the City and its Participating Entities. The purpose of this RFP is to obtain the best possible value for the City and for Participating Entities and their employees. The City is particularly interested in carriers with a demonstrated commitment to providing consistent, valuable and timely utilization information, which must comply with data requirements and reporting frequency.

The City is committed to the overall wellness of its employee base. Offerors will need to demonstrate the ability to provide preventive wellness and maintenance services and standard clinical preventive guidelines, wellness outreach communications and employee events, such as health fairs and twenty-five (25) open enrollment meetings.

The last plan design change was five (5) years ago when the $50/$150 (Single/Family) deductible went from lifetime to annual.

The City is asking that Offerors quote the plan design provided in the RFP (**Appendix D**). Identify any deviations as instructed in 2.1.3 of this RFP. It is anticipated that the proposed coverage(s) will meet or exceed those provided by the current provider.

CONTRIBUTIONS

The City contributes eighty percent (80%) of the premium for all four (4) tiers of coverage for medical, dental and vision insurance. The City will continue to provide the eighty percent (80%) premium contribution to any new plan(s). If more than one carrier is selected the City contribution will be eighty percent (80%) towards each carrier's premium. The contribution strategy for all participating entities is listed in Appendix A.

DENTAL PLAN NOTES

Proposals will be accepted from carriers capable of offering a fully insured plan that matches or exceeds the current plan design.

The City may modify benefits for 2018/2019. It is expected that the plan designs will remain relatively the same.

PART 1
INSTRUCTIONS TO OFFERORS

1.1 RFP Number and Title: P2018000015, **Fully Insured Group Dental Insurance**

1.2 Proposal Due Date: December 21, 2017 - NLT 4:00 PM (Local Time)
The time and date Proposals are due shall be strictly observed.

1.3 Purchasing Division: This Request for Proposals ("RFP") is issued on behalf of the City of Albuquerque by its Purchasing Division, which is the sole point of contact during the entire procurement process.

1.4 Authority: Chapter 5, Article 5 of the Revised Ordinances of the City of Albuquerque, 1994, ("Public Purchases Ordinance"). The City Council, pursuant to Article 1 of the Charter of the City of Albuquerque and Article X, Section 6 of the Constitution of New Mexico, has enacted this Public Purchases Ordinance as authorized by such provisions and for the purpose of providing maximum local self-government. To that end, it is intended that this Public Purchases Ordinance shall govern all purchasing transactions of the City and shall serve to exempt the City from all provisions of the New Mexico Procurement Code, as provided in Section 13-1-98K, NMSA 1978.

1.5 Acceptance of Proposal: Acceptance of Proposal is contingent upon Offeror's certification and agreement by submittal of its Proposal, to comply and act in accordance with all provisions of the following:

1.5.1 City Public Purchases Ordinance

1.5.2 City Purchasing Rules and Regulations: These Rules and Regulations ("Regulations") are written to clarify and implement the provisions of the Public Purchases Ordinance. These Regulations establish policies, procedures, and guidelines relating to the procurement, management, control, and disposal of goods, services, and construction, as applicable, under the authority of the Ordinance.

1.5.3 Civil Rights Compliance: Acceptance of Proposal is contingent upon the Offeror's certification and agreement by submittal of its Proposal, to comply and act in accordance with all provisions of the Albuquerque Human Rights Ordinance, the New Mexico Human Rights Act, Title VII of the U.S. Civil Rights Act of 1964, as amended, and all federal statutes and executive orders, New Mexico statutes and City of Albuquerque ordinances and resolutions relating to the enforcement of civil rights and affirmative action. Questions regarding civil rights or affirmative action compliance requirements should be directed to the City of Albuquerque Human Rights Office.

1.5.4 Americans with Disabilities Act Compliance: The Offeror certifies and agrees, by submittal of its Proposal, to comply and act in accordance with all applicable provisions of the Americans With Disabilities Act of 1990 and federal regulations promulgated thereunder.

1.5.5 Insurance and Bonding Compliance: Acceptance of Proposal is contingent upon Offeror's ability to comply with the insurance requirements as stated herein. Please include a certificate or statement of compliance in your Proposal and bonds as required.

1.5.6 Ethics:

1.5.6.1 Fair Dealing. The Offeror warrants that its Proposal is submitted and entered into without collusion on the part of the Offeror with any person or firm, without fraud and in good faith. Offeror also warrants that no gratuities, in the form of entertainment, gifts or otherwise, were, or will be offered or given by the Offeror, or any agent or representative of the Offeror to any officer or employee of the City with a view toward securing a recommendation of award or subsequent contract or for securing more favorable treatment with respect to making a recommendation of award.

1.5.6.2 Conflict of Interest. The Offeror warrants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required under the contract resulting from this RFP. The Offeror also warrants that, to the best of its knowledge, no officer, agent or employee of the City who shall participate in any decision relating to this RFP and the resulting contract, currently has, or will have in the future, a personal or pecuniary interest in the Offeror's business.

1.5.7 Participation/Offeror Preparation: The Offeror may not use the consultation or assistance of any person, firm company who has participated in whole or in part in the writing of these specifications or the Scope of Services, for the preparation of its Proposal or in the management of its business if awarded the contract resulting from this RFP.

1.5.8 Debarment or Ineligibility Compliance: By submitting its Proposal in response to this RFP, the Offeror certifies that (i) it has not been debarred or otherwise found ineligible to receive funds by any agency of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States; and (ii) should any notice of debarment, suspension, ineligibility or exclusion be received by the Offeror, the Offeror will notify the City immediately.

Any Proposal received from an Offeror that is, at the time of submitting its Proposal or prior to receipt of award of a contract, debarred by or otherwise ineligible to receive funds from any agency of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States, shall be rejected.

Upon receipt of notice of debarment of an Offeror awarded a contract as a result of this RFP ("Contractor"), or other ineligibility of the Contractor to receive funds from any agency of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States, the City shall have the right to cancel the contract with the Contractor resulting from this RFP for cause in accordance with the terms of said contract.

1.5.9 Goods Produced Under Decent Working Conditions: It is the policy of the City not to purchase, lease, or rent goods for use or for resale at City owned enterprises that were produced under sweatshop conditions. The Offeror certifies, by submittal of its Proposal in response to this solicitation, that the goods offered to the City were produced under decent working conditions. The City defines "under decent working conditions" as production in a factory in which child labor

and forced labor are not employed; in which adequate wages and benefits are paid to workers; in which workers are not required to work more than 48 hours per week (or less if a shorter workweek applies); in which employees are free from physical, sexual or verbal harassment; and in which employees can speak freely about working conditions and can participate in and form unions. [*Council Bill No. M-8, Enactment No. 9-1998*]

1.5.10 Graffiti Free: When required, the Contractor will be required to furnish equipment, facilities, or other items required to complete these services, that are graffiti-free. Failure of Contractor to comply with this requirement may result in cancellation of the contract resulting from this RFP.

1.6 City Contact: The sole point of contact for this RFP is the City of Albuquerque Purchasing Division. Questions regarding this RFP should be directed to the following Purchasing representative unless otherwise specified in the solicitation:

- Kassandra Ray, Senior Buyer, Department of Finance and Administrative Services, Purchasing Division
- Phone: (505) 768-3310 or E-Mail: kray@cabq.gov
- Post Office Box 1293, Albuquerque, New Mexico 87103

1.7 Contract Management: The contract resulting from this RFP will be managed by the Human Resources Department, Insurance and Benefits Division.

1.8 Clarification: Any explanation desired by an Offeror regarding the meaning or interpretation of this RFP must be requested in writing not less than ten (10) working days prior to the deadline for the receipt of Proposals to allow sufficient time for a reply to reach all Offerors before the submission of their Proposals. No extension of time will be granted based on submission of inquiries subsequent to the required date nor will such inquiries be answered. All inquiries must be directed to the Purchasing Division as stated herein. Oral explanations or instructions given before the award of the contract or at any time will not be binding. Purchasing shall prepare answers to questions in the form of Addenda to this RFP and shall post all such Addenda to the online eProcurement System.

1.9 Submission of Proposals. The Offeror's sealed Proposal **must be submitted electronically through the eProcurement system** (see *Section 1.9.1*) **, and in hard and soft copies** (see *Sections 1.9.2 and 1.9.3*) in the format outlined in Part 2 of this RFP and mailed or delivered *(See Sections 1.9.5 and 1.9.6)* pursuant to the following requirements:

1.9.1 Electronic Copy. Submit your complete Proposal including all forms, attachments, exhibits, Technical Proposal, Cost Proposal, etc. using the eProcurement System at http://www.cabq.gov/dfa/purchasing/solicitations/solicitations. If you do not have a username and password, please register as this is the only method to submit electronically on Sicomm.net. For assistance, please contact the Sicomm.net technical support at (800) 614-0563 or (505) 341-9201.

1.9.2 Hard Copy. In addition to the electronic submittal, the Offeror must also submit one (1) original and seven (7) copies of its Technical Proposal. The original Proposal shall be clearly marked as "Original" on the cover of the Proposal. In addition, in a separate envelope, clearly marked as "Cost Proposal," submit one (1) original and seven (7) copies of your Cost Proposal for this RFP.

1.9.3 Soft Copy. In addition to the electronic copy submitted through the City's eProcurement System in Section 1.91, include with your original hard copy Proposal submission, on a CD, DVD, or other media compatible with the City's system, two (2) discs, each with an electronic file of your Technical and Cost Proposals as well as all forms, attachments, exhibits, etc.

1.9.4 Proposal Package Preparation. Proposals and modifications thereof shall be enclosed in sealed envelopes and have the following identifying information on the outside:

- Name and Address of Offeror
- Closing Date and Time of RFP
- RFP Number
- RFP Title

1.9.5 Ship, Deliver, or Hand-Carry Sealed Proposals to: Office of the City Clerk, 600 Second St. NW, Plaza Del Sol, 7th Floor Room 720, Albuquerque, New Mexico 87102. **Mark all packages as stated above.** Use this address for packages sent via non United States Postal Service carriers.

1.9.6 Mail Sealed Proposals to: Office of the City Clerk, Post Office Box 1293, Albuquerque, New Mexico 87103. (Certified Mail is recommended). The City shall not be responsible for the failure of mailed Proposals to actually be received by the Office of the City Clerk by 4:00 PM (Mountain Time) of the day of closing.

ALL SEALED PROPOSALS MUST BE RECEIVED BY THE OFFICE OF THE CITY CLERK AS SPECIFIED HEREIN.

1.9.7 No other methods of Proposal delivery. Neither telephone, facsimile, nor telegraphic Proposals shall be accepted.

1.9.8 Modification. Proposals may be modified or withdrawn only by written notice, provided such notice is received prior to the Proposal Due Date.

1.9.9 Receipt of Proposals. The only acceptable evidence to establish the time of receipt of Proposals at the City Clerk's Office is the time-date stamp of that Office on the Proposal wrapper or other documentary evidence of receipt maintained by that Office. Since both electronic and hard copy submission is required, the City will treat the time-stamp of the later of the two receipts as the official documentary evidence of receipt.

1.9.10 Acknowledgment of Addenda to the Request for Proposals. Receipt of Addenda to this RFP by an Offeror must be acknowledged a) by signing and returning the Addenda, or b) by letter. Such acknowledgment may be submitted with the Proposal. Such acknowledgment must be received prior to the hour and date specified for receipt of Proposals.

1.10 Modifications to Scope of Services: In the event that sufficient funds do not become available to complete each task in the Scope of Services, the Scope of Services may be amended, based upon the cost breakdown required in the Cost Proposal.

1.11 Draft Agreement: A copy of the Draft Agreement to be entered into is included in the RFP. Please state that you accept the terms and conditions of the Draft Agreement, or note exceptions. The City's receipt of exceptions in a response is not an acceptance of any requested changes to the Draft Agreement. The Draft Agreement may differ from the final Agreement.

1.12 Contract Term: The contract resulting from this solicitation is anticipated to have a term of one (1) year with five (5) possible extensions of one (1) year each.

1.13 Evaluation Period: The City reserves the right to analyze, examine and interpret any Proposal for a period of ninety (90) days after the hour and date specified for the receipt of Proposals.

1.14 Evaluation Assistance: The City of Albuquerque, in evaluating Proposals, reserves the right to use any assistance deemed advisable, including City contractors and consultants. The City reserves the right to extend the evaluation period if it feels, in its sole discretion, such an extension would be in the best interest of the City.

1.15 Rejection and Waiver: The City reserves the right to reject any or all Proposals and to waive informalities and minor irregularities in Proposals received.

1.16 Award of Contract:

1.16.1 When Award Occurs: Award of contract occurs when a Purchase Order is issued or other evidence of acceptance by the City is provided to the Offeror. A Recommendation of Award does not constitute award of contract.

1.16.2 Award: If a contract is awarded, it shall be awarded to the responsive and responsible Offeror whose Proposal conforming to this RFP will be most advantageous to the City as set forth in the Evaluation Criteria.

1.17 Cancellation: This RFP may be canceled for any reasons and any and all Proposals may be rejected in whole or in part when it is in the best interests of the City.

1.18 Negotiations: Negotiations may be conducted with the Offeror(s) recommended for award of contract.

1.19 City-Furnished Property: No material, labor, or facilities will be furnished by the City unless otherwise provided for in this RFP.

1.20 Proprietary Data:

1.20.1 The file and any documents relating to this RFP, including the Proposals submitted by Offerors, shall be open to public inspection after the recommendation of award of a contract has been approved by the Mayor, or his designee. An Offeror may designate material as Trade Secrets, Proprietary Data, and/or other Confidential Data by separating that material from the Offeror's main Proposal, marking it as "Trade Secret", "Proprietary Data", or "Confidential Data" and uploading it separately from its main Proposal submitted in response to this RFP. **Pricing and makes and models or catalog numbers of items offered, delivery terms, and terms of payment shall not be so designated. Further, any Proposal in which a majority of pages are designated as Trade Secret, Proprietary Data, or Confidential Data may be deemed nonresponsive.**

1.20.2 The City will endeavor to restrict distribution of material separated, designated as "Trade Secret", "Proprietary Data", or "Confidential Data" and provided separately to only those individuals involved in the review and analysis of the Proposals. However, Offers are advised that, if a request for inspection of records under the New Mexico Inspection of Public Records Act (Sections 14-2-1 et seq, NMSA 1978) ("Act") is received for such materials, and they are not exempt under the Act, the City is required to disclose those records. The City shall, to the extent possible under the Act, provide the Offeror with notice before any disclosure to allow the Offeror on opportunity, within the Act's fifteen (15) day deadline, to initiate legal action (such as an injunction or other judicial remedy) to prevent the release of Trade Secret, Proprietary Data, or Confidential Data, should the Offeror wish to do so. **Notwithstanding anything to the contrary herein, the City shall not be responsible to the Offeror for any disclosure of records required by the Act or an order of a court or other tribunal with jurisdiction over the City.**

1.21 Preferences: Preferences may be available under the City of Albuquerque Public Purchases Ordinance, for this procurement. See Part 5 of this RFP for additional information.

1.22 Request for Proposals Protest Process:

1.22.1 When: If the protest concerns the specifications for a competitive solicitation or other matters pertaining to the solicitation documents, it must be received by the Chief Procurement Officer no later than 5:00 p.m. of the tenth business day prior to the deadline for the receipt of Proposals.

1.22.2 Recommendation of Award: If the protest concerns other matters relating to this solicitation, the protest must be filed with the Chief Procurement Officer no later than 5:00 p.m. of the tenth business day after the receipt of notice of the Recommendation of Award.

1.22.3 Timely Protests: Protests must be received by the Chief Procurement Officer prior to the appropriate deadline as set out herein, or they will not be considered valid. The Chief Procurement Officer may waive the deadline for good cause, including a delay caused by the fault of the City. Late delivery by the U.S. Postal Service or other carrier shall not be considered good cause.

1.22.4 How to File: Any Offeror who is aggrieved in connection with a competitive solicitation or recommendation of award of a contract may protest to the City Chief Procurement Officer. The protest shall be addressed to the Chief Procurement Officer, must be submitted in written form and must be legible. Protests may be hand-delivered or mailed. Facsimile, telephonic, telegraphic or electronic protests will not be accepted.

1.22.5 Required Information: The protest shall contain at a minimum the following;

- The name and address of the protesting party;
- The number of the competitive solicitation;
- A clear statement of the reason(s) for the protest detailing the provisions believed to have been violated;
- Details concerning the facts, which support the protest;
- Attachments of any written evidence available to substantiate the claims of the protest; and
- A statement specifying the ruling requested.

1.22.6 Address Letters and Envelopes as Follows:

- City of Albuquerque — RFP Number
- Purchasing Division — PROTEST
- Attn: Chief Procurement Officer
- PO Box 1293
- Albuquerque, New Mexico 87103

1.22.7 Protest Response by Chief Procurement Officer: The Chief Procurement Officer will, after evaluation of a protest, issue a response. Only the issues outlined in the written protest will be considered by the Chief Procurement Officer.

1.22.8 Protest Hearing: If a hearing is requested, the request must be included in the protest and received within the time limit. The filing fee of twenty dollars ($20.00) must accompany the request for hearing. Only the issues outlined in the protest will be considered by the Chief Procurement Officer, or may be raised at a protest hearing. The granting of a hearing shall be at the discretion of the Chief Procurement Officer following review of the request.

1.23 Insurance:

1.23.1 General Conditions: The City will require the successful Offeror, referred to as the Contractor, to procure and maintain at its expense during the term of the contract resulting from the RFP, insurance in the kinds and amounts hereinafter provided with insurance companies authorized to do business in the State of New Mexico, covering all operations of the Contractor under the contract. Upon execution of the contract and on the renewal of all coverages, the Contractor shall furnish to the City a certificate or certificates in form satisfactory to the City as well as the rider or endorsement showing that it has complied with these insurance requirements. All certificates of insurance shall provide that thirty (30) days written notice be given to the Risk Manager, Department of Finance and Administrative Services, City of Albuquerque, P.O. Box 470, Albuquerque, New Mexico, 87103, before a policy is canceled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. With respect to all coverages required other than professional liability or workers' compensation, the City shall be named an additional insured. All coverages afforded shall be primary with respect to operations provided.

1.23.2 Approval of Insurance: Even though the Contractor may have been given notice to proceed, it shall not begin any work under the contract resulting from this RFP until the required insurance has been obtained and the proper certificates (or policies) filed with the City. Neither approval nor failure to disapprove certificates, policies, or the insurance by the City shall relieve the Contractor of full responsibility to maintain the required insurance in full force and effect. If part of the contract is sublet, the Contractor shall include any or all subcontractors in its insurance policies, or require the subcontractor to secure insurance to protect itself against all hazards enumerated herein, which are not covered by the Contractor's insurance policies.

1.23.3 Coverage Required: The kinds and amounts of insurance required are as follows:

1.23.3.1 Commercial General Liability Insurance. A commercial general liability insurance policy with combined limits of liability for bodily injury or property damage as follows:

$1,000,000	Per Occurrence
$1,000,000	Policy Aggregate
$1,000,000	Products Liability/Completed Operations
$1,000,000	Personal and Advertising Injury
$ 50,000	Fire Legal
$ 5,000	Medical Payments

Said policy of insurance must include coverage for all operations performed for the City by the Contractor and contractual liability coverage shall specifically insure the hold harmless provisions of the contract resulting from this RFP.

1.23.3.2 Automobile Liability Insurance. A comprehensive automobile liability insurance policy with liability limits in amounts not less than $1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. The policy must include coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment both on and off work.

1.23.3.3 Workers' Compensation Insurance. Workers' compensation insurance policy for the Contractor's employees, in accordance with the provisions of the Workers' Compensation Act of the State of New Mexico, (the "Act"). If the Contractor employs fewer than three employees and has determined that it is not subject to the Act, it will certify, in a signed statement, that it is not subject to the Act. The Contractor will notify the City and comply with the Act should it employ three or more persons during the term of the contract resulting from this RFP.

1.23.3.4 Professional Liability (Errors and Omissions) Insurance. Professional liability (errors and omissions) insurance in an amount not less than $1,000,000 combined single limit of liability per occurrence with a general aggregate of $1,000,000.

1.23.3.5 Cyber Liability Insurance. Cyber liability insurance, including but not limited to liability arising out of or associated with Internet activities and the use or operation of computers and computer networks not less than $2,000,000.

1.23.4 Increased Limits: During the life of the contract the City may require the Contractor to increase the maximum limits of any insurance required herein. In the event that the Contractor is so required to increase the limits of such insurance, an appropriate adjustment in the contract amount will be made.

1.23.5 Additional Insurance: The City may, as a condition of award of a contract, require a successful Offeror to carry additional types of insurance. The type and limit of additional insurance is dependent upon the type of services provided via the contract by the successful Offeror.

1.24 Pay Equity Documentation. All Proposals shall include a Pay Equity Reporting Form which can be accessed at http://www.cabq.gov/womens-pay-equity-task-force-instructions/albuquerque-pay-equity-initiative-instructions or in the Solicitation Instructions. Offerors who believe they are exempt because they are an out-of-state contractor that has no facilities and no employees working in New Mexico are not required to report data, but must check the box verifying their status on the Pay Equity Reporting Form. Any Proposal that does not include a Pay Equity Reporting Form shall be deemed nonresponsive.

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PART 2
PROPOSAL FORMAT

2.1 Technical Proposal Format, Section One

2.1.1 Offeror Identification: State name and address of your organization or office and nature of organization (individual, partnership or corporation, private or public, profit or non-profit). Subcontractors, if any, must be identified in a similar manner. Include name and telephone number of person(s) in your organization authorized to execute the Draft Agreement. Submit a statement of compliance with all laws stated herein. Submit a statement of agreement of the terms and conditions of the Draft Agreement; state exceptions. Show receipt of Addenda if applicable. Provide a statement or show ability to carry the insurance specified.

2.1.2 Experience:

2.1.2.1 Current Experience. State relevant experience of the company and person(s) who will be actively engaged in the proposed project, including experience of subcontractors. Submit resumes for the individuals who will be performing the services for the City.

2.1.2.2 Past Experience. Describe a minimum of three (3) projects of similar scope and size, which are now complete; state for whom the work was performed, year completed, and a reference person who can be contacted regarding the work. References must be for work performed in the past three to five (3 to 5) years. State relevant experience with other municipalities or government entities.

2.1.3 Proposed Approach to Tasks: Discuss fully your proposed approach to each of the tasks described in Part 3, Scope of Services. Use charts to illustrate the number of hours dedicated to each task and who will be performing each task [individual(s)/firm(s)].

2.1.4 Management Summary: Describe individual staff and subcontractor's responsibilities with lines of authority and interface with the City of Albuquerque staff. Describe resources to be drawn from in order to complete tasks.

2.1.5 Network Composition, Access and Minimal Disruption

2.1.5.1 Provide detailed information regarding the maintenance and the composition of a broad provider network to include but not limited to the following:

2.1.5.1.1 Outline with specificity how plan members will be provided with comparable or superior geographic access (Also complete Appendix F)

2.1.5.1.2 Describe how Offeror's provider network will result in minimum disruption to current plan member services (Also complete Appendix F.)

2.1.6 Organizational Strength:

2.1.6.1 Offerors must submit a statement of relevant corporate qualifications, strengths and experience, including similar experience of subcontractors. The documentation must thoroughly describe how the Offeror has supplied expertise for similar contracts and work related to the type of dental coverage(s) being proposed. Provide a copy of the company's 2016 audited financial report labeled Appendix G.

2.1.6.2 Offerors shall include a statement of their ability to provide all desired plans.

2.1.6.3 Proposals must include three (3) external client references from clients (preferably public sector) who received similar services. One of the references must be the Offeror's largest client. One of the references must be a client who is currently handled by the Client Manager being proposed by the Offeror. In addition, three (3) references must be submitted for each proposed subcontractor. Proposals must include one (1) prior client reference for a client who terminated services, and if applicable, the reference should be a terminated client who was handled by the Client Manager being proposed by the Offeror. The minimum information that must be provided about each reference is:

2.1.6.3.1 Name of individual or company services were provided for
2.1.6.3.2 Address of individual or company
2.1.6.3.3 Name of contact person
2.1.6.3.4 Telephone number of contact person
2.1.6.3.5 Type of services provided and dates services were provided

2.1.6.4 A detailed implementation plan assuming a July 1, 2018 effective date shall be included in this section.

2.1.7 Client Management Team Qualifications

Offerors shall submit resumes of key proposed professional staff members who will be performing services under the contract awarded under this RFP. Experience narratives shall be attached that describe the specific relevant experience of the staff members in relation to the role that member will perform for the contract resulting from this solicitation. The narrative(s) must include the name of the individual(s) proposed and should include a thorough description of the education, knowledge, and relevant experience as well as certifications or other professional credentials that clearly shows how they are qualified to provide the required services to the City. The Offeror must have an Albuquerque based client Account Manager or agree to establish one as a condition of contracting.

2.1.8 Network Composition and Access

Offerors shall provide comprehensive information on their provider networks. This information shall indicate where provider networks are directly contracted and where they are leased from another entity. Hard copy provider directories may not be included, but offerors shall provide the website address where such directories can be viewed. Where requested, geo-access and disruption analysis shall be included (refer to RFP Appendices F and H.) Further, the details on the management and operation of the network shall be included. Information on expected provider and network membership shall be provided.

2.1.9 Proposal Organization: The proposal shall be organized and indexed in the following format and must contain, at a minimum, all listed items in the sequence indicated.

2.1.9.1 Letter of Transmittal: Each proposal shall be accompanied by a letter of transmittal. The letter of transmittal shall:

2.1.9.1.1 Identify the submitting organization;

2.1.9.1.2 Identify the name and title of the person authorized by the organization to contractually obligate the organization;

2.1.9.1.3 Identify the name, title and telephone number of the person authorized to negotiate the contract on behalf of the organization;

2.1.9.1.4 Identify the names, titles and telephone numbers of persons to be contacted for clarification; and

2.1.9.1.5 Be signed by the person authorized to contractually obligate the organization.

2.1.9.2 Table of Contents

2.1.9.2.1	Proposal Summary
2.1.9.2.2	Questionnaire (Appendix B)
2.1.9.2.3	Technical Workbook (Appendix F)
2.1.9.2.4	Vendor Financials (Appendix G)
2.1.9.2.5	Cost Proposal (Appendix H)

Within each section of their proposals, Offerors should address the items in the order in which they appear in this RFP. All forms provided in the RFP must be thoroughly completed and included in the appropriate section of the proposal. ***IN ADDITION TO HARD COPY, RESPONSE EXHIBITS MUST BE SUBMITTED AS A SOFT COPY IN EXCEL OR WORD FORMAT. PLEASE ONLY CONVERT/POST THE EXCEL OR WORD DOCUMENT TO PDF WHEN SUBMITTING IN SICOMM.NET. WHEN SUBMITTING THE COMPLETED EXHIBITS WITH YOUR PROPOSAL, YOU MUST RETAIN THE FILE NAMES AS ORIGINALLY POSTED ON SICOMM.NET. YOU MAY ADD THE NAME OF YOUR COMPANY AT THE END OF EACH FILE NAME WHEN SUBMITTING YOUR PROPOSAL.***

Any proposal that does not adhere to these requirements may be deemed non-responsive and rejected on that basis. The proposal summary may be included by Offerors to provide the evaluation committee with an overview of the technical and business features of the proposal; however, this material will not be used in the evaluation process unless specifically referenced from other portions of the Offeror's proposal.

2.1.10 Proposal Format: All proposals must be typewritten on standard 8-1/2" x 11" paper (larger paper is permissible for charts, spreadsheets, etc.) and placed within a binder with tabs delineating each section. Succinctness is strongly encouraged.

2.2 Cost Proposal Format, Section Two

2.2.1 Total Cost: Submit your Cost Proposal separately from your technical Proposal. If provided, follow the sample format attached to this RFP.

2.2.2 The Cost Proposal should, at a minimum, contain the following information:

2.2.2.1 Cost Proposal (Appendix H)

2.2.2.1.1 Service related performance guarantees
2.2.2.1.2 Financial offerings, discounts, and network access
2.2.2.1.3 Rates are requested for the coverages detailed in Appendix D. Quote ONLY the current plan designs, on a fully-insured basis. In the event you are not able to provide all

coverages requested, respond with those you are able to offer. Please expressly identify the coverages that are not included.

2.2.2.1.4 Plans quoted shall include claim administrative services, provider network, utilization management, large case management, disease management and wellness programs.

Note: This information should only be addressed in the Cost Proposal and NOT the Technical Proposal.

2.2.3 Offerors shall show costs as monthly premiums for four tiers of coverage.

2.2.4 All Costs: All costs to be incurred and billed to the City should be described by the Offeror for each item, to allow for a clear evaluation and comparison, relative to other Proposals received. All costs should include any applicable gross receipts taxes. The Offeror should understand that the City will not pay for any amounts not included in the Cost Proposal -- for example, insurance or taxes -- and that liability for items not included remains with the Offeror.

2.2.5 An example of the required format is attached to this RFP. Your response to this section will be used in performing a cost analysis.

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PART 3
SCOPE OF SERVICES

The goal of this RFP is to identify long-term dental insurance providers who can demonstrate the ability and commitment to meet the current plan design and future program goals. Currently, the City offers two (2) plan designs through one (1) carrier. The City seeks fully insured, non-dividend eligible options through selecting one (1) or more dental insurance providers who shall provide the following Services:

3.1 **Organizational Strength and Administration**

3.1.1 The best in class price as well as fair and auditable contract terms that are directly related to the cost of delivering such goods and services.

3.1.2 Aligns incentives and business model that drives value for the City and its members.

3.1.3 Provide comprehensive account management and customer service including resources and personnel as necessary to support the City's broader health care strategy.

3.1.4 Provide effective coordination and integration with the City's other external vendor partners.

3.1.5 Comply with the detailed process measurement model that will evaluate the successful Offeror's performance and hold it accountable for certain guaranteed standards.

3.1.6 Prepare summary plan descriptions, summary of benefits and coverage, and any other employee notices required by State or Federal Law; provide recommendations and advice on the City's benefit plan design.

3.1.7 Provide a detailed plan for implementation.

3.1.8 Provide best in class enrollee focus with staff that are determined to get any issues resolved in a timely manner.

3.1.9 Adjudicate and pay claims according to the City's benefit plan design including the application of case management and other cost saving value based measures.

3.1.10 Provide a customer service call center, online member access website, and other support services for members.

3.1.10.1 Members should at a minimum be able to access plan information on plan design, claims payment and YTD deductible and out of pocket maximum levels, locate a provider, and lookup basic dental educational materials via the providers secured website.

3.1.10.2 Provide the City with sufficient staff and technology to be able to run ad hoc financial and utilization reporting, assist the City in development and distribution of plan materials to members regarding plan design features, wellness initiatives, educational information, and member service information.

3.1.11 Provide a standard report package which includes at a minimum the following reports and frequency:

3.1.11.1 Monthly Reporting

3.1.11.1.1 Premium and paid claims by entity

3.1.11.1.2 Enrollment, both contracts and members, by entity and coverage tier

3.1.11.2 Quarterly Reporting

3.1.11.2.1 Utilization data

3.1.11.2.2 Financial data, to include billed charges, allowed charges, paid amounts year to date, member share, etc.

3.1.11.2.3 Enrollment data contract year to date

3.1.11.3 Annual Reporting

3.1.11.3.1 Dental 36 month claim lag
3.1.11.3.2 Performance Guarantee Reporting

3.2 Participant Eligibility

3.2.1 Regular employees (both part-time and full-time including those on probation)
3.2.2 Elected officials
3.2.3 Unclassified employees scheduled to work twenty (20) hours or more each week
3.2.4 Legal spouse of an employee (must provide marriage certificate)
3.2.5 Domestic partner of an employee* (must provide City's Affidavit of Domestic Partnership)
3.2.6 Children (must provide birth certificate) married, or unmarried, to the last day of the month in which the child attains age twenty-six (26) AND meet at least one (1) of the following criteria:
3.2.7 Natural child of the employee, spouse or domestic partner
3.2.8 Adopted child or a child placed in the employee's home and in process for being adopted by the employee, spouse or domestic partner
3.2.9 Court order that requires the employee, spouse or domestic partner provide health coverage for the child. (i.e. Qualified Medical Child Support Order (QMCSO))
3.2.10 Child under legal guardianship: court document that shows the employee, spouse or domestic partner has full, permanent custody of the child
3.2.11 Children age twenty-six (26), and older, may **continue** participating in the group insurance plans if they are permanently and totally physically or mentally disabled, unmarried, covered under the plan on the day before their twenty-sixth (26^{th}) birthday, eligible for tax free coverage as a qualified child or qualified relative. A child who has terminated coverage due to reaching the age limit, and then becomes disabled, is not eligible to re-enroll for coverage.

* A domestic partner is defined as a person of the same or opposite sex who lives with the employee in a long-term relationship of indefinite duration. There must be an exclusive mutual commitment similar to that of marriage, in which the partners agree to be financially responsible for each other's welfare and share financial obligations. These benefits are also available to the domestic partner's children provided that the child meets the definition of eligibility stated above.

3.3 Effective Date of Employee Coverage

3.3.1 New Employees. Coverage begins on the employee's hire date. Employees have thirty-one (31) days from their hire date to enroll through Employee Self Service and provide verification of dependent eligibility. If not on the hire date then coverage will begin on the first day of the pay period following the submission of completed forms and verification of dependent eligibility (participating entities).
3.3.2 Qualifying Events. Coverage begins on the event date as long as the employee enrolls through Employee Self Service and provides verification of the event and of dependent eligibility within thirty-one (31) days of the event. Losing or gaining eligibility for Medicare and Medicaid allows a sixty (60)-day enrollment period. An ex-spouse is not eligible to continue participation in the insurance program, except through COBRA. Therefore, when the divorce decree is submitted to the City of Albuquerque Human Resources Department's Benefits Office the end of coverage will be back dated to the day following the court stamped date on the decree.

3.3.3 Reinstatement. An employee who is terminated from the City and subsequently reinstated is eligible to have the same benefits started up again in which he/she was enrolled prior to termination. If termination was prior to the last open enrollment period then the employee may

elect to participate in the benefit options as a new employee. The employee must enroll through Employee Self Service with documentation of the reinstatement. The effective date of coverage will be the date of reinstatement.

3.3.4 Open Enrollment. Benefit changes elected during open enrollment are effective on July 1st or if cancelling coverage then the last day of coverage will be June 30th.

3.3.5 Termination of Coverage. Insurance ends at the end of the pay period in which the event that results in termination of coverage occurs. Exceptions to this are

3.3.5.1 Retirement: coverage stops at the end of month prior to PERA retirement date.

3.3.5.2 Dependents reaching the age limit: lose coverage at the end of the month of their 26th birthday.

3.3.5.3 Ex-spouses: lose coverage the day after the divorce is final.

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PART 4
EVALUATION OF PROPOSALS

4.1 Selection Process. The Mayor of Albuquerque shall name, for the purpose of evaluating the Proposals, an Ad Hoc Advisory Committee. On the basis of the evaluation criteria established in this RFP, the committee shall submit to the Mayor a list of qualified firms in the order in which they are recommended. Proposal documentation requirements set forth in this RFP are designed to provide guidance to the Offeror concerning the type of documentation that will be used by the Ad Hoc Advisory Committee. Offerors should be prepared to respond to requests by the Purchasing Office on behalf of the Ad Hoc Advisory Committee for oral presentations, facility surveys, demonstrations or other areas deemed necessary to assist in the detailed evaluation process. Offerors are advised that the City, at its option, may award this request on the basis of the initial Proposals.

4.2 Evaluation Criteria. The following general criteria, not listed in order of significance, will be used by the Ad Hoc Advisory Committee in recommending contract award to the Mayor. The Proposal factors will be rated on a scale of **0-1000** with weight relationships as stated below.

200 -- Experience and qualifications of the Offeror and personnel as shown on staff resumes to perform tasks described in Part 3, Scope of Services.

200 -- Adequacy of proposed plan design, utilization management and wellness programs to be utilized by the Offeror.

400 -- The Offeror's general approach and plans to meet the requirements of the RFP.

200 -- Cost Proposal – The costs proposed by the Contractor as described in Section 2.2 of this RFP to perform the tasks listed in Part 3, Scope of Services. The evaluation of this section will occur after the technical evaluation, based on a cost/price analysis.

4.2.1 Evaluation Factors:
The evaluation of cost factors in the selection will be determined by a cost analysis using your proposed figures (Appendix H). Please note that the lowest cost is not the sole criterion for recommending contract award.

4.2.2 Cost Factors: The evaluation of cost factors in the selection will be determined by a cost analysis using your proposed figures. Please note that the lowest cost is not the sole criterion for recommending contract award.

4.2.3 Cost Evaluation. The cost evaluation will be performed by the City Purchasing Division or designee. A preliminary cost review will ensure that each Offeror has complied with all cost instructions and requirements. In addition, Proposals will be examined to ensure that all proposed elements are priced and clearly presented. Cost Proposals that are incomplete or reflect significant inconsistencies or inaccuracies will be scored accordingly or may be rejected by the Ad Hoc Advisory Committee if lacking in information to determine the value/ cost relative to the services proposed.

PART 5
Instructions for PREFERENCE CERTIFICATION FORM
For City Local, Small, or Pay Equity Preferences and/or State Resident Business and Veteran Preferences (Goods & Services)

1. **ALL INFORMATION MUST BE PROVIDED.** A 5% Small Business Preference, a 5% Local Business Preference, a 5% State Resident Business Preference, a 5% Pay Equity Preference and/or a 5% State Resident Veteran Business Preference (collectively the latter two, "State Preference") are available for this procurement. To qualify, an Offeror **MUST** complete and submit this Preference Certification Form **WITH ITS PROPOSAL.** For a Pay Equity Preference, the City Pay Equity Business Certificate MUST be attached. For State Preference the New Mexico State certification of eligibility MUST be attached. If a Proposal is received without this Preference Certification Form and any required certifications attached, completed, signed and certified, or if this Preference Certification Form is received without the required information, the preference shall not be applied. **NO FORM SHALL NOT BE ACCEPTED AFTER THE DEADLINE FOR RECEIPT OF BIDS OR PROPOSALS.**

2. **PHYSICAL LOCATION MUST BE STATED.** To qualify for the Small business or Local Business Preference, a business must have its principal office and place of business in the Greater Albuquerque Metropolitan Area. The business location identified on the Preference Certification Form must be a physical location, street address or such. **DO NOT** use a post office box or other postal address.

3. **PREFERENCE CERTIFICATION FORM MUST BE COMPLETED BY PRINCIPAL OFFEROR.** This Preference Certification Form must be completed for the Principal Offeror, or one of the Principal Offerors if the Offeror is a joint venture or partnership, or by an individual authorized to sign for the Offeror. Subcontractors of the Offeror shall not be used to qualify a Proposal for a preference and should not complete or submit the Form.

4. **APPLICATION OF PREFERENCES.** The State Resident Business Preference or State Resident Veteran Business Preference shall be applied to any Proposals submitted that include a valid, State of New Mexico-issued, Resident Business or Resident Veteran Business Certification Number. The Small Business Preference, and the Local Business Preference shall be applied to all Proposals submitted by eligible small businesses. The local preference only will be applied to all Proposals submitted by eligible local businesses which are not small businesses. The Pay Equity Preference shall be applied to all Proposals submitted that include a City Pay Equity Business Certificate. The total percentage of all preferences awarded shall not exceed ten percent (10%).

5. **DEFINITIONS.** The following definitions apply:

- The Greater Albuquerque Metropolitan Area includes all locations within the City of Albuquerque and Bernalillo County.
- A Local Business is a business with its Principal Office and Place of Business in the Greater Albuquerque Metropolitan Area.
- A Small Business is a Local Business that employs an average of fewer than fifty (50) full-time employees in a calendar year. The calendar year immediately prior to the request for the preference should be used.
- A Principal Office is the main or home office of the business as identified in tax returns, business licenses and other official business documents.
- A Place of Business a business' location in the Greater Albuquerque Metropolitan Areas that is staffed and open to the public on a regular basis.
- A full-time employee is an employee of the business who is hired to work at least forty (40) hours per week, whether in a permanent, temporary or seasonal status. If all full-time employees of the business are hired to work a shorter work week, the Chief Procurement Officer may reduce this requirement, upon receipt of adequate documentation.
- Pay Equity Preference shall be applicable as provided in City Ordinance 5-5-31 (as amended by C/S O-17-33).
- State Resident Business and State Resident Veteran Business shall be applicable as provided in 13-1-21 NMSA 1978.

6. **ADDITIONAL DOCUMENTATION.** If requested, a business shall provide, within three (3) working days of receipt of the request, documentation to substantiate the information provided on the Preference Certification Form. The Chief Procurement Officer shall determine the sufficiency of such documentation.

7. **NO PREFERENCES SHALL BE APPLIED IF FEDERAL FUNDS ARE USED.**

VENDOR
PREFERENCE
AFFIDAVIT OF ELIGILITY

City of Albuquerque
Purchasing Division

One Civic Plaza – 7th Floor
P.O. Box 1293 Room 7012
Albuquerque, NM 87103
Phone: (505) 768-3320
Fax: (505) 768-3355

Preference Type: (Check applicable preference/s) **[ ] Local-City Business** **[ ] Small Business**
[ ] State Resident Business Preference **[ ] State Resident Veteran Business Preference** **[ ] Pay Equity Preference**

Legal Name of Firm:	
Contact Person:	Telephone:
E-mail Address:	Fax:

Mailing Address:	Physical Address (if Different):

Number of full-time employees working in the city of Albuquerque:	Attach 941 Tax Form

Check all that apply:

□ **I certify my company meets the following qualifications to be eligible for Local Business Preference:**
Maintains its principal office and place of business within the Greater Albuquerque Metropolitan Area (City of Albuquerque or Bernalillo County)

1. Such location is staffed with full-time employees.
2. Such location is open to the public on a regular basis.
3. The vendor is operating or performing its business from this location.
4. Note: A post office box shall not be considered a physical business address.

□ **I certify my company meets the following qualifications to be eligible for Small Business Preference:**

1. Meets the requirements for a Local Business Preference (see above).
2. Employs fewer than fifty (50) full-time employees in a calendar year as demonstrated by the attached 941 I.R.S. Tax Form

□ **I certify that I am attaching the Pay Equity Business Certificate.**

□ **I certify that I am attaching the New Mexico State certification of Resident Business or Resident Veteran's Business preference.**

□ **I certify that under the penalty of perjury, the foregoing statements are true and correct. I also acknowledge that any person, firm, corporation or entity intentionally submitting false information to the city in an attempt to qualify for a local or small preference shall be prohibited from bidding on City goods and/or services for a period of up to three (3) years.**

Authorized Signature:_____ Date:_____

Printed Name:_____ Title:_____

ACKNOWLEDGMENT

State of New Mexico
County of _____

Signed and sworn to before me on _____ by _____.

_____
Notary
My Commission expires on

Part 5 - Notice of NO PREFERENCES or NO SMALL AND LOCAL BUSINESS PREFERENCE

RFP NO: _____

NO PREFERENCES ARE AVAILABLE FOR THIS PROCUREMENT BECAUSE:

☐ THIS PROCUREMENT IS FOR A FEDERAL AID CONSTRUCTION PROJECT, OR INVOLVES THE EXPENDITURE OF FEDERAL FUNDS.

NO SMALL AND LOCAL BUSINESS PREFERENCES ARE AVAILABLE FOR THIS PROCUREMENT BECAUSE:

X IT IS EXPECTED THAT THE PURCHASE OR CONCESSION CONTRACT RESULTING FROM THIS PROCUREMENT SHALL BE IN EXCESS OF $5,000,000.

PART 6
DRAFT AGREEMENT

THIS AGREEMENT is made and entered into this ___ day of_____, 20__ by and between the City of Albuquerque, New Mexico a municipal corporation, ("City"), and _____, ("Contractor"), a _____, whose address is _____.

RECITALS

WHEREAS, the City issued a Request For Proposals for the Human Resources Department, P2018000015, titled "Fully Insured Group Dental Insurance", which is Exhibit A to this Agreement; and

WHEREAS, the Contractor submitted its Proposal, dated _____, in response to P2018000015, which Proposal is Exhibit B to this Agreement; and

WHEREAS, the City desires to engage the Contractor to render certain services in connection therewith, and the Contractor is willing to provide such services.

NOW, THEREFORE, in consideration of the premises and mutual obligations herein, the parties hereto do mutually agree as follows:

1. **Scope of Services.** The Contractor shall perform the following services ("Services") in a satisfactory and proper manner, as determined by the City:

Provide Group Dental Insurance in accordance with Exhibit A as supplemented by Exhibit B.

2. **Time of Performance.** Services of the Contractor shall commence on the date of final execution of this Agreement and shall be undertaken and completed in such sequence as to assure their expeditious completion in light of the purposes of this Agreement; provided, however, that in any event, all of the Services required hereunder shall be completed within one year of the date of execution of this Agreement. This Agreement may be extended for up to five (5) additional one-year periods upon written agreement of the parties.

3. **Compensation and Method of Payment.**

A. **Compensation.** For performing the Services specified in Section 1 hereof, the City agrees to pay the Contractor up to the amount of _____ Dollars ($_____), which amount includes any applicable gross receipts taxes and which amount shall constitute full and complete compensation for the Contractor's Services under this Agreement, including all expenditures made and expenses incurred by the Contractor in performing such Services.

B. **Method of Payment.** Such amount shall be paid to the Contractor in

installments, which include any applicable gross receipts taxes, as follows: TBD. Payments shall be made to the Contractor upon completion of each task, upon receipt by the City of a properly documented requisition for payment as determined by the budgetary and fiscal guidelines of the City and on the condition that the Contractor has accomplished the Services to the satisfaction of the City.

C. **Appropriations.** Notwithstanding any other provisions in this Agreement, the terms of this Agreement are contingent upon the City Council of the City of Albuquerque making the appropriations necessary for the performance of this Agreement. If sufficient appropriations and authorizations are not made by the City Council, this Agreement may be terminated at the end of the City's then current fiscal year upon written notice given by the City to the Contractor. Such event shall not constitute an event of default. All payment obligations of the City and all of its interest in this Agreement will cease upon the date of termination. The City's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final.

4. **Independent Contractor.** The Contractor is considered as an independent contractor at all times in the performance of the services described in Section 1. The Contractor further agrees that neither it nor its employees are entitled to any benefits from the City under the provisions of the Workers' Compensation Act of the State of New Mexico, or to any of the benefits granted to employees of the City under the provisions of the Merit System Ordinance as now enacted or hereafter amended.

5. **Personnel.**

A. The Contractor represents that it has, or will secure at its own expense, all personnel required in performing all of the Services required under this Agreement. Such personnel shall not be employees of or have any contractual relationships with the City.

B. All the Services required hereunder will be performed by the Contractor or under its supervision and all personnel engaged in the work shall be fully qualified and shall be authorized or permitted under state and local law to perform such Services.

C. None of the work or Services covered by this Agreement shall be subcontracted without the prior written approval of the City. Any work or Services subcontracted hereunder shall be specified by written contract or agreement and shall be subject to each provision of this Agreement.

6. **Indemnity.** The Contractor agrees to defend, indemnify and hold harmless the City and its officials, agents and employees from and against any and all claims, actions, suits or proceedings of any kind brought against said parties because of any injury or damage received or sustained by any person, persons or property to the extent arising out of or resulting from the negligent acts, errors, omissions, and performance by the Contractor under this Agreement or by reason of any asserted act or omission, neglect or misconduct of the Contractor or Contractor's agents or employees or any subcontractor or its agents or employees. The indemnity required hereunder shall not be limited by reason of the specification of any particular insurance coverage in this Agreement.

7. **Bonds and Insurance.** The Contractor shall not commence any work under this Agreement until the insurances required in Exhibit A, Section 1.23 or the bonds per the attachments to Exhibit A have been obtained and the proper certificates and riders or endorsements (or policies) have been submitted to the City.

8. **Discrimination Prohibited.** In performing the Services required hereunder, the Contractor shall not discriminate against any person on the basis of race, color, religion, gender, sexual preference, sexual orientation, national origin or ancestry, age, physical handicap or disability, as defined in the Americans With Disabilities Act of 1990, as currently enacted or hereafter amended.

9. **ADA Compliance.** In performing the Services required hereunder, the Contractor agrees to meet all the requirements of the Americans With Disabilities Act of 1990 (the "ADA"), which are imposed directly on the Contractor or which would be imposed on the City as a public entity. The Contractor agrees to be responsible for knowing all applicable rules and requirements of the ADA and to defend, indemnify and hold harmless the City, its officials, agents and employees from and against any and all claims, actions, suits or proceedings of any kind brought against said parties as a result of any acts or omissions of the Contractor or its agents in violation of the ADA.

10. **Reports and Information.** At such times and in such forms as the City may require, there shall be furnished to the City such statements, records, reports, data and information, as the City may request pertaining to matters covered by this Agreement. Unless authorized by the City, the Contractor will not release any information concerning the work product including any reports or other documents prepared pursuant to the Agreement until the final product is submitted to the City.

11. **Open Meetings Requirements.** Any nonprofit organization in the City which receives funds appropriated by the City, or which has as a member of its governing body an elected official, or appointed administrative official, as a representative of the City, is subject to the requirements of §2-5-1 *et seq.* R.O.A. 1994, Public Interest Organizations. The Contractor agrees to comply with all such requirements, if applicable.

12. **Establishment and Maintenance of Records.** Records shall be maintained by the Contractor in accordance with applicable law and requirements prescribed by the City with respect to all matters covered by this Agreement. Except as otherwise authorized by the City, such records shall be maintained for a period of three (3) years after receipt of final payment under this Agreement.

13. **Audits and Inspections.** At any time during normal business hours and as often as the City may deem necessary, there shall be made available to the City for examination all of the Contractor's records with respect to all matters covered by this Agreement. The Contractor shall permit the City to audit, examine, and make excerpts or transcripts from such records, and to make audits of all contracts, invoices, materials, payrolls, records of personnel, conditions of employment and other data relating to all matters covered by this Agreement. The Contractor understands and will comply with the City's Accountability in Government Ordinance, §2-10-1 et seq. and Inspector General Ordinance, §2-17-1 et seq. R.O.A. 1994, and also agrees to provide requested information and records and appear as a witness in hearings for the City's Board of Ethics and Campaign Practices

pursuant to Article XII, Section 8 of the Albuquerque City Charter.

14. **Publication, Reproduction and Use of Material.** No material produced in whole or in part under this Agreement shall be subject to copyright in the United States or in any other country. The City shall have unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data or other materials prepared under this Agreement.

15. **Compliance with Laws.** In providing the Scope of Services outlined herein, the Contractor shall comply with all applicable laws, ordinances, and codes of the federal, State, and local governments.

16. **Changes.** The City may, from time to time, request changes in the Scope of Services of the Contractor to be performed hereunder. Such changes, including any increase or decrease in the amount of the Contractor's compensation, which are mutually agreed upon by and between the City and the Contractor, shall be incorporated in written amendments to this Agreement.

17. **Assignability.** The Contractor shall not assign any interest in this Agreement and shall not transfer any interest in this Agreement (whether by assignment or novation), without the prior written consent of the City thereto.

18. **Termination for Cause.** If, through any cause, the Contractor shall fail to fulfill in a timely and proper manner its obligation under this Agreement or if the Contractor shall violate any of the covenants, agreements, or stipulations of this Agreement, the City shall thereupon have the right to terminate this Agreement by giving five (5) days written notice to the Contractor of such termination and specifying the effective date of such termination. In such event, all finished or unfinished documents, data, and reports prepared by the Contractor under this Agreement shall, at the option of the City, become its property, and the Contractor shall be entitled to receive just and equitable compensation for any work satisfactorily completed hereunder. Notwithstanding the above, the Contractor shall not be relieved of liability to the City for damages sustained by the City by virtue of any breach of this Agreement by the Contractor, and the City may withhold any payments to the Contractor for the purposes of set-off until such time as the exact amount of damages due the City from the Contractor is determined.

19. **Termination for Convenience of City.** The City may terminate this Agreement at any time by giving at least fifteen (15) days' notice in writing to the Contractor. If the Contractor is terminated by the City as provided herein, the Contractor will be paid an amount which bears the same ratio to the total compensation as the Services actually performed bear to the total Services of the Contractor covered by this Agreement, less payments of compensation previously made. If this Agreement is terminated due to the fault of the Contractor, the preceding section hereof relative to termination shall apply.

20. **Construction and Severability.** If any part of this Agreement is held to be invalid or

unenforceable, such holding will not affect the validity or enforceability of any other part of this Agreement so long as the remainder of the Agreement is reasonably capable of completion.

21. **Enforcement.** The Contractor agrees to pay to the City all costs and expenses including reasonable attorney's fees incurred by the City in exercising any of its rights or remedies in connection with the enforcement of this Agreement.

22. **Entire Agreement.** This Agreement contains the entire agreement of the parties and supersedes any and all other agreements or understandings, oral or written, whether previous to the execution hereof or contemporaneous herewith. Exhibits A and B, attached hereto, are hereby made a part of this Agreement.

24. **Applicable Law.** This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of New Mexico, and the laws, rules and regulations of the City of Albuquerque.

25. **Debarment, Suspension, Ineligibility and Exclusion Compliance.** The Contractor certifies that it has not been debarred, suspended or otherwise found ineligible to receive funds by any agency of the executive branch of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States. The Contractor agrees that should any notice of debarment, suspension, ineligibility or exclusion be received by the Contractor, the Contractor will notify the City immediately.

26. **Approval Required.** This Agreement shall not become binding upon the City until approved by the highest approval authority of the City required under this Agreement.

IN WITNESS WHEREOF, the City and the Contractor have executed this Agreement as of the date first above written.

CITY OF ALBUQUERQUE

Approved By:

_____

Chief Administrative Officer

Date: _____

_____, **Director**

Department _____

Date: _____

CONTRACTOR:

By: _____

Title: _____

Date: _____

City of Albuquerque
Dental Insurance Rate History

Delta Dental of New Mexico

	Plan Year 13/14	Plan Year 14/15	Plan Year 15/16	Plan Year 16/17	Plan Year 17/18
Employee Only	29.33	30.72	30.72	31.64	31.64
Couple	59.30	62.12	62.12	63.98	63.98
Single Parent	65.15	68.24	68.24	70.29	70.29
Family	88.20	92.39	92.39	95.16	95.16

Appendix A-1

Dental Eligibility and Participation
As of 8/1/2017

	Entity	Eligible	Participating	Communi-cating Eligibility	Premium Deductions Per Year	Dental ER/EE% Premium Split
1	Albuquerque	5618	5245	834 file	26	80/20
2	Albuquerque Bernalillo County Water Utility Authority	629	580	834 file	26	80/20
3	Albuquerque Housing Authority	61	57	834 file	26	80/20
4	Belen	101	74	Form	24	0/100
5	Bernalillo Town	83	71	Form	26	70/30
	Bernalillo Town Public Safety			Form	26	80/20
6	Bosque Farms	31	30	Form	24	85/15
7	Cochiti Lake	4	3	Form	26	60/40
8	Corralles	55	42	Form	24	70/30
9	Cuba	10	10	Form	26	80/20
10	Edgewood	32	25	Form	26	80/20
11	Los Ranchos De Albuquerque	13	10	Form	26	50/50
12	Middle Rio Grande Conservancy District	211	177	Form	24	80/20
13	Mountainair	11	11	Form	26	100/0
15	Sandoval County	463	384	Form	26	70/30
14	San Ysidro	5	1	Form	26	60/40
16	Southern Sandoval County Arroyo Flood Control Authority	10	10	Form	26	83/17
17	Tijeras	16	8	Form	52	80/20
	Totals	7353	6738			

Questionnaire Instructions to Vendors:

*****DO NOT ALTER THE QUESTIONS OR QUESTION NUMBERING***.**

- Provide answers to the questionnaires in MS Word format.
- Provide an answer to each question even if the answer is "not applicable" or "unknown."
- Answer the question as directly as possible.
  - If the questions asks "How many..." provide a number.
  - If the question asks "Do you..." indicate Yes or No **first**, followed by your additional narrative explanation.
- Lengthy responses may be truncated when displayed. Be concise in your response. Use bullet points as appropriate. Reconsider how to word any response that exceeds 250 words in length so that the response contains the most important points you want displayed. Responses longer than the 250 words will be truncated in review.
- Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments.
- Vendor will be held accountable for accuracy/validity of all answers.
- Remember, RFP responses will become part of the contract between the winning Vendor and The City of Albuquerque.
- Any references to "Client" in the questionnaire refer the The City of Albuquerque. Other abbreviations include CITY for the City of Albuquerque.

NOTE: Answers to the questions must be provided in hard copy and MS Word format on a Flash Drive. The Questionnaire on the Flash Drive must NOT be submitted in PDF format or password protected! Submit the signed copies of your documents as a separate PDF.

DO NOT PDF or otherwise protect the Flash Drive

MINIMUM CONTRACTUAL REQUIREMENTS
ALL VENDORS

Indicate "Yes" or "No" as to your organization's ability to meet the minimum requirements. **Failure to complete this form and include it with your response may result in elimination from consideration.**

A "Yes" response shall result in the provision being adopted in the final contract. No deviations will be accepted for "YES" answers in this section.

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
1. **Proposal, Interview, and Best and Final Responses Become Part of Contract:** Do you agree that your written response to this RFP, written information provided as part of an interview and written responses provided during a Best and Final negotiation become part of the contract between your organization and The City of Albuquerque?		
2. Agree that your proposal and pricing are **not** contingent on acceptance of other coverages or services outside the scope of this RFP.		
3. Are each of the coverage lines included in your response free-standing and not contingent upon the CITY selecting the entire package of services being offered?		
4. **Effective Date of Offer:** Bid terms are guaranteed for at least 180 days from the proposal due date.		
5. You agree that the Contract has a length of one (1) year with the option to renew for five(5) additional one year periods. Multiple year rate guarantees will be considered favorable by the evaluation committee.		
6. **Variance Provision:** Any provisions relating to reevaluation of proposed rates due to variation in enrollment or other contingencies of the quote must be clearly noted in the financial section of the questionnaire.		
7. Any changes in **financial strength** rating agencies (downgrades or upgrades) shall be disclosed to the City of Albuquerque within 30 days of the effective date of the award.		
8. **Proper Licensure:** Do you agree to maintain proper licensure as required by any state law where it relates to the services that you will be performing for The City of Albuquerque?		
9. **Prior Notice of Major Operational Changes:** Do you agree to provide no less than 30 day notice to the City of Albuquerque for any changes involving the sale, merger, data breaches, layoffs, participating provider facility terminations, consolidation or outsourcing of services to foreign countres that will impact The City of Albuquerque?		
10. **Subcontracting:** Unless otherwise explained in this RFP, do you agree that you will disclose all subcontractor arrangements.		

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
11. **Mutual Indemnification:** Do you agree that the contract will contain a mutual indemnification/hold harmless provision?		
12. **HIPAA Compliance:** Vendor attests to meeting all applicable HIPAA EDI, Privacy, Security, and HITECH requirements and agrees to hold the City of Albuquerque harmless for breaches that are the result of vendor actions.		
13. The successful vendor's proposal must contain provisions reserving these rights to City of Albuquerque: **No-Loss, No-Gain:** Current participants in any of City of Albuquerque's sponsored PPO dental and voluntary vision will be provided coverage on a "no-loss, no-gain" basis.		
14. **Eligibility Rules and Uncertain Claimant Eligibility Situations:** The vendor agrees to the specified eligibility rules established by City of Albuquerque. The vendor(s) must communicate directly with City of Albuquerque regarding any uncertain claimant eligibility situations before notifying the claimant of ineligibility.		
15. **No Member Communication Without Client Consent:** The vendor will not automatically enroll City of Albuquerque in any programs that involve any type of communication with members, without express written consent from City of Albuquerque.		
16. **Rights to Claims Data:** Selling of the City of Albuquerque's data to outside entities must be disclosed and approved in writing in advance by the City of Albuquerque.		
17. **Right to Audit:** City of Albuquerque reserves the right to review and audit the PPO dental and vision's files and financial accounting data to assure that claims subject to each proposed coverage are evaluated in accordance with the plan provisions. Additionally, the vendor agrees to allow for no less than one claim audit per year at no cost to City of Albuquerque using the auditor of City of Albuquerque's choice (so long as the auditor is not a competitor or involved in any legal proceedings with the vendor). The vendor will cooperate with any outside auditor the City of Albuquerque selects to perform the audit. This provision shall survive the termination of the agreement between the parties for a period of two (2) years.		
18. **Recoveries:** 100% of all validated recoveries made through the vendor, its subcontractors, or City of Albuquerque audits will be credited to City of Albuquerque's experience.		
19. **Maintenance, Ownership, and Transfer of Records:** a) The vendor will be required to maintain all pertinent records for seven years. This is in conjunction with prudent business practice and (as applicable) ERISA provisions; and b) The vendor will be charged with the safekeeping of plan experience information; and c) In the event of contract termination, and related to contract termination, the vendor will be required to cooperate with City of Albuquerque, or their representative, in the prompt, accurate, and orderly transfer of City of Albuquerque's plan experience, claims and utilization information to City of Albuquerque or its designated succeeding dental and/or vision plan carrier at **no added fee.**		

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
20. Termination Provisions: City of Albuquerque may terminate the contract at any time after the first complete plan year without cause, by giving 90 days written notice. City of Albuquerque can terminate with cause with 30 day notice unless proper remedy is provided by the vendor. The vendor may only terminate for cause with proper legal minimum notice requirements. (Exclude consideration of non-payment).		
21. Renewal Notification: The vendor must provide any rate changes in writing with full justification **by January 1 of the Calendar year for a July 1 effective date in that Calendar Year. (For example, January 1, 2018 is the deadline for rate actions effective July 1, 2018).** Additionally, the vendor must provide the following with each renewal package: a. Any contract language changes requested b. Specific justification of rate/fee changes, including the Rate Development/Underwriting Worksheet. c. Current enrollment by rate class d. Additional options for consideration e. All underwriting caveats f. Any proposed plan design or benefit changes		
22. Assignment or Transfer of Rights: Do you agree that you will not assign or transfer the rights or obligations of the contract or any portion thereof, without the prior written approval of City of Albuquerque?		
23. Scope of Work: Are you able to provide the services outlined in the Scope of Work?		
24. Commissions: a) Is your proposal submitted net of commissions?		
b) If commissions are built into your rates and cannot be stripped out of them will you pay them to the consultant, the Segal Group to offset the City of Albuquerque's consulting fees?		

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
If you answered "No" to any of the questions above, please provide an explanation below:		
Requirement No.	**Explanation**	

GENERAL INFORMATION (All Vendors)	VENDOR RESPONSE If your response varies based on line of coverage, please clearly indicate	
	Month and Year of Rating	
1. Indicate your firm's most recent ratings by all of the following agencies:	Rating	Date
A.M. Best		
Standard and Poor's (S&P)		
Fitch		
Moody's		
Weiss		
2. Organization background:		
a. Organization's name.		
b. Corporate headquarters address.		
c. City & State that will service the City's account.		
d. Does your firm have a local office?		
e. Date your firm became operational.		
f. Date your firm became operational for the services requested in this RFP.(Specify dental and/or vision separately.)		
g. Ownership of your firm.		
3. Is your company "affiliated" with another company? If so, describe the "affiliate relationship." "Affiliated" means owned by another company, owned by a common controlling shareholder or interest, or inter-tied by contract so as to be under the dominion or influence of another.		
4. If your firm is not a corporation, please advise who each of the partners, proprietors or other owners are and whether they have interest in any dental services provider firms.		
5. Is your firm involved in any current litigation against or from the Client? If yes, please describe.		

GENERAL INFORMATION (All Vendors)	VENDOR RESPONSE If your response varies based on line of coverage, please clearly indicate
6. Have you been involved in litigation within the last five years arising out of your performance in the administration of a Group Dental or Vision plan? Exclude routine matters involving participants that do not reflect on your performance under the contract with your Client. If the answer is yes, explain fully.	
7. a. Has your organization **acquired, been acquired by, or merged with** another organization in the past 24 months?	
b. Is your firm **anticipating restructuring or reorganizing** in the next two years? (Include any major staff relocations or office closings.)	
c. What is your plan for continuance of principles in the event of a reorganization or restructuring?	
8. Do you understand that you are prohibited from using the IIHI for any purpose other than as required by law and further agree to promptly destroy such data if you are NOT the successful bidder?	
9. Provide a description of those circumstances under which benefits continue being paid upon: a. Termination of an insured's coverage	
b. Termination of the policy	
10. Implementation: a. What is the minimum implementation lead-time needed to initiate the proposed services?	
b. List any transition issues the City should consider.	
c. List any specific administrative procedures or information your firm will need from the City in order to implement your services?	

GENERAL INFORMATION (All Vendors)	VENDOR RESPONSE If your response varies based on line of coverage, please clearly indicate
11. If your company is awarded this business, how soon after notification of the award would you be able to have a draft of the: a. Master Policy?	
b. Certificate booklet?	
c. ID Cards	
12. Complete the following information about the individual who will be assigned as the OVERALL ACCOUNT MANAGER for the City: Name & Title:	
City/State:	
Length of Time in Current Position:	
13. Complete the following information about the individual from your organization who will be assigned as the PRIMARY DAY TO DAY CONTACT for the City: Name & Title:	
City/State:	
Length of Time in Current Position:	
14. The master contract is to reflect the elimination of the actively-at-work restrictions or deferred effective date for employees and dependents eligible on the effective date of the contract. This provision however, does not remove the liability of the prior carrier for expenses incurred with respect to the extension of benefits provisions of their contract. Indicate your agreement to this stipulation.	
15. Identify any services under any subsequent contract that may be awarded as part of this RFP that are currently or planned to be performed outside the borders of the United States.	
16. Do you agree to provide the City a clear path (representative phone number or email, etc.) for employees to register complaints?	

GENERAL INFORMATION (All Vendors)	VENDOR RESPONSE If your response varies based on line of coverage, please clearly indicate
17. All sample forms and communication materials should be provided for approval to the City in advance of distribution (ID cards, claim forms, enrollment forms, booklets, brochures, flyers, mailers, etc.). Do you agree to this requirement?	
18. Does your firm have the capability to provide communication pieces in Spanish and other languages? Please specify.	
19. Do you agree to attend the Annual Open Enrollment meeting at the City's desired location (normally two meetings on one day at one location) at no additional cost?	

CUSTOMER SERVICE OPERATIONS DENTAL	VENDOR RESPONSE
1. Will there be a designated team of customer service representatives for the City?	
2. Will you provide a toll-free customer service number for claim and benefit inquiries?	
3. Are questions regarding provider billing, benefits, or member grievances covered by the same phone number? If not, please explain.	
4. What hours and days are live customer service representatives available (indicate using NM time)?	
5. Are your customer service representatives located in the continental US?	
6. What alternative services do you provide? (i.e., Assistance for the hearing impaired, 24-hour toll-free automated benefits and eligibility, bilingual option, customer service accessible via the internet, etc.).	
7. Please provide the following statistics for 2016 and 2017 (ytd): Average speed to answer: ___% within 30 seconds	
Busy rate: ___ seconds	
Abandonment Rate : ___%	
8. Will the City have online access to address additions, terminations, and status changes?	
9. Are plan participants able to access a web portal for: a. Status of claims	
b. Benefit brochure	
c. ID cards	
d. Cost estimator of common services	
e. Cost of services by a specific provider	

CUSTOMER SERVICE OPERATIONS DENTAL	VENDOR RESPONSE
f. Network Provider Quality	
g. Deductible/benefit maximum accumulator	
10. Can the City and their designated Consultant access eligibility and reporting through a secure website?	
11. What kind of reports can the City and/or their designated Consultant retrieve online?	
12. What other kinds of information can the City obtain through your website?	
13. Please provide a temporary login/password so the Client can evaluate your tools. (If Available)	
14. What methods does your organization use to measure customer satisfaction?	
15. Provide a copy of your most recent customer satisfaction survey statistics.	
16. How do your providers recognize a patient as a participant in your program – voucher, ID card, electronic connection to your eligibility database, etc.? Please explain.	

DENTAL NETWORK	VENDOR RESPONSE
1. Do you contract with individual dentists, dental group facilities, or both?	
2. Do you wholly own and operate the network you are proposing for the City?	
3. Indicate the marketing name of the network you are proposing.	
4. Provide the number of network providers that terminated in the City's service area during the past 12 months: a. By your organization	
b. By the provider	
5. What changes do you anticipate to your network over the next two years?	
6. Please provide Geo Access reports using the following access standards: For the census provided, provide a GeoAccess report to determine the following (a total of 6,738 employees must be used in each determination): Reports should reflect city, state, zip code, and number of **unique** dental providers by zip, number of employees with desired access (as defined below) for each category AND **locations (Zip Code and County) where access standards are not met** including the number of employees without desired access. a. **General Dentists:**	
Access criteria: 2 providers within 10 miles of home zip code	
b. **Specialists (excluding orthodontists):**	
Access criteria: 2 providers within 10 miles of home zip code	

DENTAL NETWORK	VENDOR RESPONSE
c. **Orthodontists:**	
Access criteria: 2 providers within 15 miles of home zip code	
7. Have you provided electronic copies of your proposed DPPO Sandoval and surrounding Counties network providers in Microsoft **Excel** format as requested?	
8. How does your organization measure the quality of care provided by the providers in your network?	
9. How many complaints per 1,000 visits do you receive on your network providers?	
10. Do any network providers include night or weekend hours?	
11. In the past 12 months and for the City's service area, what were the average number of days between a request for non-emergency appointment and the actual visit for the network you are proposing?	
12. Do network providers pay a membership fee to your organization?	

DENTAL PPO BENEFIT ADMINISTRATION	VENDOR RESPONSE
1. Are you able to match the requested PPO Dental plan?	
2. a. Does your proposed plan include any exclusions or limitations that are more restrictive than the current plan?	
b. Does your proposed plan include any services that are paid in a different benefit class than the existing plan design?	
c. Does your proposal include any pre-existing condition limitations?	
d. If yes to 'a', 'b', or 'c' above, identify any differences in the Deviations Exhibit A. Do not merely refer the reader to your proposal but specifically detail in the exhibit.	
3. Describe any exclusions or limitations on your orthodontia benefits.	
4. Describe how treatment in progress (at initial takeover) will be covered. 5. How will orthodontic claims be adjudicated? 6. What portion of claim expenses will be honored?	
7. Describe how treatment in progress will be covered if your plan is terminated during an episode of treatment. 8. What services (i.e., root canal, crowns, etc.) are covered and for what amounts?	
9. Describe any missing tooth limits your plan may have for new participants.	
10. Describe how you would handle a late entrant.	
11. Are any medications covered under the dental plan?	
12. Are implants covered under the dental plan?	
13. How does your plan handle a resin composite filling on teeth that traditionally would be treated with an amalgam?	

DENTAL PPO BENEFIT ADMINISTRATION	VENDOR RESPONSE
14. If benefits under the City's plan are exhausted or not covered, can members take advantage of your negotiated pricing? If not, please explain.	
15. How will your plan pay benefits for students who reside outside of the state?	
16. How is emergency care handled for individuals in the service areas?	
17. How is emergency care handled for individuals traveling outside the service areas?	
18. Describe how your pretreatment review system operates and the current turnaround time.	
19. What additional benefits do you offer to pregnant women?	
20. What additional benefits do you offer for plan participants with diabetes?	
21. Does your plan allow nitrous oxide analgesia? If so, please indicate any additional costs.	
22. What types of sedatives do you cover and what are the coverage limitations?	
23. Do you cover temporary fillings?	
24. Up to what age do you cover fluoride treatments and how often?	
25. Up to what age do you cover sealants and how often?	

DENTAL PPO CLAIM ADMINISTRATION SERVICES	VENDOR RESPONSE
1. From what location would this policyholder's claims be processed?	
2. What is your company's claims processing turn-around time for dental claims not involving coordination of benefits?	
3. Does your claim system have any protections against fraud by:	
a. Providers	
b. Members	
c. Employees	
4. Does your claim system have any protections against unbundling and/or upgrading claims? If so, describe in detail.	
5. a. What cost containment/management programs are available to City of Albuquerque (i.e., precertification, utilization review, etc.)?	
b. Are these programs included in your quoted premium or are they an additional cost? If an additional cost, list the cost for each individual program.	
6. a. How are network claims processed?	
b. Are any authorization forms necessary or ID cards required?	
c. Do members pay up-front and submit claims for reimbursement or are members responsible for only plan copays, deductibles and coinsurance?	
d. If paper claim submission is required, what is the turn-around time for a member's claim to be processed (date of receipt to date check is issued)?	
e. Are there any time limits for submitting claims?	

DENTAL PPO CLAIM ADMINISTRATION SERVICES	VENDOR RESPONSE
7. a. Will your organization process any non-participating provider claims?	
b. How are non-network claims processed?	
8. How do you determine Usual, Customary, and Reasonable (UCR) for non-network dental benefits (e.g., own data, percentile of HIAA data, relative value scale, Fair Health)?	
9. Does your plan use maximum allowable cost for limiting non-network allowances?	
10. What UCR level have you used for non-network claims?	
11. What percent of Fair Health for zip code 870 and 871 is your non-network allowance?	
12. Explain how maximum allowable charges are determined geographically: a. By the location of the employer, or the provider of dental services? Other? Please explain.	
b. How are specific areas delineated *(e.g.,* 5 digit zip, 3 digit zip, county)?	
13. How often is data updated?	
14. What steps are taken if the maximum allowable charge is un-coded?	
15. How are the client and plan participants supported in their resistance to charges in excess of the maximum allowable charge?	
16. How can a claimant find out what the maximum allowable charge is for a particular procedure in advance of having the procedure performed?	
17. With respect to dental surgery, do you ever reimburse assistant surgeons? 18. What is the basis for such a determination 19. How is the allowance for the assistant surgeon, if any, calculated?	

DENTAL PPO CLAIM ADMINISTRATION SERVICES	VENDOR RESPONSE
20. When you are COB secondary payor, do you use your UCR profiles or those of the primary carrier to determine your level of reimbursement?	

DENTAL PPO PLAN UNDERWRITING	VENDOR RESPONSE
1. What experience period will be used for the first renewal (e.g., first 6 months)? What period will be used in subsequent renewals?	
2. How much would the group have to change in size before the credibility percentages above would vary by more than 10 percent?	
3. What credibility do you anticipate assigning to the Client's experience at: First Renewal?	
Subsequent?	
4. How will projected incurred claims be estimated?	
5. a. Do you agree to use client specific lag to determine paid to incurred adjustments for renewal calculations?	
b. If no, describe how you adjust paid claims to incurred claims? What standard reserve factor would you use?	
6. Is retention calculated as a percentage of claims, a percentage of premium, or a per capita basis?	
7. What were your historic 2016 and 2017 DPPO trends and anticipated 2018 trends for your proposed plan in the greater Albuquerque metropolitan area? a. 2016	
b. 2017	
c. Anticipated 2018	
FINANCIAL	
1. Please list all provisions relating to reevaluation of proposed rates due to variation in enrollment or other contingencies of the quote.	

DENTAL BILLING PROCESS	VENDOR RESPONSE
1. When is premium due and when is it considered delinquent?	
2. How do you handle reconciliation of billing and enrollment issues?	
3. How often would you audit the City of Albuquerque for eligibility discrepancies?	
4. The City of Albuquerque would prefer at a minimum current month plus 60 days for retroactive terminations. What is your timeframe allowed for retroactive terminations? Is this negotiable?	

For the following categories, provide the performance standard you are willing to offer, the financial penalty (maximum dollar amount or % of administrative fees) you will agree to pay if the standard is not met, and the method of measuring the penalty.

PERFORMANCE GUARANTEES	VENDOR RESPONSE
1. **Vendor attendance at the Client meetings** Attendance by vendor representatives when requested at meetings scheduled by the Client during the contract period and implementation phase.	
2. **Vendor call (or e-mail) return timeliness** The Client or designated consultant's calls (or e-mails) to vendor are returned within 48 business hours.	
3. **Processing monthly eligibility updates** All updates to eligibility or enrollment records will be made within 3 business days after the information is received by the vendor.	
4. **Telephone call availability & answering speed** 90% of all calls are answered within 30 seconds, and telephone service is available between 8:00 am and 4:30 pm MST on business days.	
5. **Telephone call on-hold (in-queue) time** An average of less than 2 minute(s) on hold before a **human being** answers.	
6. **Telephone Abandonment Rate** An abandonment rate of less than 3% is maintained during standard business hours.	
7. **Claims Processing Accuracy** 99% of claims dollars submitted for payment will be accurately processed and paid. Regardless of whether or not these standards of performance are satisfied, the vendor must reimburse the Client for all overpayments that are not recovered from the recipient within 60 days after the overpayment is discovered. The Client will assign its right to any recover such overpayments to the vendor.	

PERFORMANCE GUARANTEES	VENDOR RESPONSE
8. **Turnaround Time on Claims Payments** 97% of all claims received will be completely processed (paid, denied, or pended for additional information) within 14 calendar days after they are received. 100% of claims will be processed within 30 calendar days of receipt.	
9. **Timeliness of Claim Reports** Each report the vendor will supply the Client will be provided within a mutually agreed upon timeframe.	
10. **Claims Coding** 99% of all claims will be coded with no errors.	
11. **Implementation** Successful implementation as defined by key milestones. Include measurable milestones in your proposal.	
12. **Data Exchange** Receive and transmit data with vendors based on a frequency defined by the business needs of the Client.	

REPORTING

1. Based on the attached required structure, do you agree to provide the following reports as identified in the table below? Please indicate if your report is available online to City of Albuquerque (and/or their consulting firm). Please include sample reports.

REPORTING – ALL VENDORS

Coverage Line	Month	Quarter	Annual	Vendor Response (Y or N)	Online Access (Y or N)	Excel (Y or N)
Dental						
Enrollment (subscriber/member) by coverage tier and active/cobra.	X					
Premiums paid	X					
Claims paid by Status (active/cobra) and in-network vs out of network	X					
Utilization report			X			
Lag report			X			
Ad Hoc Reporting Capabilities						
Ability for the City to generate Ad Hoc Reports	Determined by the City					

DEVIATIONS

Offeror Name: _____

Signature: _____

Date: _____

Deviations	
Reference in RFP	**Deviation**

Submitted by:
Company Name:

Address:

City, State, Zip:

DELTA DENTAL

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 2517
City of Albuquerque

Benefit Period: July 1 through June 30

Covered Services:	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	80%	80%
Emergency Palliative Treatment – to temporarily relieve pain	100%	80%	80%
Sealants – to prevent decay of permanent teeth	100%	80%	80%
Brush Biopsy – to detect oral cancer	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
Periodontal Maintenance – cleanings following periodontal therapy	100%	80%	80%
Basic Services			
Minor Restorative Services – fillings	85%	85%	85%
Endodontic Services – root canals	85%	85%	85%
Periodontic Services – to treat gum disease	85%	85%	85%
Oral Surgery Services – extractions and dental surgery	85%	85%	85%
Other Basic Services – misc. services	85%	85%	85%
Major Services			
Crown Repair – to individual crowns	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Relines and Repairs – to bridges, dentures, and implants	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	No Age Limit	No Age Limit	No Age Limit

* 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.
- Routine prophylaxes (cleanings) and periodontal maintenance are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Space maintainers are payable once per area per lifetime for people up to age 14.

Customer Service Number: (505) 855-7111 or (877) 395-9420
www.DeltaDentalNM.com
2500 Louisiana Boulevard NE, Suite 600, Albuquerque, NM 87110

- Bitewing X-rays are payable twice per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Diagnostic casts are Covered Services.
- Sealants are payable once per tooth per three-year period for the occlusal surface of permanent molars up to age 17. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- Prescription medicaments are Covered Services for dentally related conditions.

Maximum Benefit Amount: $1,500 per person total per Benefit Year on all services except diagnostic and preventive, X-rays, sealants, full mouth debridement, periodontal maintenance, emergency palliative, consultations, cephalometric films, photos, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption). $1,200 per person total per lifetime on cephalometric films, photos and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Deductible: $50 Deductible per person total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The deductible does not apply to diagnostic, preventive, X-rays, sealants, full mouth debridement, periodontal maintenance, emergency palliative, consultations, cephalometric films, photos, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Eligibility Provisions: An employee who works the minimum number of hours per week and/or satisfies the eligibility definition(s) and Eligibility Waiting Period as specified by the Client and agreed to by Delta Dental.

Also eligible if you are enrolled are your legal spouse, and your children, as defined in the Dental Benefit Handbook. Eligible children include children through the end day prior to the day on which the child turns age 26 regardless of employment, marital, student or dependent status, and unmarried children over age 26 who cannot support themselves because of a mental or physical impairment which meets the additional requirements for eligibility. Eligibility is subject to timely enrollment or any other applicable requirements. In addition, your domestic partner, as defined by the Group and approved by Delta Dental, and his/her children (as defined in the Dental Benefit Handbook) may enroll subject to the same timely enrollment or other applicable requirements.

Subject to any additional requirements which may apply, individuals are eligible to enroll on the first day of the payroll period following submittal of completed enrollment card when submission is within 31 days of date of hire.

Subject to any other provisions which may also apply, benefits will cease on the actual date in which the employee is terminated.

Special Benefit Provisions: None.

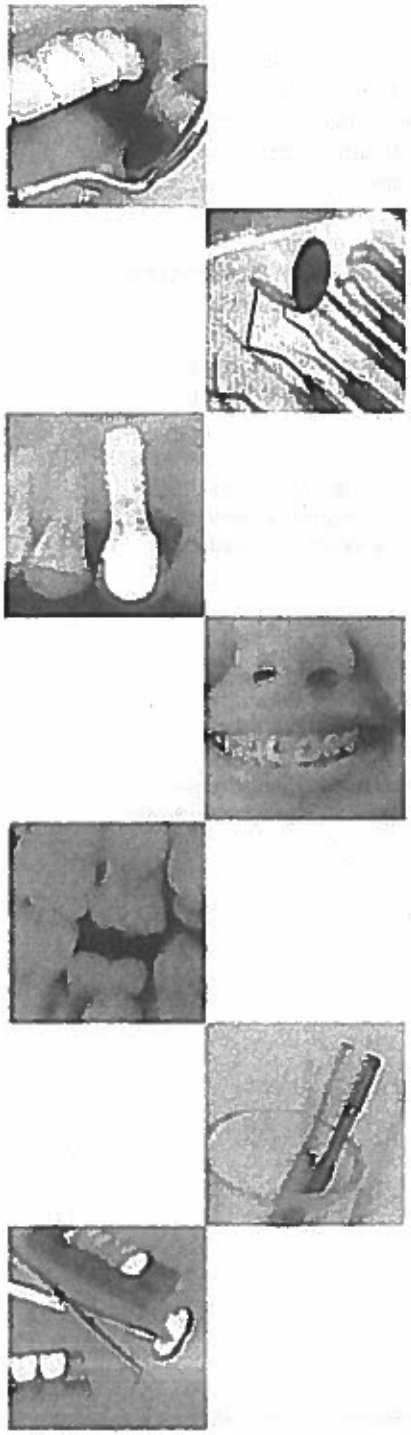
UNDERSTAND YOUR BENEFITS: This Summary of Benefits is intended only to highlight benefit levels. It does not reflect all limitations or plan provisions and does not provide complete coverage information. Refer to your Dental Benefit Handbook for other important eligibility and plan provisions and/or call Delta Dental's Benefit Services Department to speak with a representative who can answer your coverage questions.

Ask your dentist for a Pre-determination of benefits anytime more costly procedures are anticipated. When requested by a dental provider, an advance estimate of benefits payable can be provided by Delta Dental before dental care services are received. Pre-determination is strongly recommended and there is no charge for this service.

This Summary of Benefits is attached to the Dental Benefit Handbook and made part of it. This Summary of Benefits supersedes any contract provision of the Dental Benefit Handbook and the Group Administrative Services Contract.

DELTA DENTAL

Dental Benefit Handbook
For Members



Featuring the
Delta Dental PPO Point of Service Network

We do dental. ***Better.***

Dental Benefit Handbook—Frm 104PPO POS – 08/13

Delta Dental PPO[SM] Point of Service

Welcome to the growing number of people who receive fully insured dental benefits from Delta Dental of New Mexico.

Benefits are provided under a Group Dental Insurance Contract ("Contract") entered into between an employer ("Group") and Delta Dental Plan of New Mexico, Inc., ("Delta Dental"). Claims for benefits are sent to Delta Dental. Benefit determination, administration and claims payment is the responsibility of Delta Dental. In addition to providing benefits, Delta Dental administers enrollment, customer service and the Delta Dental provider network(s) selected by the Group.

This Dental Benefit Handbook, along with the Summary of Dental Plan Benefits, describes important plan provisions. Any additional provision or exception shown on the Summary of Dental Plan Benefits supersedes any contract provision in this handbook or in the Group Dental Insurance Contract.

Enrolled persons will be notified in writing by Delta Dental of any material changes to the group dental plan. Any modification of this plan will apply to all persons covered by this plan at the time of such changes, whether or not employed.

This handbook along with all supporting documentation and lists of participating New Mexico dentists are always made available to you at www.deltadentalnm.com. Please take time now to become familiar with the dental coverage. For answers to questions about the benefits, please call:

Delta Dental of New Mexico
Customer Service Department
(505) 855-7111
or
toll free (877) 395-9420

Good oral health is an important part of good general health. Delta Dental plans are designed to promote regular dental visits. Take advantage of your benefits by calling a Delta Dental dentist today for an appointment.

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I. ELIGIBILITY AND ENROLLMENT

A. Determining Eligibility

1. Individuals who meet one of the following qualifications and enroll in this plan are eligible.
   a. An employee who works the minimum number of hours per week and/or satisfies the eligibility definition(s) and Eligibility Waiting Period as specified by the Group and agreed to by Delta Dental.
   b. A dependent of the eligible employee defined as:
      i. spouse as defined by New Mexico State Law;
      ii. unmarried children from birth through the end of the month of their 25th birthday who are primarily dependent on the enrolled employee for support; unless otherwise indicated in the Summary of Dental Plan Benefits.
      iii. unmarried children age 25 or older who cannot support themselves because of mental or physical impairment that began before age 25 and are dependent on the enrolled employee for support and maintenance. Proof of these facts must be given to Delta Dental within 31 days if requested.
      iv. Please refer to your Summary of Dental Plan Benefits to verify age limitations that may apply to specific dental treatment and to the "Eligibility Provisions" to verify the dependent child age limitation.
2. The definition of "children" for the purposes of coverage under this dental plan is:
   a. natural child(ren);
   b. newly-born child(ren);
   c. stepchild(ren);
   d. child(ren) of a non-custodial spouse of any enrolled employee
   e. child(ren) for whom the enrolled employee is the legal guardian;
   f. legally adopted child(ren), including children placed with an enrolled employee or spouse for adoption. Coverage shall apply without any pre-existing benefit restrictions;
   g. foster child(ren) living in the same household as an eligible employee or spouse as a result of placement by a state licensed placement agency;
   h. dependent child(ren) required by a Qualified Medical Child Support Order (QMCSO) or a court or administrative order are also eligible for coverage without regard to any Open Enrollment restrictions.

3. The following persons are not eligible: spouses or children in military service, and any individuals not defined as eligible above. An enrolled employee may not also enroll as an enrollee of another enrolled employee under the same employer plan.

B. Enrollment Requirements

1. Employees and their eligible dependents must enroll to be covered under this plan. Unless required by law, eligible dependents may enroll only if the eligible employee enrolls. Enrollments must be completed and received within 31 days of the eligibility date.
2. Newly eligible employees and dependents may enroll in accordance with their dates of eligibility.
3. An enrolled employee may elect to enroll eligible dependents under the following conditions:
   a. eligible dependents must be enrolled at the time the eligible employee becomes enrolled, or within 31 days from the date they become dependents, or within 31 days of loss of other dental coverage, or during an Open Enrollment period;
   b. an enrolled employee may not also enroll as a dependent under the same employer's plan;
   c. dependents may enroll as the enrollee of only one enrolled employee;
   d. newly-born dependents become eligible on the date of birth and may be enrolled on the Group's effective date, within 31 days of birth or at Open Enrollment.
4. Delta Dental will allow an annual Open Enrollment period for all eligible employees of the Group. Open Enrollment is a period of time specified by the Group and approved by Delta Dental to allow eligible employees and/or their dependents to enroll in this plan or to cancel coverage under this plan for the renewed contract period. Open enrollment changes are effective the first day of the Group's renewed contract period.
5. If an eligible employee does not elect coverage when first eligible, he/she may only enroll during the next Open Enrollment period. If an eligible employee elects not to enroll himself/herself or their dependents, a waiver must be signed on the enrollment form at the time of initial eligibility. For individuals waiving due to other dental coverage, this waiver does not affect eligibility for enrollment within 31 days if a loss of coverage occurs in the future. Proof of loss of other dental coverage must be provided to Delta Dental, within 31 days.
6. Delta Dental will not pay benefits for persons who are not enrolled, nor will Delta Dental pay benefits for an enrolled person if the Group premium has not been paid for that person for the month in which dental services are performed.
7. The Group is responsible for submitting monthly premium to Delta Dental on behalf of all enrollees. Premium may include contributions by enrollees as determined by the Group.

C. Effective Dates of Coverage

1. Unless otherwise approved by Delta Dental and indicated on the Summary of Dental Plan Benefits, coverage for an enrolled employee becomes effective on the first day of the month following that employee's date of eligibility.
2. Coverage for newly-born child(ren) will become effective on the date of birth, if enrolled within 31 days, but not before the coverage date applicable to the enrolled employee.
3. Coverage for enrolled dependents, except as noted in paragraph two (2) above, becomes effective on the same date as the enrolled employee or on the first of the month following the dependent's date of eligibility.
4. Delta Dental must receive notification of any change of eligibility status within 31 days of a change in eligibility status or a qualifying event. The corresponding change in coverage will become effective on the first day of the following calendar month.

D. Re-enrollment After Voluntary Cancellation of Coverage

1. An enrolled employee may cancel employee or dependent coverage during an annual Open Enrollment period. Re-enrollment is not available until the next annual Open Enrollment period or upon subsequent loss of coverage.
2. An enrolled employee who cancels coverage or cancels dependent coverage at any time other than an Open Enrollment period may not re-enroll those same dependents unless there is a subsequent Qualifying Event or proof that the dependents remained continuously covered under another group dental plan. The eligible employee may, however, elect "employee-only" coverage at a future Open Enrollment period.
3. Re-enrollment in this plan between Open Enrollment periods after voluntary cancellation of coverage is not allowed for any reason other than the loss of other dental coverage. Re-enrollment and proof of loss of other dental coverage must be provided to Delta Dental within 31 days.

II. HOW THE DELTA DENTAL PPO POINT OF SERVICE PLAN WORKS

This section describes how your plan is designed, how you access your benefits and the effect of your dentist selection. If you have any questions regarding how your plan works, please call Delta Dental Customer Service at (505) 855-7111 or toll free (877) 395 9420.

A. Delta Dental PPO Point of Service Provider Networks Information

Delta Dental PPO Point of Service is designed to offer the greatest level of savings while still providing access to the largest nationwide network, Delta Dental Premier®. Delta Dental PPO℠ provider network is a subset of the Delta Dental Premier Provider network. Delta Dental PPO providers have agreed to the deepest discounts. Members should select a Delta Dental PPO dentist to ensure the lowest out-of-pocket costs. Coinsurance can vary based on network selection. Refer to your Summary of Dental Plan Benefits for the coinsurance applicable to each network.

1. Benefit Payment is Based on the Dentist Selected

   a. You have the lowest out-of-pocket costs when selecting a Delta Dental PPO participating dentist. Delta Dental does not require that you pre-select a dentist and does not guarantee that a particular dentist will be available. Each enrolled person in your family may choose a different dentist.

2. Delta Dental PPO Plan Participating Dentists

   a. You receive the highest level of benefit and lowest out-of-pocket costs when you visit a Delta Dental PPO participating dentist.

   b. Delta Dental PPO dentists have agreed to accept the Maximum Approved Fee from Delta Dental as payment in full and will not balance bill you above this amount.

   c. You will be responsible for any copayment and deductible (if applicable) for covered services up to the Delta Dental PPO Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

3. Delta Dental Premier Participating Dentists

   a. Selecting a Delta Dental Premier participating dentist, you will be responsible for any copayment and deductible (if applicable) for covered services up to the Delta Dental Premier Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

   b. Copayment amounts will be higher when selecting a Delta Dental Premier dentist.

   c. Delta Dental PPO and Delta Dental Premier dentists will submit your dental claims to Delta Dental for processing. Delta Dental will send payment directly to Delta Dental dentists.

4. Non-Participating Dentists

   a. You may also visit a dentist who does not participate in any of Delta Dental's networks. Selecting a non-participating dentist will result in higher out-of-pocket expenses.

   b. Non-participating dentists do not contract with Delta Dental therefore do not accept Delta Dental's Maximum Approved Fees as payment in full.

   c. In addition to any copayment, deductible, and fees for non-covered services, you will also be responsible for any difference between the dentist's submitted charge and the Maximum Approved Fees for non-participating dentists.

   d. Any payment made by Delta Dental for services received from a non-participating dentist may be paid to the dentist or directly to the enrolled subscriber. Subscribers are responsible for full payment to a non-participating dentist.

When making an appointment, confirm that the dentist participates in your specific Delta Dental network(s) referenced at the top of this Summary of Dental Plan Benefits in order to minimize your out-of-pocket expenses. For online access to New Mexico Provider Directories, or to search for a dentist nationally, visit the website at www.deltadentalnm.com and select "Find a Dentist".

B. Accessing Benefits

To use this plan follow these steps:

1. Read this handbook and the Summary of Dental Plan Benefits carefully to become familiar with the benefits, Delta Dental's method of payment and the provisions of this plan.

2. Make a dental appointment and tell the dental office that dental coverage is under this plan. If the office is not familiar with the coverage applicable to This Plan or has any questions regarding this plan, the dental office may contact the Delta Dental Customer Service Department at (505) 855-7111 or toll free (877) 395-9420.

3. Following dental treatment, a claim needs to be filed with Delta Dental. All participating Delta Dental dentist offices will file the claim directly with Delta Dental. Non-participating dentists may require patients to file their own claims. Claims for benefits must be submitted to Delta Dental in writing within 12 months from the date services were provided. Failure to submit a claim within the time limitation shall not void or reduce the claim if it is shown it was not reasonably possible to submit within the 12 months, and that the claim was submitted as soon as reasonably possible. If Delta Dental does not respond within 15 days to a request to furnish a dental claim form, the requirements for claims submission shall be deemed to have been met upon the submission to Delta Dental.

4. Enrolled individuals are responsible for filing claims for services received from a non-participating dentist outside of the United States. A claim form, including the "Patient Section," must be completed. Prior to submission to Delta Dental, the dental office providing services must complete an itemization of services that includes tooth number, if applicable, a description of each individual service, a date of service, a fee for each individual service and a signature by the dentist.

   If the services performed outside of the United States are for extractions, crowns, bridges, dentures, or partial dentures, a radiographic image of the area must be

obtained prior to the service being considered for benefits. Enrolled persons are responsible for obtaining the necessary documentation for services provided, for filing a claim with Delta Dental, and for payment to the dentist at the time services are performed.

Delta Dental will calculate foreign currency benefit payments based on published currency conversion tables that correspond to the date of service.

5. Completed claim forms should be submitted to Delta Dental, 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico 87110. The Delta Dental Customer Service Department is available Monday through Friday, 8:00 am – 4:30 pm (Mountain Time) at (505) 855-7111 or toll free (877) 395-9420.

6. Within 30 days of receiving a valid claim, Delta Dental will send an Explanation of Benefits which records Delta Dental's benefit determination, any payment made by Delta Dental and any amount still owed to the dental provider. The Explanation of Benefits will be mailed to the enrolled employee, or other appropriate beneficiary, and to the treating dentist if a Delta Dental participating dentist. The 30-day period for claim determination may be extended an additional 15 days if matters beyond the control of Delta Dental delay benefit determination. Notification of any necessary extension will be sent prior to the expiration of the initial 30-day period.

7. If a claim for benefits is reduced or denied, the Explanation of Benefits will state the reason for the adverse determination. Should an enrolled person believe Delta Dental incorrectly denied all or part of a claim, a review may be requested by following the steps described in Section V, "Claims Appeal."

8. You may appoint an Authorized Representative to make contact with Delta Dental on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue. You should go online to www.deltadentalnm.com or contact Delta Dental's Customer Service department, at (505) 855-7111 or toll free (877) 395-9420, or write them at 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico 87110 to request a form to designate the person you wish to appoint as your representative. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative.

9. For questions and assistance regarding your coverage you may contact your Human Resources department or call Delta Dental's Customer Service department at (505) 855-7111 or toll free (877) 395-9420. You may also write to Delta Dental's Customer Service department at 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico 87110. When writing to Delta Dental, please include your name, the group's name, your Member ID number, and your daytime telephone number. If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve, you may contact the Office of the Superintendent of Insurance.

10. Pre-treatment Estimates – A pre-treatment estimate of benefits provides both the patient and the dentist with an estimate of the benefit levels, maximums, and limitations that may apply to a proposed treatment plan. Most importantly, the enrolled person's share of the cost will be estimated. A Pre-Treatment Estimate is not required to receive payment, but it allows you to know what services may be covered before your dentist provides them. Your dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment. You and your

dentist should review your Pre-Treatment Estimate before treatment. Once treatment is complete, the dental office will submit a claim to Delta Dental for payment.

a. A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under this plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is received. It is not a guarantee of future dental benefits or payment.

b. Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Benefit Amount, any coordination of benefits, the status of your dentist, this plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for Pre-Treatment Estimate is not a claim for benefits or a preauthorization, precertification or other reservation of future benefits. Dental offices are very familiar with the pretreatment estimate of benefits procedures and will gladly provide this service to their patients.

C. Out-of-Pocket Expenses

To help keep premium levels affordable, this plan is designed for cost sharing between the enrolled person and Delta Dental for the services provided by a dental provider.

1. Deductible

   This plan may require enrolled persons to pay a portion of the initial expense toward some covered services in each benefit period. When applicable, the amount of this deductible is stated in the Summary of Dental Plan Benefits.

2. Patient Coinsurance (Copayment)

   The patient copayment is the percentage of covered services for which the enrolled person is responsible for payment to the dental provider. The amount of patient copayment will vary depending on the level of benefits for the particular dental treatment and the selection of a participating or a non-participating provider as described in the accompanying Summary of Dental Plan Benefits.

3. Maximum Benefit Amount

   Delta Dental will pay for covered services up to a maximum amount for each enrolled person for each benefit period. Enrolled persons are responsible for payment of amounts due for any dental services that exceed the maximum benefit applicable in the benefit period. The maximum benefit amount is stated in the Summary of Dental Plan Benefits.

D. Clinical Review

1. All claims are subject to review by a dental consultant. A dental consultant is an actively practicing dentist who has no affiliation or connection with Delta Dental other than as an independent consultant or a Delta Dental participating dentist.
2. Payment of benefits may require that an enrolled person be examined by a licensed dental consultant or an independent licensed dentist.
3. Delta Dental may require additional information prior to approving a claim. All information and records acquired by Delta Dental will be kept confidential.

E. To Whom Benefits Are Paid

1. Delta Dental will pay a participating provider directly for covered services rendered. The enrolled person is responsible for paying the provider directly for any copayment, deductible and for any non-covered services.
2. Delta Dental will pay a New Mexico non-participating provider when an assignment of benefits is received on the individual claim.
3. Delta Dental will pay a non-participating provider practicing outside the state of New Mexico when required by the Delta Dental Plan in that state, when an assignment of benefits is received on the individual claim.
4. All available benefits not paid to the dental provider shall be payable to the enrolled person or to the estate of the enrolled person.
5. Delta Dental must pay directly to the Human Services Department or Indian Health Services any eligible dental benefits under this Contract which have already been paid or are being paid by the Human Services Department or Indian Health Services on behalf of the enrolled person under the State's Medicaid Program or Indian Health Program.
6. In cases of a Qualified Medical Child Support Order (QMCSO), Delta Dental will send benefit payments directly to participating providers. Payment of benefits for services obtained from non-participating providers will be directed in compliance with the valid order of judgment provided in the QMCSO.

F. Right to Recover Benefits Paid By Mistake

If Delta Dental makes a benefit payment to the enrolled person or to a provider and the patient is subsequently determined as not eligible for all or part of that benefit, Delta Dental has the right to recover payment. If benefit payment is made under fraudulent, false, or misleading pretenses or circumstances, Delta Dental has the right to recover that payment. The right to recover a payment includes the right to deduct the amount paid from future dental benefits for any covered family member. An explanation of the payment being recovered will be provided at the time a deduction is made.

III. BENEFITS, LIMITATIONS AND EXCLUSIONS

Unless otherwise specified on the Summary of Dental Plan Benefits, the benefits, limitations and exclusions described in this section apply to this plan. A dental service will be considered for benefits based on the date the service is started. Benefits are subject to the processing policies of Delta Dental and the terms and conditions of the entire Contract. Refer to the accompanying Summary of Dental Plan Benefits for patient copayment amounts. In addition to the limitations applicable to each type of service, refer to "General Limitations and Exclusions" for a detailed list of other applicable plan exclusions.

A. Diagnostic and Preventive Services

Diagnostic: procedures to aid the dentist in choosing required dental treatment (patient screenings, oral examinations, diagnostic consultations, clinical oral evaluations and radiographic images).

Palliative: Minor, non-definitive emergency treatment to temporarily relieve pain.

Preventive: Brush biopsy and related lab tests, cleanings, application of topical fluoride, space maintainers and sealants. Periodontal maintenance is considered to be a cleaning for benefit determination or payment purposes.

B. Limitations on Diagnostic and Preventive Services

1. Benefit for patient prediagnostic screenings are limited to once in a calendar year. A separate fee for patient assessment is disallowed.
2. Brush biopsies are limited to once in a 12 month period. A separate fee for interpretation is disallowed.
3. Benefits for oral examinations, including diagnostic consultations, emergency or re-evaluation exams, clinical oral evaluations, routine cleanings and periodontal maintenance, and topical fluoride treatment are limited as shown in the Summary of Dental Plan Benefits.
4. Enrollees under the age of fourteen (14) are limited to routine child cleanings. Enrollees age fourteen (14) and over will be considered adults for the purpose of determining benefits for cleanings.
5. A separate fee for periodontal maintenance may be disallowed within three (3) months of other periodontal therapy provided by the same dentist or dental office, as determined by clinical review.
6. Full mouth debridement is only a benefit when necessary to enable comprehensive evaluation and diagnosis and is limited to once per lifetime.
7. Delta Dental will benefit a complete series of radiographic images as stated in the Summary of Dental Plan Benefits. A panoramic radiographic image with or without bitewing images is considered a complete series of radiographic images. Images exceeding the diagnostic equivalent of a complete series of radiographic images will be disallowed when taken on the same date of service. Bitewing radiographic images

exceeding the diagnostic equivalent of a complete series of radiographic images will be disallowed when taken on the same date of service.

8. Emergency palliative treatment does not include services and supplies that exceed the minor treatment of pain. Benefit is limited to radiographic images and tests necessary to diagnose the emergency condition.

9. Services for diagnostic casts, oral/facial photographic images, laboratory and diagnostic tests, non-routine diagnostic imaging, non-surgical collection of specimens, oral hygiene instruction, home fluoride, mounted case analysis, and nutrition or tobacco counseling are not covered. A separate fee for image interpretation is disallowed.

10. Pulp tests are a benefit per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are disallowed as part of any other definitive procedure on the same day, by the same dentist or dental office except for limited oral evaluation – problem focused, palliative treatment, radiographic images and protective restorations.

11. Benefits for Sealants are limited to permanent molars free from occlusal restorations and a covered service for enrollees as stated on the Summary of Dental Plan Benefits.

12. A separate fee for the replacement of a sealant by the same dentist or dental office is disallowed within two (2) years of the initial placement.

13. An age limitation may apply to services related to space maintainers. Please refer to the Summary of Dental Plan Benefits for applicable age limitations.

14. Benefits for space maintainers are limited to once per lifetime per site. A separate fee for the removal of a space maintainer by the same dentist or dental office who placed the initial appliance is disallowed. Removal of a space maintainer by a different dentist or dental office is a benefit once per space per lifetime.

15. A separate fee for the recementation or repair to a space maintainer by the same dentist or dental office is disallowed within six (6) months of the original treatment. Six (6) months after the original treatment date, recementation or repair is a benefit once per twelve (12) month period.

16. Preventive restorations are not a benefit.

17. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

C. Additional Benefits for Patients with Specified Medical Conditions

Delta Dental may pay for additional benefits for people with specified medical conditions:

1. Patients with the following medical conditions may be eligible for additional cleanings, up to four (4) total cleanings per benefit period:

   a. Diabetes with periodontal disease

   b. Pregnancy with periodontal disease

   c. Renal failure/dialysis

   d. Suppressed immune system – chemotherapy/radiation treatment, HIV positive, organ transplants, and stem cell (bone marrow) transplants

   e. Head and neck radiation patients

Note 7 - Fair Value Measurements (Continued)

Level 2 Measurements

Debt securities - U.S. government and agencies and corporate - The primary inputs to the valuation include quoted prices for identical or similar assets in markets that are not active, contractual cash flows, benchmark yields, and credit spreads.

Note 8 - Investment Income

Investment income is composed of the following for the years ended December 31, 2016 and 2015:

	2016	2015
Interest income	$ 324,389	$ 254,619
Dividend income	526,998	557,718
Amortization and accretion	(55,510)	(43,385)
Realized gain on sale of investments	473,703	282,562
Investment income	$ 1,269,580	$ 1,051,514

Note 9 - Investments Using the Equity Method

The Company maintains an investment in Renaissance Holding Company (RHC) accounted for using the equity method because the Company exercises influence over its operating and financial activity. RHC is affiliated with Renaissance Health Service Corporation through common management. RHC is a holding company of various organizations that offer dental plans that are provided on an insured basis and on an employer-funded basis. As a condition of the stockholders' agreement between the Company and RHC, in the event RHC proposes to issue additional shares, the Company has the right and option to purchase all or any part of a pro-rata share of any such shares at the same price and upon the same terms as the original purchase, with some exceptions determined by RHC's board of directors. RHC reserves call rights with respect to the Company's shares. The shares are not transferable to any person or entity other than a subsidiary or affiliate of RHC, and the shares cannot be pledged by the Company.

The Company owns approximately 4.0 percent of RHC's outstanding stock as of both years ended December 31, 2016 and 2015.

The following is a summary of financial position and results of operations of RHC as of and for the years ended December 31:

	2016	2015
Assets:		
Current assets	$ 117,446,000	$ 120,062,000
Other assets	32,391,000	26,462,000
Total assets	$ 149,837,000	$ 146,524,000
Liabilities - Current liabilities	$ 39,318,000	$ 33,404,000
Stockholder's equity	$ 110,519,000	$ 113,120,000
Revenue	$ 185,994,000	$ 167,115,000
Net (loss) income	$ (1,141,000)	$ 2,785,000

Note 10 - Unpaid Claims and Claims Adjustment Expenses

The following summarizes activity in the liability for unpaid claims and claims adjustment expenses as of December 31, 2016 and 2015:

	2016	2015
Balance as of January 1	$ 3,281,201	$ 2,224,000
Incurred related to:		
Current year	97,266,701	91,832,353
Prior years	19,027	(54,598)
Total incurred	97,285,728	91,777,755
Paid related to:		
Current year	93,610,109	88,578,017
Prior years	3,277,610	2,142,537
Total paid	96,887,719	90,720,554
Balance as of December 31	$ 3,679,210	$ 3,281,201

As a result of changes to estimates for incurred claims and claims adjustment expenses attributable to insured events of prior years, the provision for claims and claims adjustment expenses changed during 2016 and 2015. Estimates are adjusted as changes in these factors occur, and such adjustments are reported in the period of determination.

At December 31, 2016 and 2015, the unpaid claims and claims adjustment expenses included approximately $2,454,000 and $2,186,000, respectively, relating to the liability for claim payments under ASO and ASC contracts. At December 31, 2016 and 2015, the ASO and ASC premiums receivable balance included approximately $2,014,000 and $1,586,000, respectively, relating to the liability for claim payments under ASO and ASC contracts.

Note 11 - Related Party Transactions

The Company purchases various administrative support functions, including claims processing, actuarial services, technology services, and other administrative services, from entities affiliated with RHSC. These agreements bear no interest and are settled monthly. The following is a summary of transactions and balances with affiliates for 2016 and 2015:

	2016	2015
Purchased administrative services	$ 1,710,742	$ 1,486,751
Due to affiliates	389,147	520,479

During 2010, the Company invested in a surplus note totaling $800,000 issued by Delta Dental of North Carolina, an entity affiliated with the Company. Interest accrues at a rate of 4.0 percent per annum. In accordance with the requirements set forth in the note and regulatory requirements, no interest or principal is to be received without the prior written approval by the North Carolina Commissioner of Insurance. The remaining balance on the surplus note was $300,000 and $400,000 at December 31, 2016 and 2015, respectively. During 2016, the Company received a principal payment of $100,000 and an interest payment of $23,667 from Delta Dental of North Carolina. During 2015, the Company received a principal payment of $150,000 and an interest payment of $30,000 from Delta Dental of North Carolina. Accrued interest on this surplus note receivable totaled $71,932 and $80,265 at December 31, 2016 and 2015, respectively.

See Note 9 regarding the Company's investment in RHC.

Note 12 - Contributed Capital and General Reserves

In accordance with Section 59A-47-10 of the New Mexico Insurance Code, the Company maintains a required statutory reserve with fair value at least equal to $100,000. The Company maintains investments in U.S. Treasury securities with a fair value of $201,250 and $201,320 at December 31, 2016 and 2015, respectively, to satisfy these requirements.

The Company is subject to certain risk-based capital (RBC) requirements as specified by the National Association of Insurance Commissioners (NAIC). Under those requirements, the amount of capital and surplus maintained by the Company is to be determined based on various risk factors relating to the Company. At December 31, 2016 and 2015, the Company met the RBC requirements.

VENDOR PREFERENCE AFFIDAVIT OF ELIGILITY

City of Albuquerque Purchasing Division	One Civic Plaza – 7th Floor P.O. Box 1293 Room 7012 Albuquerque, NM 87103 Phone: (505) 768-3320 Fax: (505) 768-3355

Preference Type: (Check applicable preference/s) [X] **Local-City Business** [X] **Small Business** [X] **State Resident Business Preference** [ ] **State Resident Veteran Business Preference** [X] **Pay Equity Preference**

Legal Name of Firm: Delta Dental of New Mexico, Inc.	
Contact Person: JoLou Trujillo-Ottino	Telephone: (505)872-5334
E-mail Address: jottino@deltadentalnm.com	Fax: (505)883-7444

Mailing Address:	Physical Address (if Different):
2500 Louisiana Blvd. NE Ste 600	
Albuquerque, NM, 87110	

Number of full-time employees working in the city of Albuquerque:	Attach 941 Tax Form
35	

Check all that apply:

☒ **I certify my company meets the following qualifications to be eligible for Local Business Preference:**
Maintains its principal office and place of business within the Greater Albuquerque Metropolitan Area (City of Albuquerque or Bernalillo County)

1. Such location is staffed with full-time employees.
2. Such location is open to the public on a regular basis.
3. The vendor is operating or performing its business from this location.
4. Note: A post office box shall not be considered a physical business address.

☒ **I certify my company meets the following qualifications to be eligible for Small Business Preference:**

1. Meets the requirements for a Local Business Preference (see above).
2. Employs fewer than fifty (50) full-time employees in a calendar year as demonstrated by the attached 941 I.R.S. Tax Form

☒ **I certify that I am attaching the Pay Equity Business Certificate.**

☐ **I certify that I am attaching the New Mexico State certification of Resident Business or Resident Veteran's Business preference.**

☐ **I certify that under the penalty of perjury, the foregoing statements are true and correct. I also acknowledge that any person, firm, corporation or entity intentionally submitting false information to the city in an attempt to qualify for a local or small preference shall be prohibited from bidding on City goods and/or services for a period of up to three (3) years.**

Authorized Signature: JoLou Trujillo-Ottino Date: ~~12/21/2017~~ 12/19/17

Printed Name: JoLou Trujillo-Ottino Title: VP, Sales and Marketing

ACKNOWLEDGMENT

State of New Mexico
County of Bernalillo

Signed and sworn to before me on 19 Dec 2017 by JoLou Trujillo-Ottino.

OFFICIAL SEAL
ERIC T. WONG
Notary Public
State of New Mexico
My Commission Expires 13 Jun 2018

Notary

My Commission expires on
13 Jun 2018

Pay Equity Reporting Form PE10-249

Company name:	Delta Dental Plan of New Mexico, Inc.
Mailing address line 1:	2500 Louisiana Blvd NE
Mailing address line 2:	Suite 600
City, state, zip code:	Albuquerque, NM, 87110
Phone:	(505) 855-7122
E-mail address:	jottino@deltadentalnm.com
FEIN number:	85-0224562
EAN number:	76769
SHARE vendor number:	123798

Job Category	No. Females	No. Males	Gap (Absolute %)
1 - Officers and Managers	3	3	26.49%
2 - Professionals	13	1	7.23%
3 - Technicians	0	0	N/A
4 - Sales Workers	2	1	17.22%
5 - Office and Admin. Support	7	1	2.14%
6 - Craft Workers (Skilled)	0	0	N/A
7 - Operatives (Semi-Skilled)	0	0	N/A
8 - Laborers (Unskilled)	0	0	N/A
9 - Service Workers	0	0	N/A

Total # Job Categories With No Employees	5
Total # Female Only Job Categories	0
Total # Male Only Job Categories	0
Total # Females (all categories)	25
Total # Full Time Females	25
Total # Part Time Females	0
Total # Males (all categories)	6
Total # Full Time Males	6
Total # Part Time Males	0
Total # Employees	31
Female % Workforce	80.65%
Male % Workforce	19.35%
Calculated Weighted Average Gap	**10.61%**

Submit only this worksheet

Document must be signed by the principal executive of the company: ITB #:_____ RFP# P2018000015 PO# _____
Signature certifies that all employees working in New Mexico are included, the data is for the current calendar year, and any challenges to your information may require you to get third party verification at your own expense.

JoLou Trujillo-Ottino, VP, Sales & Marketing — Name and title, printed

JoLou J. Ottino — Signature

12/21/2017 — Date

How is treatment distributed by network? The big picture.

Claims paid between 01-Jan-2012 and 31-Oct-2012

Group Name

Category	% of Total	Category Total	# Treat.	Delta Dental Premier	# Treat.	Out of Network	# Treat.
Exams and Cleanings	36.48%	$74,742.79	1,402	$73,979.79	1,375	$763.00	27
X-rays	12.76%	$26,137.37	647	$25,756.37	632	$381.00	15
Sealants	1.82%	$3,720.48	115	$3,528.48	106	$192.00	9
Fillings	14.23%	$29,152.12	276	$28,868.12	270	$284.00	6
Crowns	9.53%	$19,524.65	65	$19,524.65	65	$0.00	0
Root Canals	6.99%	$14,317.60	27	$14,317.60	27	$0.00	0
Gum Disease	2.68%	$5,499.44	42	$5,209.84	36	$289.60	6
Gum Disease Cleaning	2.02%	$4,139.00	35	$4,139.00	[illegible]	$0.00	[illegible]
Extractions	7.98%	$16,346.55	154	$15,592.85	[illegible]	$753.70	[illegible]
Oral Surgery Other Than Extractions	0.39%	$792.10	5	$792.10	[illegible]	$0.00	0
Dentures	1.40%	$2,862.90	9	$2,457.40	8	$405.50	1
Bridges	0.70%	$1,430.00	5	$1,430.00	5	$0.00	0
Denture Repair	0.08%	$157.00	6	$157.00	[illegible]	$0.00	3
Braces	2.00%	$4,106.18	6	$3,947.82	5	$158.36	1
Other Services	0.94%	$1,932.60	55	[illegible]	51	$0.00	4
Total	100.00%	$204,860.78	2,849	[illegible]	[illegible]	$3,227.16	85

For more information, contact your Delta Dental of New Mexico Sales or Service Representative

Date report was run 15-Nov-2012 for report period ending 31-Oct-2012

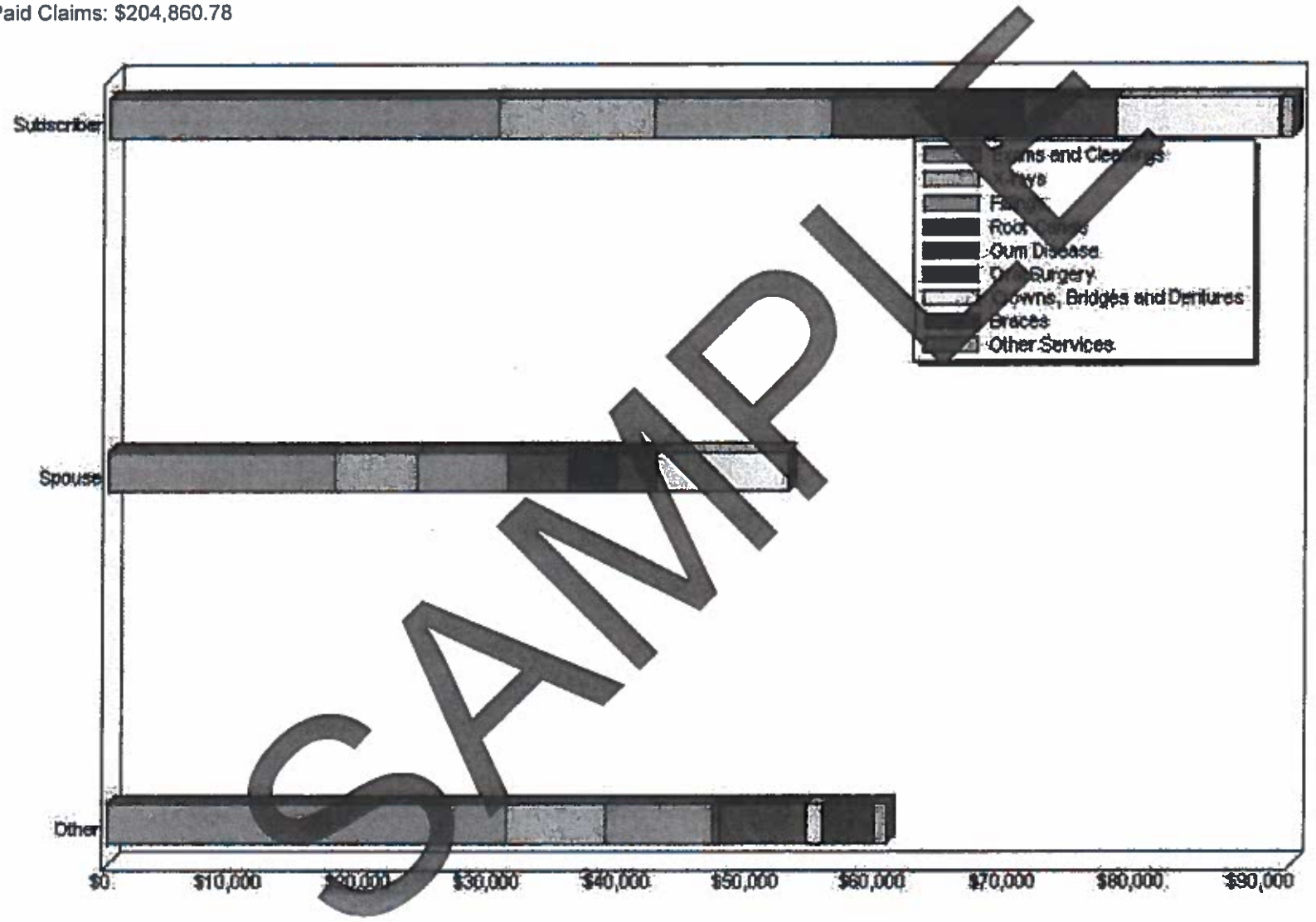
DELTA DENTAL

How is treatment cost distributed by member type?

Claims paid between 01-Jan-2012 and 31-Oct-2012

Group Name

Total Paid Claims: $204,860.78



For more information, contact your Delta Dental of New Mexico Sales or Service Representative

Date report was run 15-Nov-2012 for report period ending 31-Oct-2012

DELTA DENTAL

How are treatments and costs distributed by member?

Claims paid between 01-Jan-2012 and 31-Oct-2012

Group Name

Category	% of Total	Category Total	# Treat.	Subscriber	# Treat.	Spouse	# Treat.	Other	# Treat.
Exams and Cleanings	36.48%	$74,742.79	1,402	$30,049.25	50	$1 .88	306	$27,217.66	589
X-rays	12.76%	$26,137.37	647	$12,067.09	288	$,415.90	158	$7,654.38	201
Sealants	1.82%	$3,720.48	115	$0.00	0	$0.00	0	$3,720.48	115
Fillings	14.23%	$29,152.12	276	$13,902.22	129	$,959	65	$8,290.20	82
Crowns	9.53%	$19,524.65	65	$9,757.	34	$ .90	24	$1,238.20	7
Root Canals	6.99%	$14,317.60	27	$9,063.50	15	$4,766.10	8	$488.00	4
Gum Disease	2.68%	$5,499.44	42	$,520.	17	$2,979.44	25	$0.00	0
Gum Disease Cleaning	2.02%	$4,139.00	35	$3,217.	28	$770.00	6	$152.00	1
Extractions	7.98%	$16,346.55	154	$7,08	71	$2,691.30	35	$6,570.60	48
Oral Surgery Other Than Extractions	0.39%	$792.10	5	$ .80	2	$400.00	1	$219.30	2
Dentures	1.40%	$2,862.90	9	$,257.40	6	$605.50	3	$0.00	0
Bridges	0.70%	$1,430.00	5	$ .00	2	$950.00	3	$0.00	0
Denture Repair	0.08%	$157.00	6	$ .0	1	$75.50	5	$0.00	0
Braces	2.00%	$4,106.	6	$144.38	1	$0.00	0	$3,961.80	5
Other Services	0.94%	$1,932.	55	$963.80	19	$0.00	8	$968.80	28
Total	**100.00%**	**$204,860.78**	**2,849**	**$91,761.14**	**1,120**	**$52,618.22**	**647**	**$60,481.42**	**1,082**

For more information, contact your Delta Dental of New Mexico Sales or Service Representative

Date report was run 15-Nov-2012 for report period ending 31-Oct-2012

DELTA DENTAL

Demographics and financials: Totals by month.

Claims paid between 01-Jan-2012 and 31-Oct-2012

Group Name

Month	Subscribers	Number of Claims	Claims/Sub/Year	Paid Claims	PaidClaims/Sub	Earned Premium	Premium/Sub	Paid Loss Ratio
1/31/2012	357	93	3.13	$16,879.80	$47.28	$18,846.95	$52.23	90.52%
2/29/2012	360	108	3.60	$22,521.80	$62.56	$24,303.80	$67.51	92.67%
3/31/2012	366	108	3.54	$21,160.57	$57.82	$22,972.27	$62.77	92.11%
4/30/2012	365	108	3.55	$18,012.67	$49.35	$19,819.32	$54.30	90.88%
5/31/2012	372	108	3.48	$18,452.80	$49.60	$20,294.20	$54.55	90.93%
6/30/2012	374	111	3.56	$17,069.74	$45.64	$18,921.04	$50.59	90.22%
7/31/2012	378	118	3.75	$24,168.95	$63.90	$26,027.15	$68.85	92.81%
8/31/2012	382	134	4.21	$23,200.27	$60.73	$25,091.17	$65.68	92.46%
9/30/2012	386	99	3.08	$20,483.96	$53.07	$22,394.66	$58.02	91.47%
10/31/2012	388	136	4.21	$22,923.12	$59.08	$24,843.72	$64.03	92.27%
Total	**3,728**	**1,123**	**3.61**	**$204,860.78**	**$54.95**	**$223,314.38**	**$59.90**	**91.74%**

For more information, contact your Delta Dental of New Mexico Sales or Service Representative

Date report was run 15-Nov-2012 for report period ending 31-Oct-2012

DELTA DENTAL

What are my paid claims and exposure by month?

Claims paid between 01-Jan-2012 and 31-Oct-2012

Group Name

Month	Subscribers	Paid Claims	PaidClaims/Sub
1/31/2012	357	$16,879.80	$47.28
2/29/2012	360	$22,521.80	$62.56
3/31/2012	366	$21,160.57	$57.82
4/30/2012	365	$18,012.67	$49.35
5/31/2012	372	$18,452.80	$49.60
6/30/2012	374	$17,069.74	$45.64
7/31/2012	378	$24,156.05	$63.90
8/31/2012	382	$23,200.27	$60.73
9/30/2012	386	$20,483.96	$53.07
10/31/2012	388	$22,923.12	$59.08
Total	**3,728**	**$204,860.78**	**$54.95**

For more information, contact your Delta Dental of New Mexico Sales or Service Representative

Date report was run 15-Nov-2012 for report period ending 31-Oct-2012

DELTA DENTAL

How has my rate code distribution (family mix) changed over the years?

Group Name

Month	Subscribers	Spouses	Dependents	employee_only	employee_spouse	employee_spouse_children	composite	employee_child	employee_children	RateCode07	RateCode08	RateCode09
8/31/2012	351	137	293	176	44	93	0	18	20	0	0	0
9/30/2012	366	141	301	183	47	94	0	20	22	0	0	0
10/31/2012	379	143	301	194	49	94	0	20	22	0	0	0

For more information, contact your Delta Dental of New Mexico Sales or Service Representative

Date report was run 15-Nov-2012 for report period ending 31-Oct-2012

DELTA DENTAL

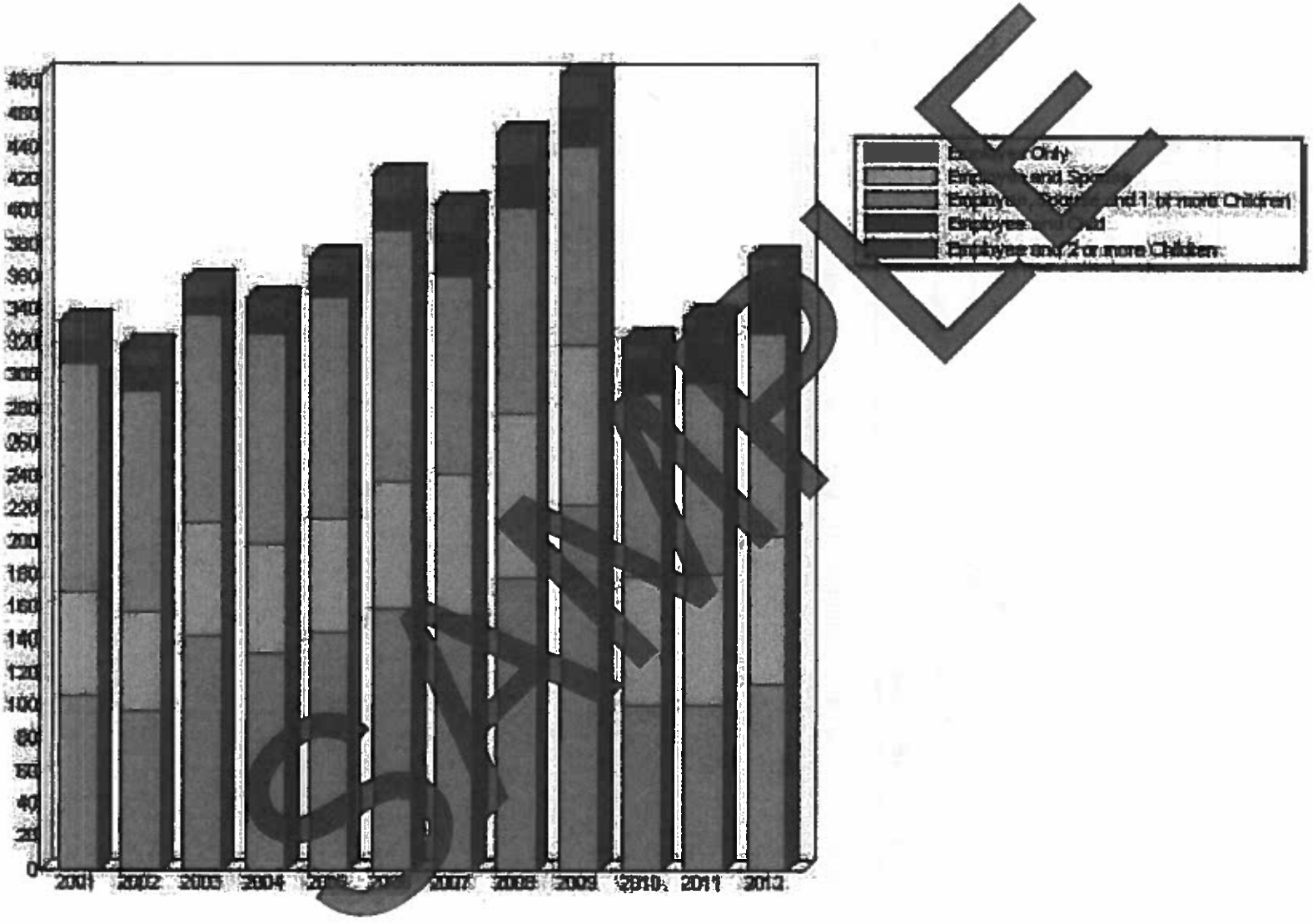
Selections for this report set are as follows:

Date report was run 15-Nov-2012 for report period ending 31-Oct-2012
Aztec Well Servicing Company

How has my rate code distribution (family mix) changed over the years?

For the period 01-Feb-2001 to 31-Oct-2012

Group Name



For more information, contact your Delta Dental of New Mexico Sales or Service Representative

Date report was run 15-Nov-2012 for report period ending 31-Oct-2012

DELTA DENTAL

DELTA DENTAL

Delta Dental of New Mexico
Cost Proposal

Cost

Delta Dental of New Mexico (DDNM) is happy to offer the City of Albuquerque a rate pass from their current rates that is guaranteed for 2 years. On years 3 and 4 DDNM is offering a not to exceed of 5% for each year.

DDNM is offering the exact plan the City is currently offering. This plan is unique to Delta Dental.

As the incumbent carrier DDNM will continue to offer the largest networks in the state and the nation to the City's employees. DDNM is also happy to discuss our Aggregate Discount with the City. This information can be found in the City's annual savings report.

Performance Guarantees

DDNM is offering the same performance guarantees we are currently performing and a few more request in the bid. The proposed guarantees are included in this cost proposal.

DELTA DENTAL

PROPOSED

Report Name: Quarterly Performance Standards - Delta Dental of New Mexico Global Data
Report Produced for: City of Albuquerque and Participating Entities
Group Number: 2517
Reporting Period: July 2018 through June 2019

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Claims Turnaround												
90% of claims processed within 15 working days		% 15 days			% 15 days			% 15 days			% 15 days	
97% of investigated claims paid within 30 days		% 30 days			% 30 days			% 30 days			% 30 days	
Penalty: $300 per quarter												
Claims Processing Accuracy												
Measurement: 97% The percentage of audited claims processed accurately. Calculated as the total number of audited claims processed with error, divided by the total number of audited claims. Error means any type of error (e.g., coding, procedural, system payment, etc). Each type of error is counted as one		%			%			%			%	
Penalty: $300 per applicable quarter												
Financial Payment Accuracy												
Measurement: 99% The percentage of audited client claims dollars paid accurately. Calculated as a total audited paid dollars minus the absolute value of over/under payments, divided by total audited paid dollars.		%			%			%			%	
Penalty: $300 per applicable quarter												
Telephone Response												
Measurement: 90% within 30 seconds The time between a call entering the ACD and being answered by a Customer Service Representative.		%			%			%			%	
Penalty: $300 per applicable quarter												
Abandonment Rate												
Measurement: Less than 5% The percent of calls that the caller hangs up prior to the call being answered.		%			%			%			%	
Penalty: $300 per applicable quarter												
Report Delivery												
Required claims report(s) delivered by the end of the month following the end of the reporting period.												
Penalty: $1000 per applicable month												
Vendor Attendance at Client Meetings												

Attendance by vendor representatives when requested by the City during the contract period.

Penalty: $300 per missed meeting

EXHIBIT 3

DELTA DENTAL

Delta Dental PPO℠ Point of Service
Summary of Dental Plan Benefits
For Group #2517
City of Albuquerque

Benefit Period: July 1 through June 30

Deductible: $50 Deductible per person total per Benefit Period limited to a maximum Deductible of $150 per family per Benefit Period

Maximum Benefit Amount: $1,500 per person total per Benefit Period

Orthodontic Lifetime Maximum: $1,200 per person total per lifetime

Covered Services

	Delta Dental PPO℠ Provider	Delta Dental Premier® Provider	Non-Participating Provider*
	You Pay	You Pay	You Pay*
Diagnostic and Preventive Services			
Diagnostic and Preventive Services – exams, cleanings, topical fluoride, and space maintainers	No Charge	20%	20%
Emergency Palliative Treatment – to temporarily relieve pain	No Charge	20%	20%
Sealants – to prevent decay of permanent teeth	No Charge	20%	20%
Brush Biopsy – to detect oral cancer	No Charge	20%	20%
Radiographs – images	No Charge	20%	20%
Periodontal Maintenance – cleanings following periodontal therapy	No Charge	20%	20%
Basic Services			
Minor Restorative Services – fillings	15%	15%	15%
Endodontic Services – root canals	15%	15%	15%
Periodontic Services – to treat gum disease	15%	15%	15%
Oral Surgery Services – extractions and dental surgery	15%	15%	15%
Other Basic Services – misc. services	15%	15%	15%
Major Services			
Crown Repair – to individual crowns	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Relines and Repairs – to bridges, dentures, and implants	50%	50%	50%
Prosthodontic Services – bridges, dentures, and implants	50%	50%	50%
TMD Treatment – Medically Necessary treatment of Temporomandibular Joint Disorder, including diagnostic imaging	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit	No Age Limit	No Age Limit	No Age Limit

**Selecting a Non-Participating Provider may result in higher out-of-pocket expenses, even when there is no change in Benefit level between in-network and out-of-network Benefits. Non-Participating Providers do not accept Delta Dental's Maximum Approved Fees as payment in full. You will be financially responsible for balance billed amounts, or amounts that exceed the Non-Participating Provider's reimbursement. See the section titled "Your Network."*

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Routine prophylaxes (cleanings), periodontal maintenance, and scaling in the presence of generalized moderate or severe gingival inflammation are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or topical fluoride treatment. The patient should talk with his or her Provider about treatment.
- Topical fluoride treatments are payable twice per calendar year for people up to age 19.
- Space maintainers are payable once per area per lifetime for people up to age 14.
- Bitewing images are payable twice per calendar year and a complete series of radiographic images (which include bitewing images) or panoramic radiographic image is payable once in any five-year period.
- Sealants are payable once per tooth per two-year period for the occlusal surface of permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are covered services on all teeth.
- Implants and implant-related services are payable once per tooth in any five-year period.
- Medically Necessary TMD is a covered Benefit. Pre-Treatment Estimate required.
- Prescription medicaments are covered services for dentally related conditions.

Additional Plan Information

Deductible: Does not apply to Diagnostic and Preventive Services, radiographic images, sealants, full mouth debridement, periodontal maintenance, emergency palliative treatment, consultations, cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Maximum Benefit Amount: This dental Plan includes Preventive Care Security (PCS); Diagnostic and Preventive Services will not reduce your Maximum Benefit Amount. The Maximum Benefit Amount applies to all services except Diagnostic and Preventive, radiographic images, sealants, full mouth debridement, periodontal maintenance, emergency palliative treatment, consultations, cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Orthodontic Lifetime Maximum: Applies to cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Pre-Treatment Estimates: Delta Dental recommends that you ask your Provider for a Pre-Treatment Estimate when more-costly procedures are anticipated. This free report estimates your applicable dental Benefits and out-of-pocket expenses for proposed dental services. Please see the Dental Benefit Handbook for more information. Pre-Treatment Estimates are optional unless specified otherwise in this Summary of Dental Plan Benefits.

Eligibility Provisions

An Eligible Employee is an employee who satisfies the eligibility definition(s) and Eligibility Waiting Period as specified by the Group and agreed to by Delta Dental. Waiting period shall not exceed twelve (12) months.

Eligible Employees may enroll on the first day of the month following the first day of the payroll period following submittal of completed enrollment card when submission is within 31 days of date of hire, subject to any additional requirements which may apply.

Benefits will cease on the actual day of the month in which the employee is terminated, subject to any additional requirements which may apply.

Special Benefit Provisions

None.

Your Network: Delta Dental PPO Point of Service

This section describes the types of Providers you may visit under your Plan and how fees and payments will work for different Providers.

Delta Dental PPO Provider	
Participates with Delta Dental?	Yes
Out-of-Pocket Costs for This Plan:	Lowest
Delta Dental Pays Up To:	Delta Dental PPO Maximum Approved Fees
Provider May Balance Bill You?	No
Description	You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental PPO Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

Delta Dental Premier Provider	
Participates with Delta Dental?	Yes
Out-of-Pocket Costs for This Plan:	Higher than Delta Dental PPO
Delta Dental Pays Up To:	Delta Dental Premier Maximum Approved Fees
Provider May Balance Bill You?	No
Description	You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental Premier Maximum Approved Fees. You are also responsible for the full payment for any non-covered services. Coinsurance amounts may be higher when selecting a Delta Dental Premier Provider.

Non-Participating Provider	
Participates with Delta Dental?	No
Out-of-Pocket Costs for This Plan:	Highest
Delta Dental Pays Up To:	Delta Dental's Non-Participating Maximum Approved Fees
Provider May Balance Bill You?	Yes, up to the Provider's Submitted Amount
Description	In addition to any Coinsurance, Deductible (if applicable), and fees for non-covered services, you will be responsible for any difference between Delta Dental's Non-Participating Maximum Approved Fees and the Provider's Submitted Amount. Subscribers are responsible for full payment to a Non-Participating Provider. Any payment made by Delta Dental for services received from a Non-Participating Provider may be paid to the Provider or directly to the Subscriber.

Understanding Your Benefits

This Summary of Dental Plan Benefits has been prepared only for Open Enrollment purposes.

This Summary of Dental Plan Benefits only highlights Benefit levels; it does not provide complete coverage information. Refer to your Dental Benefit Handbook for other important eligibility and Plan provisions. This Summary of Dental Plan Benefits is attached to and is a component of the Dental Benefit Handbook. To the extent that the rules in the Dental Benefit Handbook conflict with the ones stated in this Summary of Dental Plan Benefits, the rules in this Summary of Dental Plan Benefits control.

Call Delta Dental's Customer Service Department at (877) 395-9420, or log into the Consumer Toolkit via www.deltadentalnm.com, for answers to questions about Benefits and claims.

EXHIBIT 4

Exhibit 4

Entities Participating under City of Albuquerque

City of Albuquerque

Albuquerque Bernalillo County Water Authority Utility

Sandoval County

Middle Rio Grande Conservancy District

City of Belen

Southern Sandoval County Arroyo Flood Control Authority

Town of Bernalillo

Town of Cochiti Lake

Village of Corrales

Village of San Ysidro

Town of Edgewood

Town of Mountainair

Village of Cuba

Village of Tijeras

Village of Bosque Farms

Village of Los Ranchos De Albuquerque

Village of Jemez Springs

EXHIBIT 5

Rules and Regulations – Guidelines for Enrollment

These rules and regulations apply to employees of the City of Albuquerque and government entities that have elected to participate in the same insurance plans. There may be differences in eligibility between entities. For example, not all governing bodies of the entities have approved allowing an employee's domestic partner and his/her children to be eligible for insurance coverage. Entities also differ in the employer contribution towards insurance premiums. Please check with your employer's Benefits Office for clarification. Employees with family members working for any participating entity may not double cover any family member on the same group insurance plan.

Who is Eligible:

- Regular employees (including those on probation)
- Elected officials
- Legal spouse of an employee
- Domestic Partner of an employee*
- Children who are under age 26 AND meet at least one of the following criteria:
  - Natural child of the employee, spouse or domestic partner
  - Placed in the employee's home and in process of being adopted by the employee, spouse or domestic partner
  - Adopted by the employee, spouse or domestic partner
  - Court order that requires the employee, spouse or domestic partner provide health insurance coverage for the child
  - Court document that shows the employee, spouse or domestic partner has full, permanent custody of the child
  - Children over age 26 may **continue** participating in the group insurance plans if they are physically or mentally disabled and are not eligible for any other plan. This continuation is subject to normal enrollment guidelines and documentation approved by the insurance carrier.

* A domestic partner is defined as a person of the same or opposite sex who lives with the employee in a long-term relationship of indefinite duration and has not been married to anyone during the previous 12 months. There must be an exclusive mutual commitment similar to that of marriage, in which the partners agree to be financially responsible for each other's welfare and share financial obligations. These benefits are also available to the domestic partner's children provided that the child meets the definition of eligibility stated above. Note the criteria and required documents in the *Changing Benefit Elections* section.

Benefit Options:

Options vary by participating entity but may include:

Medical Insurance
Dental Insurance
Vision Insurance
Term Life Insurance
Auto & Home Insurance
Legal Insurance
Short Term Disability Insurance
Flexible Spending Accounts (Medical, Dependent Care, Parking/Transit)

Coverage Options

Employee Only	Employee Plus Spouse or Domestic Partner
Single Parent	Family

Changing Benefit Elections and Qualifying Life Events:

Many of the rules for enrollment and eligibility are made by the Internal Revenue Service because they allow your salary to be reduced by the premiums you pay before taxes are calculated (Internal Revenue Code Section 125.) Only medical, dental, vision and flexible spending account benefits listed on the previous page are deducted on a pre-tax basis. Other benefit options are post-tax. Important rules to know are:

Once you have made an election during your initial enrollment period of 31 days from your hire date then you are **locked into that decision until the next open enrollment. Exceptions to this are qualifying life events. Please note: Qualifying Life Events do not allow you to change your Presbyterian Gym Membership election. The only time to elect participation, or disenrollment, is during open enrollment.**

You must provide documentation of the Life Event and log into PeopleSoft Employee Self Service (ESS) to enroll within **31 days of the Life Event.** Documents should be scanned and you will be prompted to upload them during your Life Event entry in ESS. Qualifying Life Events and acceptable documents are:

- **Marriage** - Marriage certificate
- **Domestic Partnership meeting eligibility requirements** – Affidavit* and three proofs of financial interdependence
- **Termination of Domestic Partnership agreement – Affidavit of Termination of Domestic Partnership form must be complete.**
- **Divorce** – Court issued, date stamped, divorce decree (Ex-spouses are ineligible for coverage after the divorce except through COBRA. Divorce not reported timely may result in full responsibility of claims and loss of COBRA rights.)
- **Birth** – Hospital certificate/ Proof of birth is acceptable to add your dependent. Birth certificate is required upon receipt
- **Death** – Death certificate
- **Change in employment status** affecting benefits eligibility (for you or your spouse) - Letter/form from employer that is notification of the job change, coverage ending or new eligibility period of your Spouse/Domestic Partner's employer
- **Open Enrollment** – If you are adding a dependent for which you have not yet established proof of your relationship then you must do so at this time.
- **Involuntary loss of coverage** – Official notification of involuntary loss
- **Dependent child losing eligibility** - Official notification of loss
- **Dependent change of residence** that affects benefits eligibility - Documentation of the change or a letter explaining the change
- Dental Insurance Only – **dependent child between the ages of 2 and 3** may be added to a plan in which you are already enrolled – you must submit a written request

* The **Affidavit of Domestic Partnership:** is a City form and legal document in which both the employee and the domestic partner swear that they meet the following criteria:

- Both are unmarried and have been for at least 12 months
- Reside in the same residence for at least 12 months and intend to do so indefinitely

- Meet the age requirements for marriage in the state of New Mexico
- Are not related by blood to the degree prohibited in a legal marriage in the State of New Mexico
- Are financially responsible for each other's welfare and share financial obligations

In addition to the notarized affidavit, **three** of the following documents are also required.

- Joint lease/mortgage or ownership of property
- Jointly owned motor vehicle, bank or credit account (only one qualifies)
- Domestic partner named as beneficiary of the employee's life insurance
- Domestic partner named as beneficiary of the employee's retirement benefits
- Domestic partner named as primary beneficiary in the employee's will
- Domestic partner assigned as power of attorney or legal designee by the employee
- Both names on a utility bill
- Both names on an investment account

Adding a Domestic Partner can be done through Employee Self Service (ESS). The Affidavit of Domestic Partnership can be found on the City's website in the forms section of HR>Employee Benefits.

The Federal Government does not recognize domestic partners as qualified dependents and therefore the premium paid for their coverage cannot be pre-tax. In addition, the employee must pay tax on the portion of the premium paid by the city for the domestic partner and his/her covered children. Employees wanting to change benefit elections involving a domestic partner must adhere to the same rules regarding qualifying events.

Delayed Enrollment: Missing the initial enrollment period, 31-day qualifying event period or the annual open enrollment period, may result in **delayed enrollment**, a delay in notification of loss of coverage and **paying for coverage no longer provided (such as for an ex-spouse.)** Alternatively, delayed entry may result in double deductions for premiums due for backdated coverage. The effective date will depend on the event.

Name/Address Changes: It is important to keep your employer and the insurance plans informed when you experience a name and/or address change to prevent a disruption of service and receipt of important policy information. Please make updates yourself through PeopleSoft Employee Self Service. Address changes in ESS will automatically be communicated to the vendors. An employee's name change requires uploading a Social Security Card with the new name on it.

Effective Date of Coverage, Changes and/or Terminations:

New Employees – Coverage begins on your hire date which is the first day of the pay period. Pay periods begin on Saturday and are two weeks long. New Employee Orientation (NEO) is usually held on Monday following the beginning of a pay period. You have 31 days from your hire date to complete the online enrollment process and upload verification of dependent eligibility.

- **Qualifying Life Events** – Coverage begins on the first day of the pay period following your event date. Three exceptions to this are for the birth of a child, marriage and divorce. The coverage begins on the date of birth if documentation and online entry are completed within the 31-day enrollment period. Delaying the entry

of a Life Event may result in extra deductions for premiums due. Losing or gaining eligibility for Medicaid allows a 60-day enrollment period.

An ex-spouse or domestic partner is not eligible to continue participation in the insurance program, except through COBRA (see the next page). Therefore, when the divorce decree is uploaded into PeopleSoft and the Divorce Life Event is entered, the end of coverage will be back dated to the day following the court stamped date on the decree.

- **Reinstatement** – An employee who is terminated from the City and subsequently reinstated is eligible to re-enroll in benefits through ESS by selecting the Life Event "I had a Life Status Change Not Listed Above." The required document is the letter of reinstatement. The effective date of coverage will be the first day of the pay period following the reinstatement.
- **Open Enrollment**-This is a three week (or longer) period established annually (usually in May/June) that allows all benefits eligible employees to make changes to their benefit elections without having experienced a qualifying life status change. Annual premium changes also occur at this time and will automatically be updated on the 1st paycheck containing July 1st, without you having to make a new election.

Benefit changes elected during open enrollment are effective on July 1st or if you are cancelling coverage then the last day of coverage will be June 30th. It is the only time to make benefit changes without a Qualifying Life Event.

Effective 7/1/2016 Presbyterian Health Plan offers the option of a gym membership for no additional premium. The only time to elect participation, or disenrollment, is during open enrollment.

- **Termination of Coverage**

Insurance ends at the end of the pay period in which the event occurs. Exceptions to this are

- Retirees' coverage stops at the end of the month prior to the PERA retirement date
- Dependents reaching the age limit lose coverage at the end of the month after their 26th birthday
- Ex-spouses lose coverage the day after the divorce is final
- Domestic Partners lose coverage the end of the pay period in which the termination notice is signed.

Double Coverage:

Neither you, nor your spouse, domestic partner nor dependent child who works for the City, or one of our participating entities (i.e. Sandoval County), may be double covered on medical, dental, vision or voluntary term life. The only exception to this is when you or your spouse/domestic partner is retiring or terminating and the only alternative to double coverage is a gap in coverage. Double coverage can last no longer than two weeks with proper documentation.

Insurance Premium and Benefit Plan Participation Payments:

The City pays a substantial portion of medical, dental and vision premiums regardless of the coverage options you elect. Your benefit payments are deducted for coverage during the same two week period for which you are paid. Your earnings are reduced by your portion of the medical, dental and vision insurance premiums before Federal, State and FICA taxes are calculated, thereby saving you money.

Leave Without Pay/FMLA/Military Leave:

Employees are responsible for paying their Group Health Premiums regardless of receiving a paycheck. This means if your employment status is "active" and you do not receive a paycheck then you will be responsible for paying the employee AND the employer portion of your medical, dental, vision premiums, and also your current deduction(s) for other supplemental benefits in that period. You will be responsible for making payment arrangements through the Insurance and Benefits Office (contact information is provided in the back of this booklet). Payment arrangements depend on the situation and will be reviewed on an individual basis. Failure to either make payment arrangements or to make timely payments will result in cancellation of benefits back to the end of the pay period for which the premiums were paid.

NOTE: You are exempt from having to pay the employer's portion if you are on military leave or approved leave under the Family Medical Leave Act.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is the federal law that allows the employer to offer continued participation in medical, dental, and/or vision group insurance coverage if your employment terminates (18 months maximum) or your covered dependent loses eligibility (36 months maximum.) The Insurance & Benefits Office monitors when dependent children are approaching the end of eligibility on the last day of the month in which they turn 26 and will automatically cancel their coverage and have the notification of COBRA options mailed to them. Domestic partners of employees are eligible to continue coverage under COBRA when their eligibility ends under the active employee plans. Electing to continue coverage must be made within 60 days of the date eligibility was lost on the active employee plans or from the notification of the loss of coverage. Therefore, continued coverage will be offered to children losing eligibility or ex-spouses of employees whenever you submit documentation of the qualifying event. However, all the months since the coverage ended must be paid in order to reinstate coverage. The cost of the coverage is 102% of the full monthly premium. You will receive written notification of your rights and responsibilities after you upload documentation into PeopleSoft when you or your dependent experience an event that qualifies. Additional information is available in the Insurance and Benefits Office and on the City's website.

EXHIBIT 6

DELTA DENTAL

Dental Benefit Handbook

Delta Dental of New Mexico

Thank you for choosing Delta Dental of New Mexico for your fully insured dental benefits. We recommend reviewing this Dental Benefit Handbook for general information about your Benefits, including topics such as eligibility, how to use your Benefits, and how we define Benefits and their accompanying limitations and exclusions. Please refer to your Summary of Dental Plan Benefits for specific information about your Plan and available Provider network(s).

Benefits are provided under a Group Dental Insurance Contract ("Contract") entered into between an employer ("Group") and Delta Dental Plan of New Mexico, Inc. ("Delta Dental"). Claims for Benefits are sent to Delta Dental. Benefit determination, administration, and claims payment are the responsibility of Delta Dental. In addition to providing Benefits, Delta Dental administers enrollment, customer service, and the Delta Dental Provider network(s) selected by the Group.

This Dental Benefit Handbook, along with the Summary of Dental Plan Benefits, describes important Plan provisions. To the extent that anything set forth in this Handbook conflicts with your Summary of Dental Plan Benefits, your Summary of Dental Plan Benefits will control. Any modification to this Plan will apply to all Enrollees covered by this Plan at the time of such changes.

This Handbook, along with all supporting documentation and lists of Delta Dental Participating Providers, is always available at www.deltadentalnm.com. Please take time now to become familiar with your dental coverage. For answers to questions about Benefits, please call:

Delta Dental of New Mexico
Customer Service Department
(505) 855-7111 or toll-free (877) 395-9420

Oral health is an important part of your overall wellness. Delta Dental plans are designed to promote regular dental visits. Take advantage of your Benefits by calling a Delta Dental Participating Provider today for an appointment.

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

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I. Eligibility and Enrollment

A. Determining Eligibility

Subject to the eligibility rules set forth in your Summary of Dental Plan Benefits, the following eligibility rules apply. To the extent that these rules conflict with those stated in your Summary of Dental Plan Benefits, the rules in your Summary of Dental Plan Benefits control.

1. Individuals who meet one of the following qualifications and enroll in this Plan are eligible:
    a. An employee who satisfies the eligibility definition(s) and Eligibility Waiting Period as specified by the Group and agreed to by Delta Dental. Eligibility Waiting Period shall not exceed twelve (12) months.
    b. A dependent of the Eligible Employee defined as:
        i. Spouse as defined by New Mexico State Law;
        ii. Domestic Partner as defined by the Group or as otherwise required by law, unless stated otherwise in the Summary of Dental Plan Benefits;
        iii. children from birth through the end of the month of their twenty-sixth (26th) birthday, unless stated otherwise in the Summary of Dental Plan Benefits;
        iv. children age twenty-six (26) or older who cannot support themselves because of mental or physical impairment that began before age twenty-six (26) and are dependent on the Enrolled Employee for support and maintenance. Proof of these facts must be given to Delta Dental within thirty-one (31) days if requested.
        v. Please refer to your Summary of Dental Plan Benefits to verify age limitations that may apply to specific dental treatment and to the "Eligibility Provisions" to verify the dependent child age limitation.
2. The definition of "children" for the purposes of coverage under this dental Plan is:
    a. natural child(ren);
    b. newly born child(ren);
    c. stepchild(ren);
    d. child(ren) of a non-custodial parent;
    e. child(ren) for whom the Enrolled Employee is the legal guardian;
    f. legally adopted child(ren), including children placed with an Enrolled Employee, Spouse, or Domestic Partner for adoption. Coverage shall apply without any pre-existing Benefit restrictions;
    g. foster child(ren) living in the same household as an Eligible Employee, Spouse, or Domestic Partner as a result of placement by a state licensed placement agency;

h. dependent child(ren) required by a Qualified Medical Child Support Order (QMCSO) or a court or administrative order are also eligible for coverage without regard to Open Enrollment restrictions.

3. The following persons are not eligible: Spouse, Domestic Partner, or children in military service; and any individuals not defined as eligible above.

B. Enrollment Requirements

1. Employees and their Eligible Dependents must enroll to be covered under this Plan. Unless required by law, Eligible Dependents may enroll only if the Eligible Employee enrolls. Enrollments must be completed and received within thirty-one (31) days of the eligibility date.

2. Newly Eligible Employees and dependents may enroll in accordance with their dates of eligibility.

3. An Enrolled Employee may elect to enroll Eligible Dependents under the following conditions:

   a. Eligible Dependents must be enrolled at the time the Eligible Employee becomes enrolled, or within thirty-one (31) days from the date they become dependents, or within thirty-one (31) days of loss of other dental coverage, or during an Open Enrollment period;

   b. An Enrolled Employee may not also enroll as a dependent under the same employer's Plan;

   c. A dependent may enroll as the Enrollee of only one Enrolled Employee;

   d. Newly born dependents become eligible on the date of birth and may be enrolled on the Group's Effective Date, within thirty-one (31) days of birth, or at Open Enrollment.

4. Delta Dental will allow an annual Open Enrollment period for all Eligible Employees of the Group. Open Enrollment is a period of time specified by the Group and approved by Delta Dental to allow Eligible Employees and/or their dependents to enroll in this Plan or to cancel coverage under this Plan for the renewed Contract period. Open Enrollment changes are effective the first day of the Group's renewed Contract period.

5. While an Enrollee is covered by Delta Dental, that person agrees to provide Delta Dental with any information it needs to process claims and administer Benefits. This includes allowing Delta Dental to have access to his or her dental records.

6. If an Eligible Employee does not elect coverage when first eligible, he/she may only enroll during the next Open Enrollment period. If an Eligible Employee elects not to enroll himself/herself or his/her dependents, a waiver must be signed on the enrollment form at the time of initial eligibility. For individuals waiving due to other dental coverage, this waiver does not affect eligibility for enrollment within thirty-one (31) days if a loss of coverage occurs in the future. Proof of loss of other dental coverage must be provided to Delta Dental within thirty-one (31) days.

7. Delta Dental will not pay Benefits for persons who are not enrolled, nor will Delta Dental pay Benefits for an Enrolled Person if the Group Premium has not been paid for that person for the month in which dental services are performed.

8. The Group is responsible for submitting monthly Premium to Delta Dental on behalf of all Enrollees. Premium may include contributions by Enrollees as determined by the Group.

C. Effective Dates of Coverage

1. Unless otherwise approved by Delta Dental and indicated in the Summary of Dental Plan Benefits, coverage for an Enrolled Employee becomes effective on the first day of the month following that employee's date of eligibility.

2. Coverage for newly born child(ren) will become effective on the date of birth, if enrolled within thirty-one (31) days, but not before the coverage date applicable to the Enrolled Employee.

3. Coverage for Enrolled Dependents, except as noted in paragraph two (2) above, becomes effective on the same date as the Enrolled Employee or on the first of the month following the dependent's date of eligibility.

4. You must notify Delta Dental in a timely manner through your employer or organization of any event that changes the eligibility status of an Enrollee or Eligible Dependent. Events that can affect the eligibility status of an Enrollee or Eligible Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service. With respect to Qualifying Events that require the enrollment of an individual into this Plan, including but not limited to marriage, birth, or adoption, Delta Dental must receive notification of such Qualifying Event within thirty-one (31) days of such Qualifying Event. Delta Dental may require proof of the Qualifying Event.

D. Re-Enrollment after Voluntary Cancellation of Coverage

1. An Enrolled Employee may cancel employee or dependent coverage during an annual Open Enrollment period. Re-enrollment is not available until the next annual Open Enrollment period or upon subsequent loss of coverage.

2. Re-enrollment in this Plan between Open Enrollment periods after voluntary cancellation of coverage is not allowed for any reason other than the loss of other dental coverage or another Qualifying Event. Re-enrollment and proof of loss of other dental coverage must be provided to Delta Dental within thirty-one (31) days.

II. Accessing Your Benefits

This section describes basic information about selecting a Provider and how to access your Benefits. Please refer to your Summary of Dental Plan Benefits for specific information about the network(s) available under your Plan and the effect of your Provider selection. If you have additional questions regarding how your Plan works, please call Delta Dental Customer Service at (505) 855-7111 or toll-free (877) 395-9420.

A. General Information About Selecting a Provider

1. Your Summary of Dental Plan Benefits, available at www.deltadentalnm.com, contains specific information about your dental Plan's network(s).
2. You will have the lowest out-of-pocket costs when you select a Provider who participates in the network specified at the top of your Summary of Dental Plan Benefits.
3. Delta Dental does not require that you pre-select a Provider and does not guarantee that a particular Provider will be available.
4. Search for Participating Providers on www.deltadentalnm.com. The search feature allows you to find Providers in New Mexico or nationally, based on network, specialty, last name, and/or location.
5. Each Enrolled Person in your family may choose a different Provider.
6. You are responsible for the full payment for any non-covered services.

B. Accessing Benefits

To use this Plan, follow these steps:

1. Read this Handbook and the Summary of Dental Plan Benefits carefully to become familiar with your Benefits, network(s), Delta Dental's method of payment, and the provisions of this Plan.
2. Make a dental appointment and tell the dental office that dental coverage is under this Plan. If the office is not familiar with the coverage applicable to this Plan or has questions regarding this Plan, the dental office may contact the Delta Dental Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420.
3. Following dental treatment, a claim needs to be filed with Delta Dental. All Delta Dental Participating Providers will file the claim directly with Delta Dental. Non-Participating Providers may require patients to file their own claims. Claims for Benefits must be submitted to Delta Dental in writing within twelve (12) months from the date services were provided. Failure to submit a claim within the time limitation shall not void or reduce the claim if it is shown it was not reasonably possible to submit within the twelve (12) months. Upon review, Delta Dental will make a final determination.
4. Enrolled individuals are responsible for filing claims for services received from a Non-Participating Provider, including Providers outside of the United States. A claim form, including the "Patient Section," must be completed. Prior to submission to Delta Dental, the dental office providing services must

complete an itemization of services that includes the name of the clinic and Provider, tooth number or area of the oral cavity (if applicable), a description of each individual service, a date of service, a fee for each individual service, and a signature by the Provider. Upon review of any out-of-country claim, Delta Dental may respond to you with a letter requiring your signature acknowledging you received the specified dental services.

For out-of-country claims, Delta Dental requires an itemized receipt indicating the country's currency. For Mexican claims, the receipt must be numbered, include a tax stamp as mandated by Mexican legislation, and show the paid amount in pesos (not U.S. dollars). Compliance is required by Mexico's Tax Authorities.

If the services performed outside of the United States are for extractions, crowns, bridges, dentures, or partial dentures, a radiographic image of the area must be obtained prior to the service being considered for Benefits. Enrolled Persons are responsible for obtaining the necessary documentation for services provided, filing a claim with Delta Dental, and paying the Provider at the time services are performed.

Delta Dental will calculate foreign currency Benefit payments based on published currency conversion tables that correspond to the date of service.

5. Completed claim forms should be submitted to Delta Dental, 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico, 87110. The Delta Dental Customer Service Department is available Monday through Friday, 8:00 a.m. – 4:30 p.m. (Mountain Time) at (505) 855-7111 or toll-free (877) 395-9420.

6. Within thirty (30) days of receiving a valid claim, Delta Dental will make available an Explanation of Benefits which records Delta Dental's Benefit determination, any payment made by Delta Dental, and any amount still owed to the dental Provider. The Explanation of Benefits will be made available to the Enrolled Employee, or other appropriate beneficiary, and to the treating Provider if a Delta Dental Participating Provider. The thirty (30) day period for claim determination may be extended by an additional fifteen (15) days if matters beyond the control of Delta Dental delay Benefit determination. Notification of any necessary extension will be sent prior to the expiration of the initial thirty (30) day period.

   In the event a Group does not pay its monthly Premium, all claims for that Group will be placed on hold. If a claim is on hold for more than thirty (30) days, it may be denied, in which case the Enrolled Employee would become responsible for any outstanding fees owed to the dental Provider.

7. If a claim for Benefits is reduced or denied, the Explanation of Benefits will state the reason for the Adverse Benefit Determination. Should an Enrolled Person believe Delta Dental incorrectly denied all or part of a claim, a review may be requested by following the steps described in Section V, "Claims Appeal."

8. You may appoint an Authorized Representative to make contact with Delta Dental on your behalf with respect to any Benefit claim you file or any review of a denied claim you wish to pursue. To download the form to designate your Representative, visit www.deltadentalnm.com, or request a form by

calling the Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420, or mailing a letter to 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico, 87110. Once you have appointed an Authorized Representative, Delta Dental will communicate directly with your Representative.

9. For questions and assistance regarding your coverage, you may contact your Human Resources Department or call Delta Dental's Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420. You may also write to Delta Dental's Customer Service Department at 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico, 87110. When writing to Delta Dental, please include your name, the Group's name, your member ID number, and your daytime telephone number. If you need the assistance of the government agency that regulates insurance, or have a complaint you have been unable to resolve, you may contact the Office of Superintendent of Insurance.

10. Pre-Treatment Estimates – A Pre-Treatment Estimate of Benefits provides both the patient and the Provider with an estimate of the Benefit levels, maximums, and limitations that may apply to a proposed treatment plan. Most importantly, the Enrolled Person's share of the cost will be estimated, allowing you to know what services may be covered before your Provider provides them. A Pre-Treatment Estimate is not required to receive payment, unless specified in the Summary of Dental Plan Benefits. Your Provider submits the proposed dental treatment to Delta Dental in advance of providing the treatment. You and your Provider should review your Pre-Treatment Estimate before treatment. Once treatment is complete, the dental office will submit a claim to Delta Dental for payment.

    a. A Pre-Treatment Estimate is for informational purposes only and is not required before you receive dental care, unless specified in the Summary of Dental Plan Benefits. It is not a prerequisite or condition for approval of future dental Benefits payment. You will receive the same Benefits under this Plan whether or not a Pre-Treatment Estimate is requested. The Benefits estimate provided on a Pre-Treatment Estimate notice is based on Benefits available on the date the notice is received. It is not a guarantee of future dental Benefits or payment.

    b. Availability of dental Benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for Benefits, your available annual or lifetime Maximum Benefit Amount, Coordination of Benefits, the status of your Provider, this Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a claim for Benefits or a preauthorization, precertification, or other reservation of future Benefits.

11. If an Enrollee receives emergency care for services specified in your dental Plan and cannot reasonably reach a Participating Provider (as outlined in the Summary of Dental Plan Benefits), the emergency care rendered during the course of the emergency will be reimbursed as though the Enrollee had been treated by a Participating Provider.

C. Out-of-Pocket Expenses

The following out-of-pocket expenses may apply to your Plan:

1. **Deductible**
   This Plan may require Enrolled Persons to pay a portion of the initial expense toward some Covered Services in each Benefit Period. When applicable, the amount of this Deductible is stated in the Summary of Dental Plan Benefits.

2. **Patient Coinsurance**
   The patient Coinsurance is the percentage of Covered Services that the Enrolled Person is responsible for paying to the dental Provider. The amount of patient Coinsurance will vary depending on the level of Benefits for the particular dental treatment and the selection of a Participating or a Non-Participating Provider as described in the accompanying Summary of Dental Plan Benefits.

3. **Maximum Benefit Amount**
   Delta Dental will pay for Covered Services up to a maximum amount for each Enrolled Person for each Benefit Period. Enrolled Persons are responsible for payment of amounts due for any dental services that exceed the Maximum Benefit Amount applicable in the Benefit Period. The Maximum Benefit Amount is stated in the Summary of Dental Plan Benefits.

D. Clinical Review

1. All claims are subject to review by a Dental Consultant. A Dental Consultant is a licensed New Mexico Dentist who has no affiliation or connection with Delta Dental other than as an independent consultant.

2. Payment of Benefits may require that an Enrolled Person be examined by a licensed Dental Consultant or an Independent Licensed Dentist.

3. Delta Dental may require additional information prior to approving a claim. All information and records acquired by Delta Dental will be kept confidential.

E. To Whom Benefits Are Paid

1. Delta Dental will pay a Participating Provider directly for Covered Services rendered. The Enrolled Person is responsible for paying the Provider directly for any Coinsurance, Deductible, and non-covered services.

2. Delta Dental will pay a New Mexico Non-Participating Provider when an assignment of Benefits is received on the individual claim.

3. Delta Dental will pay a Non-Participating Provider practicing outside the state of New Mexico when required by law or when required by the Delta Dental Plan in that state, and when an assignment of Benefits is received on the individual claim.

4. All available Benefits not paid to the dental Provider shall be payable to the Enrolled Person or to the estate of the Enrolled Person.

5. Delta Dental must pay directly to the Human Services Department or Indian Health Services any eligible dental Benefits under this Contract which have already been paid or are being paid by the Human Services Department or

Indian Health Services on behalf of the Enrolled Person under the state's Medicaid Program or Indian Health Program.

6. In cases of a Qualified Medical Child Support Order (QMCSO), Delta Dental will send Benefit payments directly to Participating Providers. Payment of Benefits for services obtained from Non-Participating Providers will be directed in compliance with the valid order of judgment provided in the QMCSO.

F. Right to Recover Benefits Paid by Mistake

If Delta Dental makes a Benefit payment to the Enrolled Person or to a Provider and the patient is subsequently determined as not eligible for all or part of that Benefit, Delta Dental has the right to recover payment. If Benefit payment is made under fraudulent, false, or misleading pretenses or circumstances, Delta Dental has the right to recover that payment. The right to recover a payment includes the right to deduct the amount paid from future dental Benefits for any covered family member. An explanation of the payment being recovered will be provided at the time a deduction is made.

III. Benefits, Limitations, and Exclusions

Your Benefits are outlined in your Summary of Dental Plan Benefits. Unless specified otherwise in the Summary of Dental Plan Benefits, the following Benefits, limitations, and exclusions described in this section apply to this Plan. A dental service will be considered for Benefits based on the date the service is started. Benefits are subject to the Processing Policies of Delta Dental and the terms and conditions of the entire Contract. Refer to the accompanying Summary of Dental Plan Benefits for patient Coinsurance amounts. In addition to the limitations applicable to each type of service, refer to "General Limitations and Exclusions" for a detailed list of other applicable Plan exclusions. To the extent that anything set forth herein conflicts with your Summary of Dental Plan Benefits, your Summary of Dental Plan Benefits will control.

A. Diagnostic and Preventive Services

Diagnostic: Procedures to aid the Provider in choosing required dental treatment (patient screenings, oral examinations, diagnostic consultations, diagnostic casts, clinical oral evaluations, and radiographic images).

Palliative: Minor, non-definitive emergency treatment to temporarily relieve pain.

Preventive: Brush biopsy and related lab tests, cleanings, application of topical fluoride, space maintainers, and sealants. Periodontal maintenance is considered to be a cleaning for Benefit frequency determination.

B. Limitations on Diagnostic and Preventive Services

1. Benefit for patient prediagnostic screenings is limited to once in a calendar year. A separate fee for patient assessment is Disallowed.
2. A caries risk assessment and documentation, with a finding of low, moderate, or high risk, is a Benefit once every thirty-six (36) months.
    a. A separate fee for a caries risk assessment is Disallowed when submitted for children under the age of three (3).
    b. A separate fee for a caries risk assessment is Disallowed within twelve (12) months of the date of service.
    c. A caries risk assessment is not a Benefit at twelve (12) to thirty-six (36) months from the date of service.
    d. A separate fee for a caries risk assessment is Disallowed when the procedure is performed in addition to any other risk assessment procedure on the same date of service by the same Provider or dental office.
3. Brush biopsies are limited to once in a twelve (12) month period. A separate fee for interpretation is Disallowed.
4. Benefits for oral examinations, including diagnostic consultations, emergency or re-evaluation exams, clinical oral evaluations, routine cleanings, and topical fluoride treatment are limited as shown in the Summary of Dental Plan Benefits.

5. Enrollees under the age of fourteen (14) are limited to routine child cleanings. Enrollees age fourteen (14) and over will be considered adults for the purpose of determining Benefits for cleanings.

6. Delta Dental will Benefit a complete series of radiographic images as stated in the Summary of Dental Plan Benefits. A panoramic radiographic image with or without bitewing images is considered a complete series of radiographic images. Images exceeding the diagnostic equivalent of a complete series of radiographic images will be Disallowed when taken on the same date of service. Bitewing radiographic images exceeding the diagnostic equivalent of a complete series of radiographic images will be Disallowed when taken on the same date of service.

7. Emergency palliative treatment does not include Services and Supplies that exceed the minor treatment of pain. Benefit is limited to radiographic images and tests necessary to diagnose the emergency condition.

8. Services for diagnostic casts, oral/facial photographic images, laboratory and diagnostic tests, non-routine diagnostic imaging, non-surgical collection of specimens, oral hygiene instruction, home fluoride, mounted case analysis, and nutrition or tobacco counseling are not covered. A separate fee for image interpretation is Disallowed.

9. Pulp tests are a Benefit per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are Disallowed as part of any other definitive procedure on the same day by the same Provider or dental office except for limited oral evaluation (problem focused), palliative treatment, radiographic images, and protective restorations.

10. Benefits for sealants are limited to permanent molars free from occlusal restorations and a Covered Service for Enrollees as stated in the Summary of Dental Plan Benefits.

11. A separate fee for the replacement or repair of a sealant by the same Provider or dental office is Disallowed within two (2) years of the initial placement.

12. An age limitation may apply to services related to space maintainers. Please refer to the Summary of Dental Plan Benefits for applicable age limitations.

13. Benefits for space maintainers are limited to once per lifetime per site. A separate fee for the removal of a space maintainer by the same Provider or dental office who placed the initial appliance is Disallowed. Removal of a space maintainer by a different Provider or dental office is a Benefit once per space per lifetime.

14. Benefits for distal shoe space maintainers are payable once per area per lifetime for people up to age nine (9).

15. A separate fee for the repair or adjustment of a distal shoe space maintainer by the same Provider or dental office who placed the initial appliance is Disallowed.

16. A separate fee for the recementation, re-bond, or repair to a space maintainer by the same Provider or dental office is Disallowed within six (6) months of the original treatment. Six (6) months after the original treatment

date, recementation, re-bond, or repair is a Benefit once per twelve (12) month period.

17. Preventive restorations are not a Benefit.
18. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

C. Additional Benefits for Patients with Specified Medical Conditions

Delta Dental may pay for additional Benefits for people with specified medical conditions.

1. Patients with the following medical conditions may be eligible for additional cleanings, up to four (4) total cleanings per Benefit Period:
    a. Diabetes with periodontal disease
    b. Pregnancy with periodontal disease
    c. Renal failure/dialysis
    d. Suppressed immune system—chemotherapy/radiation treatment, HIV positive, organ transplants, and stem cell (bone marrow) transplants
    e. Head and neck radiation patients
    f. Individuals at risk for infective endocarditis
2. Qualifying heart conditions are:
    a. History of infective endocarditis
    b. Certain congenital heart defects (ex. one ventricle instead of the normal two)
    c. Individuals with artificial heart valves
    d. Heart valve defects caused by acquired conditions like rheumatic heart disease
    e. Hypertrophic cardiomyopathy (causes abnormal thickening of the heart muscle)
    f. Individuals with pulmonary shunts or conduits
    g. Mitral valve prolapse (MVP) (blood leakage)
3. In addition, head and neck radiation patients may also be eligible for additional topical fluoride treatments, up to two (2) total topical fluoride treatments per Benefit Period.
4. It is important to notify your Provider of these or any other serious medical conditions and to discuss what treatment options may be right for you.
5. You must be able to submit to Delta Dental a documented diagnosis of any of the above conditions to qualify for additional procedures.

D. Restorative Services

Restorative services are amalgam, resin-based composite restorations (fillings), or stainless steel and prefabricated stainless steel restorations. These Covered Services are a Benefit for the treatment of visible destruction of the hard tooth structure resulting from the process of decay or injury.

E. Limitations on Restorative Services

1. A separate fee for the replacement of a restoration or any component of a restoration on a tooth for the same surface by the same Provider or dental office is Disallowed if done within twenty-four (24) months of the initial service.
2. When multiple restorations involving multiple surfaces of the same tooth are performed, Benefits will be limited to that of a multi-surface restoration. A separate Benefit may be allowed for a non-contiguous restoration on the buccal or lingual surface(s) of the same tooth subject to clinical review.
3. Unless listed in the Summary of Dental Plan Benefits, resin restorations in posterior teeth are limited to premolars and maxillary first molars. On all other teeth, they are considered optional services and are limited to the equivalent amalgam restoration Benefit.
4. Prefabricated resin crowns are a Benefit for primary anterior teeth only.
5. Services for metallic, porcelain/ceramic, or composite/resin inlays are limited to the Benefit for the equivalent amalgam/resin filling procedure.
6. Services for metallic, porcelain/ceramic, or composite/resin onlays are subject to clinical review, and limitations on optional services may apply.
7. Replacement of existing restorations (fillings) for any purpose other than treating active tooth decay or fracture is not covered.
8. Separate fees for more than one (1) pin per tooth or a pin performed on the same date of service as a build-up are Disallowed. A separate fee for the replacement of pin retention on the same tooth, by the same Provider or dental office, within twenty-four (24) months is Disallowed.
9. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

F. Basic Services

Anesthesia: Intravenous sedation and general anesthesia.

Endodontics: The treatment of teeth with diseased or damaged nerves (for example, root canals).

Extractions: Surgical extractions. Extraction of coronal remnants of a primary tooth and extraction of an erupted tooth or exposed root are considered non-surgical extractions for Benefit determination purposes.

Oral Surgery: Oral surgery including oral maxillofacial surgical procedures of all hard and soft tissue of the oral cavity.

Periodontics: The treatment of diseases of the gums and supporting structures of the teeth.

G. Limitations on Basic Services

1. Evaluation for deep sedation or general anesthesia is Disallowed when billed in conjunction with an evaluation by the same Provider or dental office.
2. Intravenous (IV) sedation and general anesthesia are not Benefits for non-surgical extractions and/or patient apprehension.
3. Intravenous (IV) sedation and general anesthesia are Benefits only when administered by a licensed Provider in conjunction with specified surgical procedures, subject to clinical review and when Medically Necessary.
4. Nitrous oxide and non-intravenous conscious sedation are not covered Benefits.
5. Benefits for pulpal therapy procedures are limited to once in a twenty-four (24) month period.
6. A separate fee is Disallowed for pulp therapy procedures when performed on the same day, by the same Provider or dental office, as other surgical procedures involving the root.
7. A separate fee is Disallowed for a pulp cap placed on the same day as a restoration or within twenty-four (24) months of a pulp cap placed on the same tooth by the same Provider or dental office.
8. A pulpotomy or pulpal debridement is a Benefit once per tooth per lifetime.
9. Pulpotomies and pulpal therapy procedures are limited to primary teeth.
10. Benefits for certain oral surgery procedures are subject to the receipt of an operative report and clinical review, and may be reduced by benefits provided under the patient's medical benefits coverage, if applicable.
11. Root canal therapy in conjunction with overdentures is not a Benefit.
12. Re-treatment of root canal therapy or re-treatment of surgical procedures involving the root, by the same Provider or dental office, within twenty-four (24) months, is considered part of the original procedure and a separate fee is Disallowed.
13. Apexification Benefits are limited to permanent teeth, once per tooth per lifetime. This procedure is Disallowed if performed by the same Provider or dental office within twenty-four (24) months of root canal therapy.
14. Endodontic endosseous implants are not a Benefit.
15. Tooth transplantation, including re-implantation, is not a Benefit.
16. Scaling in the presence of generalized moderate or severe gingival inflammation is considered to be a cleaning for Benefit frequency determination.

17. Periodontal maintenance is considered to be a cleaning for Benefit frequency determination. Benefits for periodontal maintenance are limited as shown in the Summary of Dental Plan Benefits.

18. A separate fee for periodontal maintenance may be Disallowed within three (3) months of other periodontal therapy provided by the same Provider or dental office, as determined by clinical review.

19. Full mouth debridement is only a Benefit when necessary to enable comprehensive evaluation and diagnosis on a subsequent visit and is limited to once per lifetime.

20. Periodontal scaling and root planing are a Benefit once per quadrant or site in a two (2) year period.

21. Localized delivery of antimicrobial agents may be performed at six (6) weeks to six (6) months after initial therapy (scaling and root planing or surgery) on no more than two (2) sites per quadrant, with pocket depth at least five (5) millimeters and less than ten (10) millimeters.

    a. If different teeth are treated in the quadrant within twelve (12) months, the treatment is not a Benefit.

    b. If the same teeth are re-treated within twenty-four (24) months, the treatment is not a Benefit.

22. Periodontal surgeries, such as gingivectomy, gingival flap, osseous surgery, bone grafts, and tissue graft procedures are limited to once per site in a three (3) year period.

23. Gingivectomy or gingivoplasty to allow access for a restorative procedure is considered part of the restorative procedure.

24. A bone replacement graft, biologic materials, or guided tissue regeneration in conjunction with an apicoectomy, gingivectomy, crown lengthening, retrograde filling, root amputation, periradicular surgery, soft tissue grafts, subepithelial tissue grafts, extraction, implant site, ridge augmentation, anatomical crown exposure, wedge procedure, or an apically positioned flap is a Specialized Procedure and not a Benefit.

25. Extra-oral soft tissue grafts (grafting of tissues from outside the mouth to oral tissues) or bone graft accession from a donor site is not a Benefit.

26. Separate fees for crown lengthening in the same site are Disallowed when charged by the same Provider or dental office within three (3) years.

27. Additional fees for more than two (2) quadrants of osseous surgery on the same day of service are Disallowed.

28. Separate fees for postoperative visits and/or dressing changes by the same Provider or dental office performing the treatment are Disallowed.

29. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

H. Major Services

Crown Build-Ups and Substructures: Benefits when necessary to retain a cast restoration due to extensive loss of tooth structure from caries, fracture, or endodontic treatment.

Crowns and Cast Restorations, Including Repairs to Covered Procedures: Benefits when a tooth is damaged by decay or fractured to the point that it cannot be restored by an amalgam or resin filling.

Implants: Specified services, including repairs, and related prosthodontics. A crown Benefit is considered the same whether it is placed on a natural tooth or an implant.

Prosthodontics: Procedures for construction, modification, or repair of bridges and partial or complete dentures.

TMD Treatment: Medically Necessary treatment of Temporomandibular Joint Disorder, including related diagnostic imaging.

I. Limitations on Major Services

1. Replacement of cast restorations (including veneers, crowns, pontics, inlays, and onlays) and associated procedures (such as cores and substructures) on the same tooth are not a Benefit if the previous placement is less than five (5) years old.
2. Inlays are not a Covered Service and will be optioned to an amalgam or resin restoration.
3. Veneers are not a Covered Service and will be optioned to a resin restoration.
4. Replacement of a bridge or denture is not a Benefit if the previous placement is less than five (5) years old.
5. Services which are beyond the standard of care customarily provided, or not necessary to restore function, are limited to the Benefit applicable to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
6. Cantilever bridges are beyond the standard of care customarily provided and are subject to clinical review.
7. Overdentures are not a Covered Service.
8. Substructures are only a Benefit when necessary to retain a cast restoration due to the extensive loss of tooth structure from caries or fracture. Substructures are Disallowed when enough tooth structure is present to retain a cast restoration.
9. The fee for a core build-up and/or substructures is Disallowed when performed in conjunction with inlays, onlays, ¾ crowns, and veneers.
10. Posts and cores in addition to a crown are a Benefit only on endodontically treated teeth. In addition to the requirement for endodontic treatment, anterior teeth must have insufficient tooth structure to support a cast restoration. Fees are Disallowed when these requirements are not satisfied.

11. A separate fee for the recementation or re-bond to crowns, implants, inlays, onlays, posts and cores, veneers, or bridges within six (6) months of the original treatment by the same Provider or dental office is Disallowed.

12. A separate fee for the repair to crowns, inlays, onlays, or veneers within twenty-four (24) months of the original treatment by the same Provider or dental office is Disallowed.

13. Services for the recementation, re-bond, or repair to crowns, implants, inlays, onlays, posts and cores, veneers, or bridges are a Benefit once per twelve (12) months. Procedures to modify existing partials and dentures are considered construction of prosthesis, not the repair of prosthesis.

14. A pontic required due to spaces in excess of those resulting from the extraction of the normal complement of natural teeth is a special condition of that patient's mouth and is not a Benefit.

15. Surgical placement of an implant body is a Benefit once per tooth per five (5) year period.

16. Implant supported prosthetics and/or abutment supported crowns are not a Benefit if the previous placement is less than five (5) years old. This limitation applies to the placement of crowns on natural teeth, abutment supported crowns on implants, and fixed partial denture pontics.

17. Implant maintenance procedures are limited to twice in a Benefit Period.

18. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure are subject to these limitations and/or exclusions:

    a. A separate fee is Disallowed when the procedure is performed in conjunction with routine cleanings, periodontal maintenance, root planing and scaling, gingival flap procedures, periodontal osseous surgery, or debridement of a peri-implant defect.

    b. This Benefit is limited to once per tooth per twenty-four (24) months.

    c. A separate fee for this procedure by the same Provider or dental office within twenty-four (24) months of initial therapy is Disallowed.

    d. A separate fee is Disallowed when this procedure is performed within twelve (12) months of implant-supported crown or bridge procedures by the same Provider or dental office.

19. Stress breaker, semi-precision, or precision attachments or the replacement of an implant/abutment supported prosthesis is considered an optional service and is not a Benefit.

20. A separate fee for the removal of an implant within twenty-four (24) months of the original placement, by the same Provider or dental office, is Disallowed. After twenty-four (24) months, this service is a Benefit once per tooth per lifetime.

21. A separate fee is Disallowed for a radiologic surgical implant index.

22. A posterior fixed bridge and a partial denture are not Benefits in the same arch. Benefit is limited to the allowance for a partial denture.
23. Temporary restorations, temporary implants, and temporary prosthodontics are considered part of the final restoration. A separate fee by the same Provider or dental office is Disallowed.
24. Benefits for porcelain crowns or porcelain supported prosthetics on posterior teeth are limited to premolars and maxillary first molars. On all other teeth, they are considered optional services and Benefits are limited to the equivalent metal crown or metal supported prosthetic Benefit.
25. Maxillofacial prosthetics and related services are not a Benefit.
26. Crowns, implants, prosthodontics, and all related services are not Benefits for Enrollees under the age of sixteen (16).
27. Fees for full or partial dentures include any reline/rebase, adjustment, or repair required within six (6) months of delivery except in the case of immediate dentures. After six (6) months, adjustments to dentures are a Benefit twice in a twelve (12) month period and relines or rebases are a Benefit once in a three (3) year period.
28. Tissue conditioning is not a Benefit more than twice per denture unit in a three (3) year period.
29. Treatment of Temporomandibular/Craniomandibular Disorders (TMD) is covered within the scope of dental practice and does not include coverage for orthodontic appliances and treatment, crowns, bridges, and dentures unless the disorder is trauma related.
30. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

J. Orthodontic Services

No payment will be made by Delta Dental for Orthodontic Services unless stated in the Summary of Dental Plan Benefits.

Orthodontic Services are procedures performed by a Provider using appliances to treat poor alignment of teeth and their surrounding structure. The Benefit determination for the Orthodontic Lifetime Maximum may include specific non-orthodontic procedure codes that are directly related, as determined by Delta Dental, to be part of an orthodontic treatment plan. Procedures directly related to Orthodontic Services will only be considered eligible expenses if Benefits for Orthodontic Services apply.

Payment for charges that exceed the maximum Benefit applicable to Orthodontic Services is the patient's responsibility. Refer to the Summary of Dental Plan Benefits to verify if this Plan includes coverage for Orthodontic Services along with specific and lifetime Benefit provisions.

Diagnostic casts will be considered for payment at the Diagnostic and Preventive Services Coinsurance level when performed in conjunction with covered Orthodontic Services. Payments for diagnostic casts are part of the Orthodontic Lifetime Maximum.

K. Limitations on Orthodontic Services

1. If the Enrolled Person is already in orthodontic treatment, Benefits shall commence with the first treatment rendered following the patient's Effective Date or any applicable Benefit waiting period. Charges for treatment incurred prior to the patient's Effective Date are not covered.
2. Benefits are determined based on the total cost and total months of treatment.
3. Benefits will end immediately if orthodontic treatment is stopped.
4. Charges to repair or replace any orthodontic appliance (including, but not limited to, retainers and replacement retainers) are not covered, even when the appliance was a covered Benefit under this or any other Plan.
5. Charges for radiographic images (except for cephalometric radiographic images) and extractions are not covered under Orthodontic Services.
6. Oral/facial photographic images and diagnostic casts are a Benefit once per orthodontic treatment case. Additional fees for these procedures are Disallowed when performed by the same Provider or dental office.
7. Self-directed or "at-home" orthodontic treatment is not a Benefit.
8. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

L. General Limitations and Exclusions

1. A Benefit waiting period prior to obtaining some services applies if stated in the Summary of Dental Plan Benefits. This means an Enrolled Person is not eligible for Benefits for those services until he/she has been continually enrolled under this Contract for the time frame stated in the Summary of Dental Plan Benefits.
2. Services for any covered procedures which exceed the frequency or age limitation shown in the Summary of Dental Plan Benefits are not eligible for Benefits. Unless stated otherwise, all frequency limitations are measured from the last date a procedure was performed according to the patient's dental records.
3. Services beyond treatment that is considered the standard of care customarily provided are considered "optional or specialized services." These services may include the use of alternative techniques, special materials, and services of a cosmetic intent.
    a. If an Enrolled Person receives optional or specialized services, Benefits may be provided based on the customary or standard procedure. A determination of optional or specialized services is not an opinion or judgment on the quality or durability of the service. The Enrolled Person will be responsible for any difference between the cost of optional or specialized services and any Benefit payable.
4. Charges for cone beam CT capture and interpretation services are not a Benefit.

5. Treatment of injuries or illness covered by Workers' Compensation or employers' liabilities laws or services received without cost from any federal, state, or local agencies are not a Benefit.
6. Treatment to restore tooth structure lost from wear is not covered.
7. Cosmetic surgery or procedures are not covered.
8. Prosthodontic services or any single procedure started before the patient is covered under this Plan is not eligible for Benefits.
9. Prescribed drugs, pain medications, desensitizing medications, and therapeutic drug injections are not covered unless part of a Medically Necessary TMD treatment plan and subject to approval by Delta Dental.
10. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dental or medical Provider for treatment in any such facility are not Covered Services.
11. A separate fee for a consultation with a medical care professional is Disallowed.
12. Dental case management services are subject to these limitations and/or exclusions:
    a. A separate fee for addressing appointment compliance barriers is Disallowed.
    b. A separate fee for care coordination is Disallowed.
    c. Motivational interviewing is not a Benefit.
        i. If this service is performed on the same date of service as nutritional counseling for control of dental disease, tobacco counseling for the control and prevention of oral disease, or oral hygiene instructions, a separate fee for this service is Disallowed.
    d. Patient education to improve oral health literacy is not a Benefit.
        i. If this service is performed on the same date of service as nutritional counseling for control of dental disease, tobacco counseling for the control and prevention of oral disease, or oral hygiene instructions, a separate fee for this service is Disallowed.
13. Orthodontic Services, or any services related to an orthodontic treatment plan, are not covered unless stated in the Summary of Dental Plan Benefits.
14. Treatment must be provided by a licensed Dentist or a person who by law may work under a licensed Dentist's direct supervision.
15. A separate charge for office visits, non-diagnostic consultations, case presentations, or cancelled or missed appointments is not covered.
16. Treatment to correct harmful habits is not covered.
17. A separate charge is Disallowed for behavior management, infection control, sterilization, supplies, and materials.

18. Charges for Services or Supplies that are not necessary according to accepted standards of dental practice are not Benefits.
19. Charges for Services, Supplies, or devices which are not a Dental Necessity are not Benefits.
20. Services or Supplies, as determined by Delta Dental, that are Experimental or Investigational in nature are not covered. This includes Services and Supplies required to treat complications from Experimental or Investigational procedures.
21. A hemisectioned tooth will not be Benefited as two (2) separate teeth.
22. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion is not a Benefit.
23. Treatment to stabilize teeth is not a Benefit.
24. Occlusal or athletic mouth guards and related services are not a Benefit unless part of a Medically Necessary TMD treatment plan and subject to approval by Delta Dental.
25. Replacement of existing restorations (fillings) for any purpose other than treating active tooth decay or fracture is not covered. A tooth fracture or crack is defined as tooth structure that is mobile and/or separated from the natural tooth structure.
26. Charges for treatment of craze lines are not a Benefit. A "craze line" is a visible micro-fracture located in coronal enamel that does not break or split the continuity of the tooth structure.
27. Sales tax is not a Benefit.
28. Separate fees are Disallowed for procedures which are routinely considered by Delta Dental to be part of another service, if performed by the same Provider or dental office on the same date of service.
29. Services or Supplies excluded by the policies and procedures of Delta Dental, including the Processing Policies, are not a Benefit.
30. Services or Supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage are not covered by the Plan.
31. Services or Supplies received due to an act of war or terrorism, declared or undeclared, are not a Covered Service.
32. Services or Supplies that are not within the categories of Benefits selected by your employer or organization and that are not covered under the terms of this Handbook are not a Benefit.

IV. Coordination of Benefits

Coordination of Benefits (COB) applies to this Plan when an Enrollee has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether this Plan's Benefits are determined before or after another plan's benefits.

An Enrolled Person will provide Delta Dental with the necessary information needed to administer COB. Delta Dental may release required information or obtain required information in order to coordinate the Benefits of an Enrolled Person.

Delta Dental follows National Association of Insurance Commissioners (NAIC) guidelines for COB.

A. Determining Which Plan is Primary

To determine which plan is primary, Delta Dental considers which Enrollee of a family is involved in a claim and the coordination provisions of the other plan. The primary plan is determined by the first of the following rules that applies:

1. **Medicaid or Indian Health Services** – Delta Dental is always the primary plan to any benefits payable by Medicaid or Indian Health Services.
2. **Non-Coordinating Plans** – If you have another plan that does not coordinate benefits, it will always be the primary plan.
3. **Hospital, Surgical/Medical, or Prescription Drug Plans** – These are the primary plan if the plan provides benefits for dental related services including but not limited to: treatment due to accidental injuries, surgical extraction of impacted wisdom teeth, oral surgery, the administration of general anesthesia, and Temporomandibular Joint Disorder.
4. **Employee or Subscriber** – The plan that covers the Enrolled Person other than as an Enrolled Dependent is primary. For example, the plan that covers you as the employee or Subscriber, neither laid off nor retired, is the primary plan.
5. **Children and the Birthday Rule** – The plan of the parent whose birthday is earliest in the calendar year is always primary for children. For example, if your birthday is in January and your Spouse's birthday is in March, your plan will be primary for all of your children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.
6. **Children with Parents Divorced or Separated**
    a. If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.
    b. If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the child's health care expenses, Delta Dental follows the birthday rule (see rule 5 above). If neither of these rules applies, the order will be determined as follows:
        i. First, the plan of the parent with custody of the child;

ii. Then, the plan of the Spouse of the parent with custody of the child;

iii. Next, the plan of the parent without custody of the child; and

iv. Last, the plan of the Spouse of the parent without custody of the child.

7. **Laid-Off or Retired Enrollees** – The plan that covers the Enrollee as a laid-off or retired employee or as a dependent of a laid-off or retired employee.

8. **COBRA Coverage** – The plan that is provided under a right of continuation pursuant to federal or a similar state law (that is COBRA).

9. **Other Plans** – If none of the rules above determines the order of benefits, the plan that has covered the Enrollee for the longer period will be primary.

B. How Delta Dental Pays as Primary

When Delta Dental is the primary plan, Delta Dental will pay for Covered Services as if you had no other coverage.

C. How Delta Dental Pays as Secondary

When Delta Dental is the secondary plan, it will pay for Covered Services based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan. However, Delta Dental may pay less than it would have paid as the primary plan if the balance is lower than that amount.

D. Right of Recovery

If Delta Dental pays more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The people it has paid or for whom it has paid;

   a. Insurance companies; or

   b. Other organizations.

V. Claims Appeal

A. Voluntary Appeal Procedure

1. An Enrolled Person may request a review of a claim by following Delta Dental's claim appeal procedures. All of Delta Dental's claim appeal procedures are voluntary and are designed to provide a full and fair review of any Adverse Benefit Determination. An Adverse Benefit Determination means a denial, reduction, or termination of a Benefit or a failure to make payment, in whole or in part, on a claim.

2. The decision as to whether to request a review or to appeal a claim will have no effect on the patient's right to any other Benefits under the Plan. In addition, the following provisions are assured. The Enrolled Person:

   a. will be notified in writing by Delta Dental of any Adverse Benefit Determination and the reason(s) for the Adverse Benefit Determination;

   b. may submit written comments, documents, records, narratives, radiographs, clinical documentation, and other information relating to the claim which Delta Dental will take into consideration, whether or not such information was submitted or considered in the initial Benefit determination;

   c. shall be provided, upon request and free of charge, reasonable access to and/or copies of all documents, records, and other information in the possession of Delta Dental that is relevant to the claim;

   d. may choose a Representative to act on his or her behalf at the Enrolled Person's expense;

   e. will not be charged any fees or costs incurred by Delta Dental as part of the voluntary appeals process;

   f. has one hundred eighty (180) days following receipt of a notification of an Adverse Benefit Determination within which to appeal;

   g. will receive a response to the appeal from Delta Dental in writing within thirty (30) days of receipt of the request;

   h. is not required to file an appeal prior to arbitration or taking civil action;

   i. is assured that the review of any Adverse Benefit Determination under appeal will not be conducted by the same person or a subordinate of the person who determined the initial Adverse Benefit Determination;

   j. may also appeal an Adverse Benefit Determination to the Consumer Relations Division of the New Mexico Office of Superintendent of Insurance.

B. Informal Claim Review Process

Most claim-related requests may be handled informally by calling the Delta Dental Customer Service Department at (505) 855-7111 or toll-free at (877) 395-9420. Enrolled Persons always have the opportunity to describe problems, submit explanatory information, and allow Delta Dental to correct errors quickly.

C. Formal Claim Appeal Process

If an Enrolled Person disagrees with a Benefit determination, a formal review of the claim may be requested by filing an appeal with Delta Dental within one hundred eighty (180) days following receipt of Delta Dental's notification of an Adverse Benefit Determination. An appeal is a formal, written request to change a previous decision made by Delta Dental. There are two (2) types of appeals: Appeal of Claim Processing Procedure and Appeal of Claim for Dental Treatment.

1. Appeal of Claim Processing Procedure means the Enrolled Person is requesting a review of the application by Delta Dental of an administrative, procedural, or Plan Benefit provision which resulted in an Adverse Benefit Determination.

    a. An Adverse Benefit Determination may be appealed by sending a request in writing to Delta Dental describing the reasons for requesting a review and including any additional information that the Enrollee wishes to be considered.

    b. A Delta Dental representative, who is neither the individual who made the initial claim determination nor the subordinate of such individual, will conduct a review of the claim. The results of the review will be provided in writing to both the Enrolled Person and to the treating dental Provider, as appropriate.

2. Appeal of Claim for Dental Treatment is a request for a review of an Adverse Benefit Determination that resulted from a clinical review conducted by a Delta Dental Dental Consultant. Three (3) voluntary options for appeal are available:

    a. The Enrolled Person may appeal an Adverse Benefit Determination by sending a request in writing to Delta Dental describing the reasons for the appeal and including any additional information the Enrolled Person wishes to be considered. A Dental Consultant, who is neither the individual who made the initial claim determination nor the subordinate of that individual, will provide a full and fair subsequent and independent review of the claim.

        i. If the second consulting Dentist determines the treatment was Dentally Necessary, Delta Dental will recalculate the claim for available Benefits and send written notification of payment to the Enrolled Person and the treating Provider. In the event the second consulting Dentist also determines the treatment was not Dentally Necessary according to the terms of the Group Dental Insurance Contract or standard dental treatment, the Adverse Benefit Determination will be upheld. Delta Dental will send notification to the Enrolled Person and to the treating dental Provider, as appropriate.

    b. The Enrolled Person may appeal an Adverse Benefit Determination and request an independent oral examination by writing to Delta Dental, describing the reasons for the request, and including additional information the Enrolled Person wishes to be considered. A Dental Consultant, who has neither been involved in previous determinations of

the claim under review nor is a subordinate of that individual, will provide a full and fair independent review of the claim.

i. If the second consulting Dentist agrees the treatment was Dentally Necessary, Delta Dental will recalculate the claim for available Benefits and send written notification of payment to the Enrolled Person and the treating dental Provider, as appropriate.

ii. In the event the second consulting Dentist determines the treatment was not Dentally Necessary according to the terms of this Plan or standard dental treatment, an oral examination will be scheduled with a mutually agreed upon licensed Dentist. The fee for this oral examination will be the responsibility of Delta Dental and will not apply to the frequency limitations on exams under this Plan's Benefit provisions. If that examining Dentist agrees the treatment was Dentally Necessary, Delta Dental will recalculate the claim for available Benefits and send written notification of payment to the Enrolled Person and the treating Provider. In the event the examining Dentist determines the treatment was not Dentally Necessary according to the terms of this Plan or standard dental treatment, the Adverse Benefit Determination will be upheld. Delta Dental will send written notification to the Enrolled Person and to the treating Provider, as appropriate.

c. The Enrolled Person may appeal an Adverse Benefit Determination and request an external peer review by the local or state dental society. Delta Dental will provide the Enrolled Person with information on how to initiate the peer review process through the New Mexico Dental Association.

D. Grievance

No person shall be subject to retaliatory action by Delta Dental for any reason related to a grievance. All written appeals must be directed to Delta Dental, Attention: Claims Manager, 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico, 87110.

E. Office of Superintendent of Insurance

Contact the New Mexico Office of Superintendent of Insurance (OSI) at any time for assistance with a claim appeal:

Office of Superintendent of Insurance
1120 Paseo de Peralta
Santa Fe, NM 87501
Phone: 1-855-4-ASK-OSI

F. New Mexico Board of Dental Health Care

Contact the New Mexico Board of Dental Health Care to file a complaint about a Provider:

NM Board of Dental Health Care
P.O. Box 25101
Santa Fe, NM 87504
Phone: (505) 476-4622 (ask for the Compliance Liaison)

VI. Termination of Coverage

A. When Coverage for an Enrolled Person Ends

1. Unless stated otherwise in the Summary of Dental Plan Benefits, coverage ends on the last day of the month for which Premium is paid for an enrolled Subscriber who loses coverage due to:

   a. loss of eligibility;

   b. voluntary cancellation of coverage;

   c. cancellation of this Plan by your Group or Delta Dental;

   d. entering an unapproved leave of absence. Upon return to work, coverage may resume as specified by the Group and agreed to by Delta Dental. An employee absent from work due to an approved leave of absence, including those governed by the "Family Medical Leave Act of 1993," may continue coverage without interruption during a leave period if the Group continues to report the Subscriber as an Enrollee and Premium is paid on the Enrollee's behalf.

2. An Enrolled Dependent loses coverage along with the enrolled Subscriber, or on the last day of the month in which dependent status is lost, whichever is earlier. Coverage for dependent children who reach age twenty-six (26) will automatically be terminated by Delta Dental the last day of the month in which the dependent child turns age twenty-six (26) unless Delta Dental receives proof of the dependent child's qualification for extended eligibility. Refer to the Summary of Dental Plan Benefits for any exceptions to the age twenty-six (26) limitation.

3. A Subscriber and/or dependent may be eligible to continue coverage depending on the size of the Group and if certain conditions are met. Please refer to Section VII, "Continuation of Coverage," in this Handbook.

B. When Payment for Claims Ends

If an Enrolled Person loses coverage, Delta Dental will only pay claims for Covered Services incurred prior to the loss of coverage. To be considered for payment, claims must be submitted to Delta Dental in writing within twelve (12) months after the services have been provided and for which Benefits are payable.

C. Termination of Coverage for Group's Failure to Pay Premium

Delta Dental will only provide Benefits for claims submitted on Enrolled Persons as long as the Group has paid the Premium to Delta Dental for the period in which the services were performed.

VII. Continuation of Coverage

A Group may be subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This means that Enrolled Persons may be entitled to continue coverage at their own expense under this dental Plan following certain Qualifying Events if certain conditions are met. To be eligible for continued coverage, the Enrolled Person must be enrolled in this Plan on the day before the Qualifying Event occurs. The Group is responsible for providing Enrolled Persons with notification of COBRA continuation rights and for any/all administration related to those COBRA rights.

VIII. ERISA

This Group dental Plan may be subject to the Employee Retirement Income Security Act of 1974 (ERISA), which provides for certain rights and protections. When applicable, the Group is responsible for providing Enrolled Persons notification of ERISA rights.

IX. Notice of Privacy Practices

This section describes how Delta Dental protects the medical information of Enrolled Persons. Delta Dental understands that medical and health information is private and is committed to protecting the confidentiality and security of that information.

Delta Dental is required to provide this notice by law, specifically, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Delta Dental must:

- make certain to maintain the privacy of each Enrolled Person's protected health information;
- provide this notice of our legal duties and privacy practices with respect to protected health information;
- follow the terms of the notice that is currently in effect; and
- describe an Enrolled Person's rights with respect to protected health information and how Enrollees can exercise those rights.

This notice was effective April 14, 2003, and will remain in effect until amended.

Protected health information is information that may identify an Enrolled Person and relate to the past, present, or future health, treatment, or payment for health care services for that Enrollee. This notice applies to all of the medical records maintained by Delta Dental. An individual's Provider may have different policies or notices regarding the Provider's use and disclosure of medical information created in the Provider's office.

Delta Dental safeguards protected health information from inappropriate use or disclosure. Delta Dental employees, and those of companies that help Delta Dental service the dental Plan, are required to comply with Delta Dental requirements that protect the confidentiality of protected health information. Delta Dental will not disclose protected health information to any other company or person for their use in marketing their products to any individual without the expressed permission of that individual. However, as described in this notice, Delta Dental will use and disclose protected health information about an Enrolled Person for business purposes to administer the dental Plan and when required or authorized by law.

For answers to questions about this notice, contact:

Delta Dental of New Mexico
Chief Privacy Officer
P.O. Box 30416
Lansing, MI 48909-7916
(517) 347-5451

This Notice of Privacy Practices is also available on the Delta Dental Web site: www.deltadentalnm.com

A. How Delta Dental May Use and Disclose Protected Health Information

The following categories describe different ways that Delta Dental is permitted to use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways Delta Dental is permitted to use and disclose information will fall within one of the categories.

1. **Payment:** Delta Dental may use and disclose protected health information to determine eligibility for Plan Benefits, to make Benefit payments for the treatment and services received from Providers, to determine Benefit responsibility under this Plan, to issue Premium billings, and to coordinate Plan coverage. For example, the medical information contained on claims may be used to reimburse Providers for their services. Delta Dental may tell an Enrolled Person's Provider about dental history to determine whether this Plan will cover treatment. Delta Dental may also disclose protected health information to other insurance carriers and organizations to coordinate Benefit payments with respect to a particular claim.

2. **Health Care Operations:** Delta Dental may use and disclose protected health information as necessary for company operations. For example, Delta Dental may use medical information in connection with: providing customer service, establishing Premium and underwriting rules, evaluating a request for dental Benefit products, administering those products, quality assurance, clinical review, and processing transactions requested by an Enrolled Person. Delta Dental may also disclose protected health information to Delta Dental affiliates, and to business associates outside of Delta Dental, if those affiliates or associates need to receive protected health information to provide a service to Delta Dental and will agree to abide by specific rules relating to the protection of protected health information. Examples of business associates are data processing companies, insurance agents, attorneys, auditors, or companies that furnish administrative support or services.

3. **Health-Related Benefits or Services:** Delta Dental may use protected health information to provide an Enrolled Person with information about Benefits available under the dental Plan.

4. **Incidental Disclosures:** Certain incidental disclosures of protected health information occur as a byproduct of lawful and permitted use and disclosure of protected health information. These incidental disclosures are permitted if Delta Dental applies reasonable safeguards related to protected health information.

5. **Others Involved in an Enrolled Person's Health Care:** Unless an Enrolled Person objects, Delta Dental may disclose protected health information to a

dependent of the Enrolled Person's family, a relative, or any other person specifically identified, that directly relates to that person's involvement in the Enrolled Person's health care or payment for health care. If the Enrolled Person is unable to agree or object to such a disclosure, Delta Dental may disclose such information as necessary in an emergency or if Delta Dental determines that it is in the best interest of the Enrolled Person based on professional judgment.

6. **As Authorized by an Enrolled Person:** Other uses and disclosures of protected health information not covered by this notice and permitted by the laws that apply to Delta Dental will be made only with an Enrolled Person's written authorization or that of a legal representative. An Enrolled Person may authorize Delta Dental to use protected health information or disclose it to another person for a designated purpose. Such an authorization shall be valid for a specified length of time, not to exceed twenty-four (24) months. An Enrolled Person may withdraw the authorization in writing at any time, except to the extent that Delta Dental has taken action relying on the prior authorization, i.e., Delta Dental cannot take back disclosures already made with authorization.

7. **Authorized by Law for Public Benefit:** Delta Dental may use or disclose protected health information as authorized by law for the following purposes deemed to be in the public interest:

   a. as required by law;

   b. to avert a serious threat to health or safety;

   c. to report to federal, state, or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations;

   d. for public health activities including reporting births and deaths, victims of abuse or neglect, reaction to medications or problems with products, and to prevent or control disease, injury, or disability;

   e. to a coroner, medical examiner, or funeral director to assist in identifying a deceased individual or to determine the cause of death. Delta Dental may also release protected health information for organ donation purposes;

   f. in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons, or similar process;

   g. to federal officials for intelligence, counterintelligence, and other national security activities authorized by law;

   h. as authorized to comply with Workers' Compensation laws and other similar legally established programs;

   i. to a correctional institution if an Enrolled Person is an inmate at that correctional institution or law enforcement official if an Enrolled Person is under the custody of that law enforcement official;

j. in response to a court or administrative order if the Enrollee or the Enrollee's estate is involved in a lawsuit or a dispute. Delta Dental may also disclose protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell the Enrollee about the request or to obtain an order protecting the protected health information requested;

k. to any government agency or regulator with whom the Enrolled Person has filed a complaint or as part of a regulatory agency examination.

B. Individual Rights Regarding Protected Health Information

The following rights concerning protected health information apply under HIPAA.

An Enrolled Person may contact Delta Dental at the location listed in this notice to submit a request or for an explanation on how to submit a request, obtain forms, or get other additional information.

1. **Right to Inspect and Copy Protected Health Information:** In most cases, an Enrolled Person has the right to inspect and obtain a copy of his or her protected health information maintained by Delta Dental. To inspect and copy protected health information, an Enrollee must submit a request in writing. If a copy of protected health information is requested, a fee may be charged for the costs of copying, mailing, or other supplies associated with the request. However, certain types of protected health information will not be made available for inspection and copying. This includes protected health information collected by Delta Dental in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances Delta Dental may deny a request to inspect and obtain a copy of protected health information. A review of that denial may be requested. An individual chosen by Delta Dental who was not involved in the original decision to deny the request will conduct the review. Delta Dental will comply with the outcome of that review.

2. **Right to Amend Protected Health Information:** If an Enrolled Person believes his or her protected health information is incorrect or that an important part of it is missing, the Enrollee has the right to ask Delta Dental to amend the protected health information while it is kept by or for Delta Dental. This request, and the reason for the request, must be submitted in writing. Delta Dental may deny the request if it is not in writing or does not include a reason that supports the request. In addition, Delta Dental may deny the request if it is to amend protected health information that (a) is accurate and complete; (b) was not created by Delta Dental, unless the person or entity that created the information is no longer available to make the amendment; (c) is not part of the protected health information kept by or for Delta Dental; or (d) is not part of the protected health information which would be permitted to inspect and copy.

3. **Right to a List of Disclosures:** An Enrolled Person has the right to request a list of the disclosures Delta Dental has made of his or her protected health information. This list will not include disclosures made (a) for treatment, payment, or health care operations; (b) for purposes of national security, law enforcement, or to corrections personnel; (c) made pursuant to person's

authorization; or (d) made directly to the Enrolled Person. The request must be submitted in writing and state the time period applicable to the list of disclosures. The time period may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form the list is requested (for example, on paper or electronically). The first list requested within a twelve (12) month period will be free. Delta Dental may charge the individual making the request for responding to additional requests. Delta Dental will identify the cost involved and the individual making the request may choose to withdraw or modify the request before any costs are incurred.

4. **Right to Request Restriction or Limitation on Protected Health Information:** An Enrolled Person has the right to request a restriction or limitation on protected health information used or disclosed for treatment, payment, or health care operations, or request disclosure to someone who may be involved in the care or payment of his or her care, such as a family member. To request a restriction, an Enrollee must send the request in writing and tell Delta Dental (a) what information should be limited; (b) whether the limitation would apply to Delta Dental use, disclosure, or both; and (c) to whom the limits would apply (for example, disclosures to a Spouse, Domestic Partner, or parent). While Delta Dental will consider the request, Delta Dental is not required to agree to it. Delta Dental will not agree to restrictions on protected health information uses or disclosures that are legally required, or which are necessary to administer Delta Dental business.

5. **Right to Request Confidential Communications:** An Enrolled Person has the right to request that Delta Dental communicate protected health information in a certain way or at a certain location if the Enrolled Person informs Delta Dental that communication in another manner may endanger the Enrolled Person. For example, the Enrolled Person may request that Delta Dental only make contact at work or by mail. To request confidential communications, a request must be sent in writing, which specifies how or where you wish to be contacted. Delta Dental will accommodate all reasonable requests.

6. **Right to Receive a Copy of the Notice:** An Enrolled Person may request a copy of our notice at any time by contacting the Privacy Office or by using the Web site, www.deltadentalnm.com. If this notice is obtained via the Web site or by electronic mail, the Enrolled Person is also entitled to request a paper copy.

7. **Right to File a Complaint:** If an Enrolled Person believes his or her privacy rights have been violated, he or she may file a complaint with Delta Dental or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. There will not be a penalty for filing a complaint. For answers to questions about how to file a complaint, please contact Delta Dental at (505) 883-4777, (800) 999-0963, or HIPAAprivacy@deltadentalnm.com.

C. Additional Information

Changes to this Notice: Delta Dental reserves the right to change the terms of this notice at any time. Delta Dental reserves the right to make the revised or changed notice effective for protected health information previously received as well as any protected health information received in the future. The effective

date of this notice and any revised or changed notice will be included in the notice. Enrolled Persons will receive a copy of any revised notice from Delta Dental by mail or by e-mail, but only if e-mail delivery is offered by Delta Dental and the Enrolled Person agrees to such delivery.

Further Information: For additional information regarding the Delta Dental HIPAA Medical Information Privacy Policy or general Delta Dental privacy policies, please contact Delta Dental at (505) 883-4777, (800) 999-0963, or HIPAAprivacy@deltadentalnm.com, or write to:

Delta Dental of New Mexico
Chief Privacy Officer
P.O. Box 30416
Lansing, MI 48909-7916
(517) 347-5451

X. General Conditions

A. Assignment

Services and Benefits are for the personal Benefit of Enrolled Persons and cannot be transferred or assigned, except as otherwise stated in Section II(E) of this Handbook.

B. Subrogation and Right of Reimbursement

If Delta Dental provides Benefits under this Plan and you have a right to recover damages from another, Delta Dental is subrogated to that right.

To the extent that this Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you or your Eligible Dependent has to recover from another, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions. You or your legal representative must do whatever is necessary to enable Delta Dental to exercise its rights under this provision.

If you or your Eligible Dependent recovers damages from any party or through any coverage named above, you must reimburse Delta Dental from that recovery to the extent of payments made under this Plan.

C. Obligation to Assist in Delta Dental's Reimbursement Activities

If you are involved in an automobile accident or require Covered Services that may entitle you to recover from a third party and Delta Dental advances payment to prevent financial hardship to you or your family, you and your Eligible Dependents have an obligation to help Delta Dental obtain reimbursement for the amount of the payments advanced for which another source was also responsible for making payment. You and your Eligible Dependents are required to provide Delta Dental with information about other insurance coverage (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another health plan), and the identity of any other person or entity, and his or her insurers (if known), that may be obligated to provide payments or benefits for the same Covered Services that Delta Dental already paid.

D. Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to your acts or acts of your Enrolled Dependents, it may recover that payment from you or your Enrolled Dependents. Delta Dental may recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Enrolled Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

E. Actions

No action on a legal claim arising out of or related to this Plan shall be brought against Delta Dental without first providing Delta Dental sixty (60) days' written

notice of the legal claim, unless prohibited by applicable state law. In addition, no action can be brought more than three (3) years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

F. Governing Law

This Plan will be governed by and interpreted under the laws of the state of New Mexico.

G. Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Enrolled Dependents than is provided by this Plan, that law shall control over the language of this Handbook and the Summary of Dental Plan Benefits.

XI. Definitions

Adverse Benefit Determination: Any denial, reduction, or termination of the Benefits for which you filed a claim. Or, a failure to provide or to make payment (in whole or in part) of the Benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which Benefits are otherwise provided was Experimental or Investigational, or was not Medically Necessary or appropriate.

Allowed Amount: The Maximum Approved Fees determined by Delta Dental and considered for each dental procedure before application of Coinsurance and Deductible.

Benefit Period: The time period during which the Deductible and Maximum Benefit Amount accumulate and frequency limitations apply, as shown in the Summary of Dental Plan Benefits.

Benefits: The amount Delta Dental will pay for covered dental services described in Section III, "Benefits, Limitations, and Exclusions," and in the Summary of Dental Plan Benefits.

Contract: The Group Dental Insurance Contract document, including Article I, "Declarations," Dental Benefit Handbook, Summary of Dental Plan Benefits and successor agreements, or renewals now or hereafter issued or executed.

Coinsurance: The percentage of the dental Provider's approved fee due from the Enrolled Person to the dental Provider.

Covered Services: The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Handbook.

Deductible: The amount an Enrolled Person or family must pay toward Covered Services before Delta Dental makes any payment for those Covered Services.

Delta Dental: Delta Dental of New Mexico or Delta Dental Plan of New Mexico, Inc.

Delta Dental Member Company: An individual benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Dental Benefit Handbook: This document. Delta Dental will provide Benefits as described in this Handbook. Any changes in this Handbook will be based on changes to the Contract between Delta Dental and your employer or organization.

Dental Consultant: An independent contractor paid by Delta Dental of New Mexico to conduct claims review. The review of dental insurance claims is defined in the practice of dentistry in the New Mexico Dental Practice Act. A Dental Consultant must be a licensed Dentist.

Dental Necessity (Dentally Necessary): A Service or Supply provided by a Dentist or other Provider that has been determined by Delta Dental as generally accepted dental practice for the Enrolled Person's diagnosis and treatment. Delta Dental may use Dental Consultants to determine generally accepted dental practice standards and if a service is a Dental Necessity. These Services or Supplies are in accordance with generally accepted local and national standards of dental practice, and not primarily for the convenience of the Enrolled Person or Provider. The

Services/Supplies are the most appropriate that can safely be provided. The fact that a Provider has performed or prescribed a Service or Supply does not mean it is a Dental Necessity.

Dentist: A duly licensed Dentist, legally entitled to practice dentistry at the time and in the place services are provided.

Disallowed: A fee for a service that is Disallowed is not Benefited by Delta Dental, nor collectable from the patient by the Participating Provider.

Domestic Partner: A Domestic Partner, as defined by the Group or as otherwise required by law, is treated the same as a Spouse for Benefit determinations and Plan administration. Domestic Partners are covered unless stated otherwise in the Summary of Dental Plan Benefits.

Eligible Dependent: A person who meets the conditions of dependent eligibility outlined in Section I, "Eligibility and Enrollment," whether or not actually enrolled.

Eligible Employee: An employee who meets the conditions of employee eligibility outlined in Section I, "Eligibility and Enrollment," whether or not actually enrolled.

Enrolled Dependent: An Eligible Dependent whose completed enrollment information has been received and approved by Delta Dental, and for whom Premium is paid.

Enrolled Employee: An Eligible Employee whose completed enrollment information has been received and approved by Delta Dental, and for whom Premium is paid.

Enrolled Person or Enrollee: An Enrolled Employee, Enrolled Dependent, COBRA-enrolled person, or other individual who meets the conditions of eligibility outlined in Section I, "Eligibility and Enrollment," whose completed enrollment information has been received and approved by Delta Dental, and for whom Premium is paid.

Experimental/Investigational: A treatment, procedure, facility, equipment, drug, device, or Supply that is not accepted as standard dental treatment for the condition being treated or any items requiring federal or other government agency approval if such approval had not been granted at the time services were rendered. To be considered standard dental practice and not Experimental/Investigational, the treatment must have met all five of the following criteria:

1. A technology must have final approval from the appropriate regulatory government bodies;
2. The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcome;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives; and
5. The technology must be attainable outside the Investigational settings.

Group: The employer named in the Summary of Dental Plan Benefits.

Independent Licensed Dentist: A licensed Dentist that is actively practicing dentistry.

Maximum Approved Fee: The Maximum Approved Fee is the lowest of: (a) the Submitted Amount; (b) the lowest fee regularly charged, offered, or received by an individual Provider for a dental Service or Supply, irrespective of the Provider's contractual agreement with another dental benefits organization; or (c) the maximum fee that the local Delta Dental Plan approves for a given procedure in a

given region and/or specialty based upon applicable Participating Provider schedules and internal procedures. Participating Providers agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Benefit Amount: The maximum dollar amount Delta Dental will pay in a Benefit or lifetime Period for Covered Services for each Enrolled Person.

Medical Necessity (Medically Necessary): Means that a dental item or service satisfies each of the following criteria: (a) is recommended by a Dentist or other qualified dental professional practicing within the scope of his or her license who has personally evaluated the patient; (b) is essential to and provided for prevention, evaluation, diagnosis, or treatment of the patient's dental condition, disease, or injury; (c) is consistent with the symptoms, finding, and diagnosis related to the patient's dental condition, disease, or injury; (d) is clinically appropriate for diagnosis and treatment of the patient's dental condition, disease, or injury in terms of type, frequency, extent, site, and duration of the intervention; (e) is considered to be effective intervention for the patient's dental condition, disease, or injury which can reasonably be expected to have beneficial health outcomes that outweigh potential harmful effects; (f) is performed in accordance with relevant credible scientific evidence and generally accepted professional standards of care; and (g) is required for reasons other than the convenience of the patient or treating Provider. Delta Dental may use Dental Consultants to determine Medical Necessity.

Non-Participating Approved Amount: The maximum fee allowed per procedure for services rendered by a Non-Participating Provider as determined by Delta Dental.

Non-Participating Provider: A Provider who has not signed a Contract with any Delta Dental Plan to participate in any of Delta Dental's Provider networks. Non-Participating Providers do not accept Delta Dental's Maximum Approved Fees as payment in full. Non-Participating Providers may bill the patient the full submitted charge as well as any charges for Disallowed services.

Open Enrollment: A period of time specified by the Group to allow eligible persons to enroll in this Plan or to cancel coverage under this Plan for the renewed Contract period.

Out-of-Country Provider: A Provider whose office is located outside the United States and its territories. Out-of-Country Providers are not eligible to sign participating agreements with Delta Dental.

Participating Provider: A Provider who has agreed to abide by a Delta Dental Participating Provider Agreement.

Premium: The monthly amount due to Delta Dental for Enrolled Persons.

Pre-Treatment Estimate: A written estimate issued by Delta Dental that outlines dental Benefits that may be available under your coverage for your proposed dental treatment. A Pre-Treatment Estimate is voluntary and optional unless specified in the Summary of Dental Plan Benefits.

Processing Policies: Delta Dental's policies and guidelines used for Pre-Treatment Estimates and payment of claims. The Processing Policies may be amended from time to time.

Provider: A legally licensed Dentist, or any other legally licensed dental practitioner, rendering services within the scope of that practitioner's license.

Qualifying Event: A specific, qualified circumstance that alters the eligibility status of an Enrollee or Eligible Dependent under the Group dental Plan. Qualifying Events include but are not limited to: marriage, birth, divorce, and involuntary loss of other coverage. The changes an Enrollee or Eligible Dependent makes to coverage due to a Qualifying Event must be consistent with that particular event. Events may affect eligibility differently. You must notify Delta Dental in a timely manner through your employer or organization of any event that changes the eligibility status of an Enrollee or Eligible Dependent. With respect to Qualifying Events that require the enrollment of an individual into this Plan, including but not limited to marriage, birth, or adoption, Delta Dental must receive notification of such Qualifying Event within thirty-one (31) days of such Qualifying Event. Delta Dental may require proof of the Qualifying Event.

Services and Supplies: Those Services, Supplies, or devices that are considered safe, effective, and appropriate for the diagnosis or treatment of the existing condition. Covered Services and Supplies do not include Experimental Services, Supplies, or devices. For the purposes of this Plan, Delta Dental reserves the right to make the final decision as to whether Services, Supplies, or devices are Experimental under this definition.

Sound Natural Teeth: Those teeth that are either primary (A through T or AS through TS) or permanent (1 through 32 and 51 through 82) dentition that have adequate hard and soft tissue support.

Specialized Procedure: The term "Specialized Procedure" describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

Spouse: The individual legally married to a Subscriber as determined and recognized by New Mexico state law.

Submitted Amount: The amount a Provider bills to Delta Dental for a specific treatment or service. A Participating Provider cannot charge you or your Enrolled Dependents for the difference between this amount and the Maximum Approved Fee.

Subscriber: Means all people who are members or employees of the Group specified in the Summary of Dental Plan Benefits, are certified as being eligible by the Group, and are enrolled to receive Benefits under this Plan.

Summary of Dental Plan Benefits: A description of the specific provisions of your dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Handbook. To the extent that anything set forth in this Handbook conflicts with your Summary of Dental Plan Benefits, your Summary of Dental Plan Benefits will control.

Temporomandibular Joint Disorder (TMD): A disorder and/or dysfunction associated with temporomandibular/craniomandibular structure.

This Plan: The dental coverage established for eligible persons pursuant to this Handbook.

EXHIBIT 7

DELTA DENTAL

Report Name: Quarterly Performance Standards - Delta Dental of New Mexico Global Data
Report Produced for: City of Albuquerque and Participating Entities
Group Number: 2517
Reporting Period: July 2018 through June 2019

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Claims Turnaround												
90% of claims processed within 15 working days		% 15 days			% 15 days			% 15 days			% 15 days	
97% of investigated claims paid within 30 days		% 30 days			% 30 days			% 30 days			% 30 days	
Penalty: $300 per quarter												
Claims Processing Accuracy												
Measurement: 97% The percentage of audited claims processed accurately. Calculated as the total number of audited claims processed with error, divided by the total number of audited claims. Error means any type of error (e.g., coding, procedural, system, payment, etc). Each type of error is counted as one and no more than one error can be assigned to		%			%			%			%	
Penalty: $300 per applicable quarter												
Financial Payment Accuracy												
Measurement: 99% The percentage of audited client claims dollars paid accurately. Calculated as a total audited paid dollars minus the absolute value of over/under payments, divided by total audited paid dollars.		%			%			%			%	
Penalty: $300 per applicable quarter												
Telephone Response												
Measurement: 90% within 30 seconds The time between a call entering the ACD and being answered by a Customer Service Representative.		%			%			%			%	
Penalty: $300 per applicable quarter												
Abandonment Rate												
Measurement: Less than 5% The percent of calls that the caller hangs up prior to the call being answered.		%			%			%			%	
Penalty: $300 per applicable quarter												
Report Delivery												
Required claims report(s) delivered by the end of the month following the end of the reporting period.												

Penalty: $1000 per applicable month

Vendor Attendance at Client Meetings

Attendance by vendor representatives when requested by the City during the contract period.

Penalty: $300 per missed meeting

INTERGOVERNMENTAL AGREEMENT

THIS AGREEMENT is made and entered into by and between the City of Albuquerque, New Mexico, a municipal corporation ("City"), and Water Utility Authority, a government entity, 400 Marquette NW # 5027, Albuquerque NM 87102, (hereinafter referred to as "Entity").

RECITALS

WHEREAS, the City maintains a group benefits program for eligible employees and their dependents, including medical, dental, vision, life, and other group voluntary benefits; and

WHEREAS, the services and benefits provided to City employees through the group benefits program are provided by contracted providers ("Providers"); and

WHEREAS, the Entity wishes to participate in the City's Provider agreements to offer eligible Entity employees and their dependents the same benefits available to City employees; and

WHEREAS, the City and Entity are willing to enter into a cooperative agreement to offer the City group benefits program to Entity employees.

NOW THEREFORE, in consideration of the premises and mutual obligations herein, the parties hereto do mutually agree as follows:

1. **PARTICIPATION**. As provided herein, the Entity shall participate in the City group benefits program and shall be entitled to the same plan of benefits and the same monthly premium structure available to the City. In order to receive the benefits of participation, the Entity must offer to its employees only the medical, dental and vision plans contracted by the City. Competing or alternative plans are not allowed. The Entity may also elect to participate in other benefit plans the City offers its employees at the same rate but exclusivity is not required. These options include: gym membership and/or employee assistance program with the medical plan (the employer's FICA expense due to the imputed income for employees' gym enrollment is the Entity's responsibility to pay), life insurance, short term disability, long term disability, flexible spending accounts, legal insurance, and home and auto insurance, and deferred compensation.

A. **ELIGIBILITY, ENROLLMENT, AND OTHER PARTICIPATION CRITERIA.** The following are guidelines for enrollment provided by the City, which reflects eligibility, enrollment and participation criteria. These guidelines for enrollment apply to employees of all Entities electing to participate in the City group benefits program.

I. **ELIGIBILITY TO PARTICIPATE:**

a. Regular employees (including those on probation) scheduled to work twenty (20) hours, or more per week;

b. Elected officials;

c. Unclassified employees scheduled to work thirty (30) hours or more each week (excluding temporary, students, and seasonal employees scheduled to work fewer than six (6) months in a twelve (12) month period);

d. Children under age twenty-six (26) AND who meet at least one (1) of the following criteria:

i. Natural child of the employee, spouse or domestic partner;

ii. Placed in the employee's home and in process for legal adoption or guardianship by the employee, spouse or domestic partner;

iii. Adopted by the employee, spouse or domestic partner;

iv. A court order exists that requires the employee, spouse or domestic partner to provide medical insurance coverage for the child;

v. A court document exists that shows the employee, spouse or domestic partner has full, permanent custody of the child; and

vi. Children over age twenty-six (26) may **continue** participating in the group insurance plans if they are physically or mentally handicapped and are not eligible for any other plan. This continuation is subject to normal enrollment guidelines and approval by the insurance carrier.

e. Legal spouse of an employee; and

f. Domestic partner of an employee. A domestic partner is defined as a person of the same or opposite sex who lives with the employee in a long-term relationship of indefinite duration. There must be an exclusive mutual commitment similar to that of marriage, in which the partners agree to be financially responsible for each other's welfare and share financial obligations. These benefits are also available to the domestic partner's children provided that the child meets the definition of eligibility stated above in Sections 1.A.I.d.

II. **ENROLLMENT.** A permanent/probationary employee may enroll without regard to pre-existing medical conditions within thirty-one (31) days of the date on which permanent employment begins, during scheduled annual open enrollment periods, under the loss of coverage provision or under the Health Insurance Portability and Accountability Act (HIPAA) provision. In addition, newly eligible dependents may be enrolled within thirty-one (31) days of the qualifying event or open enrollment period (typically 3 weeks long). Children placed in an employee's home pending legal adoption may be added within thirty-one (31) days from date of placement; or, a dependent for which the employee is assigned permanent legal guardianship may be added within thirty-one (31) days from the date of the signed order. Newborns must be enrolled within thirty-one (31) days from the date of birth or any medical expenses related to that birth will be the responsibility of the employee. Dependent children between the age of two (2) and three (3) can be added to the employees' dental plan at any time, provided the employee is enrolled in dental at the time the child's enrollment form is submitted or electronically enrolled. An employee may enroll within thirty-one (31) days of the date the employee marries or acquires a child through birth or adoption.

III. **CHANGING BENEFIT ELECTIONS AND QUALIFYING LIFE EVENTS.** The Internal Revenue Service makes many of the rules for enrollment and eligibility because it allows the salary to be reduced by the premiums before taxes are calculated (Internal Revenue Code Section 125). Important rules to know are:

a. Once an election has been made during the initial enrollment period of thirty-one (31) days from the hire date then the election is locked until the next open enrollment; and

b. Exceptions to this are qualifying life events due to a life status change ("Life Status Change"). Qualifying Life Events do not allow employees to change their Gym Membership election unless they are enrolling in medical insurance from not being enrolled at all. The only time to elect participation, or disenrollment, is during open enrollment. Documentation must be provided for the Life Status Change and forms, or electronic submission, must be completed within thirty-one (31) days of the qualifying event. Qualifying Life Events and acceptable documents are:

i. Marriage - Marriage certificate;

ii. Domestic Partnership meeting eligibility requirements – Affidavit:

(a) The Affidavit of Domestic Partnership is a legal document in which both the employee and the domestic partner swear that they meet the following criteria:

(1) Both are unmarried and have been so during the past twelve (12) months;

(2) Reside in the same residence for at least twelve (12) months and intend to do so indefinitely;

(3) Meet the age requirements for marriage in the State of New Mexico;

(4) Are not related by blood to the degree prohibited in a legal marriage in the State of New Mexico; and

(5) Are financially responsible for each other's welfare and share financial obligations.

(b) In addition to the notarized Affidavit, three (3) proofs of financial interdependence of the following documents are also required:

(1) Joint lease/mortgage or ownership of property;

(2) Jointly owned motor vehicle, bank or credit account (only one qualifies);

(3) Domestic partner named as beneficiary of the employee's life insurance;

(4) Domestic partner named as beneficiary of the employee's retirement benefits;

(5) Domestic partner named as primary beneficiary in the employee's will;

(6) Domestic partner assigned as power of attorney or legal designee by the employee;

(7) Both names on a utility bill; or

(8) Both names on an investment account.

(c) The employee's domestic partner is not required to visit the Human Resources Office in order to receive benefits. The employee may submit the signed and notarized Affidavit of Domestic Partnership with the other required documents; and

(d) The Federal Government does not recognize domestic partners as qualified dependents and therefore the premium paid for their coverage cannot be pre-tax. In addition, the employee must pay tax on the portion of the premium paid by the Entity for the domestic partner and his/her covered children. Employees wanting to change benefit elections involving a domestic partner must adhere to the same rules regarding Qualifying Life Events:

iii. Divorce – A court issued divorce decree;

iv. Birth – A hospital certificate or state issued birth certificate;

v. Adoption - A court issued adoption certificate of adoption;

vi. Legal Guardianship - A court issued decree of legal guardianship;

vii. Death – A death certificate;

viii. Change in employment status affecting benefits eligibility (for the employee or the employee's spouse or domestic partner) - Letter/form from employer that is notification of the job change, coverage ending or new eligibility;

ix. Involuntary loss of coverage – Official notification of loss;

x. Dependent change of residence that affects benefits eligibility - notification of change; and

xi. Gaining or losing eligibility for Medicare or Medicaid by the employee or a dependent (sixty (60) day window to request the change of coverage).

c. Dependent child losing eligibility - Official notification of loss or calculation of reaching age twenty-six (26); and

d. Missing the initial enrollment period, thirty-one (31)-day qualifying event period or the annual open enrollment period may result in delayed enrollment, a delay in notification of loss of coverage and paying for coverage no longer provided (such as an ex-spouse.) Alternatively delayed enrollment may result in double deductions for premiums due for backdated coverage. The effective date will depend on the event.

2. **OPEN ENROLLMENT.** Open Enrollment is a three (3) week (or longer) period established annually (usually in May) that allows all benefits eligible employees to make changes to their benefit elections without having experienced a Life Status Change. This is the only opportunity to make changes without a Qualifying Life Event. Members are not required to make a new election, except when the City requires a positive open enrollment. A positive open enrollment means that all benefits-eligible employees must take action in order to continue to receive their elected benefits. Annual premium changes also occur at this time and the Entity is responsible for making payroll deduction adjustments to ensure the monthly premium due July 1st is accurate.

3. **WHEN COVERAGE BEGINS.**

A. For newly eligible employees, coverage begins according to the Entity's own policy, but no later than 31 days from the employee's hire date, after submission of enrollment forms to the Entity's Human Resources Office or electronic enrollment. When enrolling during an open enrollment period, coverage begins on the first (1st) day of the City's fiscal year.

B. Qualifying Life Events – Coverage begins on the first day of the pay period following the event date. Three (3) exceptions to this are for the birth of a child, marriage and divorce. The coverage begins on the date of birth if documentation and forms are completed and submitted to the Human Resources Office within the thirty-one day (31-day) enrollment period, or electronically submitted. Delaying the submission of documentation and forms may result in extra deductions for premiums due. Losing or gaining eligibility for Medicaid allows a sixty day (60-day) enrollment period. An ex-spouse or domestic partner is not eligible to continue participation in the insurance program, except through COBRA. Therefore, when the divorce decree is submitted to the Human Resources Office with the cancellation form, the end of coverage will be back dated to the day following the court stamped date on the decree or the employee's signature on the Domestic Partnership Termination form.

4. **TERMINATION OF COVERAGE.** Benefits terminate at the end of the pay period in which the Life Status Change occurs. Exceptions to this are:

A. Retirement - End of month prior to PERA retirement date;

B. Dependent reaching age limit - End of dependent's twenty-sixth (26th) birth month; and

C. Ex-Spouses - lose coverage the day after the divorce is final. Divorces not reported in a timely manner may result in disciplinary action, full responsibility of claims and loss of COBRA rights.

5. **ELIGIBILITY CHANGES.** The employee is responsible for reporting and submitting to the Entity's Human Resources Office any dependent eligibility changes. Employees will be responsible for any costs incurred by dependents after a Life Status Change has rendered either the employee or the dependent ineligible to receive benefits.

6. **HOME ADDRESS CHANGES.** The employee is responsible for submitting home address change information on the appropriate form or electronic submission to the Entity's Human Resources Office.

7. **VERIFICATION PROCEDURES.** All dependent information recorded by the insured on the enrollment form is subject to verification by the Entity.

A. Employees are required to provide a copy of a marriage certificate when enrolling a spouse and a birth certificate or other acceptable proof of legal child dependent status when enrolling dependent children.

B. Employees are required to provide an affidavit and other related documents in order to prove eligibility when enrolling a domestic partner and/or domestic partner's child(ren).

C. During the course of each City fiscal year, the City may conduct an audit to verify dependent eligibility.

D. The Entity will be required to terminate any dependent from all insurance coverage, if the employee fails to submit requested evidence of eligibility or dependent status. Employees who have falsified enrollment documents to fraudulently obtain Entity insurance coverage may be subject to disqualification from participation in the City's group benefit program. Such employees may be subject to legal or disciplinary action as may be determined by the Entity and/or the City.

8. **COBRA CONTINUATION.** The Comprehensive Omnibus Budget Reconciliation Act (COBRA) of 1985 provides for continuation of health care coverage for a covered employee and covered dependents due to a qualifying event that causes loss of coverage.

A. A qualifying event is defined as termination of employment (other than for gross misconduct) or reduction in hours of employment; covered employee's death; a divorce or legal separation of a spouse from a covered employee; a covered employee's entitlement to Medicare; or if a child no longer satisfies the plan's definition of a dependent child ("Qualifying Event").

B. COBRA continuation coverage may be available for eighteen (18) months in the event of termination or thirty-six (36) months in the event of death, divorce/legal separation,

entitlement to Medicare, or loss in dependent status. All continuation of health benefits under COBRA legislation are subject to premium payments of one hundred percent (100%) plus a two percent (2%) administrative fee. Coverage will terminate earlier than permitted by legislation if the participant becomes ineligible due to other coverage or if the participant fails to make premium payments.

C. The covered employee or dependent is required to notify the Entity's Human Resources Office of a divorce, legal separation, and/or child losing dependent status within sixty (60) days after the date of the event or notice of the event, whichever is later.

D. Responsibilities of each party are as follows:

I. **The Entity**.

a. The Entity shall be subject to all the terms and conditions of City Provider agreements for those benefits in which the Entity participates. The City, upon request, will provide the Provider agreements to the Entity. Entity agrees that all terms and conditions contained herein shall be directly enforceable by Provider against Entity;

b. The Entity shall review its group voluntary benefit programs and determine the merits of participation in the City-sponsored benefit programs, such as voluntary life, disability, deferred compensation programs and all other applicable benefit programs. Participation with Voluntary Benefit programs are subject to negotiations between Entity and the respective Provider;

c. The Entity shall administer eligibility, enrollment and participation criteria in the same manner as the City, as required by City Provider agreements, as set forth in Section 1.A. above. Service contracted individuals shall not be eligible to participate in benefits under this Agreement;

d. The Entity is responsible for verification of the eligibility status of its employees as outlined in Section 1.A. above, in a satisfactory manner as determined by the City;

e. The Entity shall make monthly premium payments directly to each Provider by the first of the month for that month's coverage. Failure to do so may result in the cancellation of this Agreement;

f. If the Entity is not paying the monthly premium as invoiced by the Provider then the Entity is responsible for sending to each Provider a roster of participating employees that includes premium details that total to the payment made to the Provider;

g. The Entity shall promote and highly encourage completion of the Personal Health Assessment throughout its entire benefits eligible member population;

h. The Entity shall collaborate to the extent possible on wellness projects that are initiated for all Entities by the Health and Wellness Coordinator in the City's Insurance and Benefits Office;

i. The Entity shall develop and maintain a premium payment and reconciliation system as required by City Provider agreements; and

j. The Entity shall administer and be responsible for working with Providers to insure the functions of enrollment and the transmission of eligibility information.

i. **Payment of Premiums (Employer).**

(a) The Entity will pay monthly premiums for all participating employees. The Entity will initiate payment of the aggregate premium to become due on or before the first (1st) day of the month of coverage based on enrollment lists generated by the Entity on the fifteenth (15th) calendar day of the month prior to the month for which payment will become due. The lists will be financially adjusted to reflect enrollments and terminations which have occurred during the thirty (30) day period immediately preceding issuance of the lists. The lists will also be adjusted to reflect adjustments resulting from employer/Provider reconciliation actions.

(b) The fifteen (15) day rule will apply to new enrollments and terminations which occur during the plan year. The fifteen (15) day rule affects payment fees as follows:

(1) Enrollment - The Entity will pay a full monthly premium for covered members who enroll on or before the fifteenth (15th) calendar day of the month of enrollment but will not pay a monthly premium for members who enroll on or after the sixteenth (16th) calendar day of the month of enrollment; and

(2) Termination - The Entity will not pay a monthly premium for covered members who terminate coverage on or before the fifteenth (15th) calendar day of the month of termination but will pay a monthly premium for members who terminate coverage on or after the sixteenth (16th) calendar day of the month of termination.

(c) If an employee fails to notify the Entity's Human Resources Office of termination of employment or other loss of eligibility and the Entity has continued to issue a premium on behalf of the employee, the Entity will be entitled to a premium refund from the Provider for the overpayment, not to exceed a ninety (90) day refund from the date of preparation and submittal of a termination form or electronic eligibility file, to the Provider. If through administrative error, the Entity continues to pay a premium for a terminated employee after submittal of termination forms to the Provider, the Entity will be entitled to a refund, from the Provider, of all payments made after submittal of termination forms. The Entity will make such adjustments on the monthly payment report.

(d) On each monthly payment, the Entity will include adjustments for prior month new enrollments and terminations, applying the fifteen (15) day rule. The Entity, by identifying a covered member on the payment document as terminated or by failing to list a covered member on the payment document, authorizes the Provider to immediately discontinue (terminate) Services to the member pending resolution of the non-payment problem.

ii. **Payment of Premiums (Employee); and**

(a) Premium payments for active employees are deducted each pay period from employee payroll checks. Except as provided herein, Federal, State and FICA taxes are deducted after the health, dental and vision payments have been deducted, reducing taxable income. These pre-tax premiums cannot be used again at year-end for employee tax purposes;

(b) Entity employees on approved inactive status, for which payroll deductions for insurance are not made, are responsible for making premium payments directly to the Entity's Human Resources Office. Such inactive status includes Worker's Compensation/disability, Family Medical Leave or any Leave Without Pay status. Failure to make premium payments will result in cancellation of insurance; and

(c) Individuals participating under COBRA will make monthly payments of one hundred two percent (102%) directly to the COBRA administrator.

iii. **Reconciliation of Payment Discrepancies.**

(a) All monthly payments shall be subject to reconciliation by the Provider. The Provider shall compare information on the payment roster with Provider information to identify discrepancies in covered members, payment fees, contract types or other discrepancies. Upon identifying discrepancies, the Provider will first research its own files to account for enrollments, terminations, changes in contract types (e.g., single, couple, single parent or family) which recently have been received by the Provider. If a roster is not provided by the Entity with the payment then the Provider will rely on its own records of enrollment and reconciliation will become the responsibility of the Entity.

(b) After completing an internal accounting of discrepancies, the Provider will transmit to the Entity a list of covered members for whom names or status do not match. The list transmitted to the Entity for a specific month shall be the basis for all further reconciliation of discrepancies and financial adjustments for the month reconciled. No subsequently discovered discrepancies shall be applied retroactively. After submittal to the Entity of a specific month's discrepancy list, additional names may not be added for adjustment purposes; however, names or amounts transmitted shall remain subject to this reconciliation process until a mutually satisfactory resolution of all identified discrepancies has been reached.

(c) Adjustments for any amounts payable or refundable to either party will be made only for a sixty (60) day period from the first (1st) day of the month reconciled.

(d) The Entity will research discrepancies, make a determination as to the financial amounts identified by the Provider, make the appropriate adjustment on the subsequent monthly payment and provide the Provider with an explanation and supporting documentation for any disputed amounts.

k. Default in Payments. In the event the Entity fails to make premium payments to a Provider within the grace period required in the Provider agreements, the Provider may suspend its performance and the Entity employees shall not be eligible for coverage until such time payment by the Entity is made in full as specified in the Provider agreements;

l. The Entity shall be responsible for sending proper notification in a timely manner of new and terminating employees to the COBRA administration Provider;

m. The Entity shall attend at least two (2) meetings scheduled by the City for all Entities and Providers;

n. The Entity will be responsible for all fees and/or taxes related to the Affordable Care Act outside of those included in the premium; and

o. The Entity shall be responsible for all costs associated with the administration of this Agreement, including payment of premiums and other miscellaneous administration costs, including but not limited to printing and mailing, incurred for Entity employees.

II. **The City.**

a. The City may conduct periodic audits of Entity eligibility, enrollment, verification, payment, reconciliation and other criteria designed to assure that the benefits program is being administered in accordance with the provisions of this Agreement and Provider agreements. The City will provide a written report of audit findings to the Entity;

b. The City shall assist the Entity (upon request) with benefits staff training, interpretation of Provider agreements and advocating on behalf of employees in administering the benefits program;

c. The City shall assist the Entity in scheduling and conducting open enrollment meetings and in otherwise providing technical benefit interpretations and explanations; and

d. The City shall negotiate an employee benefits program for eligible employees, including medical, dental, vision, life insurance, and other group voluntary benefits. The City retains the right to modify the plan of benefits or premium structure during annual contract negotiations to obtain benefits for employees.

9. **Term of Agreement**. This Agreement shall commence July 1, 2018, and shall be undertaken and completed in such sequence as to assure its expeditious completion in light of the purposes of this Agreement; provided, however, that in any event, all of the Services required hereunder shall be completed by June 30, 2019.

10. **Compensation and Method of Payment**.

A. **Compensation**. The Entity agrees to pay the City Human Resources Department an annual fee in the amount of Eighteen Thousand Six Hundred Eighty Dollars and no/100 ($18,680.00), which amount includes any applicable gross receipts taxes and which amount shall constitute full and complete compensation for the Entity's participation.

Annual Participation Fee		$500.00
Per Benefits Eligible Employee Per Year Fee	#606 Employees x $30.00	$18,180.00
		$18.680.00

This annual fee is determined by the City and may be changed. The fee is for costs associated with City work performed in providing the group benefits program participation and is not for costs incurred by the Entity in administration of the benefits program. During the first year, the fee may be prorated depending on when the participation begins.

B. **Method of Payment**. Such amount shall be payable in full by the end of the last City fiscal quarter following the effective date of this Agreement and shall include any applicable gross receipts taxes. Such amount shall be paid to the City upon receipt by the Entity of a requisition for payment.

11. **Independent Contractor**. Neither the Entity nor its employees are considered to be employees of the City for any purpose whatsoever. The Entity is considered as an independent contractor at all times. The Entity further agrees that neither it nor its employees are entitled to any benefits from the City under the provisions of the Workers' Compensation Act of the State of New Mexico, or to any of the benefits granted to employees of the City under the provisions of the Merit System Ordinance as now enacted or hereafter amended.

12. **Liability**. Neither party shall be responsible for liability incurred as a result of the other party's acts or omissions in connection with this Agreement. Any liability incurred in connection with this Agreement is subject to the immunities and limitations of the New Mexico Tort Claims Act, NMSA 1978, §41-4-1 et seq., as amended.

13. **Discrimination Prohibited**. The Entity shall not discriminate against any person on the basis of race, color, religion, gender, sexual preference, sexual orientation, national origin or ancestry, age, physical handicap, or disability.

14. **ADA Compliance**. The Entity agrees to meet all the requirements of the ADA. The Entity agrees to be responsible for knowing all applicable requirements of the ADA and to defend, indemnify and hold harmless the City, its officials, agents and employees from and against any and all claims, actions, suits or proceedings of any kind brought against said parties as a result of any acts or omissions of the Entity or its agents in violation of the ADA.

15. **Reports and Information**. At such times and in such forms as the City may require, there shall be furnished to the City such statements, records, reports, data and information, as the City may request pertaining to matters covered by this Agreement. Unless otherwise authorized by the City or required by law, the Entity will not release any information concerning the work product including any reports or other documents prepared pursuant to this Agreement.

16. **Establishment and Maintenance of Records**. Records shall be maintained by the Entity in accordance with applicable law and requirements prescribed by the City with respect to all matters covered by this Agreement. Except as otherwise authorized by the City, such records shall be maintained for a period of three (3) years after receipt of final payment under this Agreement.

17. **Audits and Inspections**. At any time during normal business hours and as often as the City may deem necessary, there shall be made available to the City for examination all of the Entity's records with respect to all matters covered by this Agreement. The Entity shall permit the City to audit, examine, and make excerpts or transcripts from such records, and to make audits of all contracts, invoices, materials, payrolls, records of personnel, conditions of employment and other data relating to all matters covered by this Agreement. The Entity understands and will comply with the City's Accountability in Government Ordinance, §2-10-1 et seq. and the Inspector General Ordinance, §2-17-1 et seq. R.O.A. 1994, and also agrees to provide requested information and records and appear as a witness in hearings for the City's Board of Ethics and Campaign Practices pursuant to Article XII, Section 8 of the Albuquerque City Charter.

18. **Ownership, Publication, Reproduction and Use of Material.** The City is the owner of and shall have unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data or other materials prepared under this Agreement. No material produced in whole or in part under this Agreement shall be subject to copyright in the United States or in any other country.

19. **Compliance With Laws**. In performing the Services required hereunder, the Entity shall comply with all applicable laws, ordinances, and codes of the Federal, State and local governments.

20. **Changes**. Any changes to this Agreement shall be mutually agreed upon by and between the City and the Entity, and shall be incorporated in written amendments to this Agreement.

21. **Assignability.** The Entity shall not assign any interest in this Agreement and shall not transfer any interest in this Agreement (whether by assignment or novation), without the prior written consent of the City thereto.

22. **Termination for Cause**. If, through any cause, the Entity shall fail to fulfill in a timely and proper manner its obligations under this Agreement or if the Entity shall violate any of the covenants, agreements, or stipulations of this Agreement, the City shall thereupon have the right to terminate this Agreement by giving written notice to the Entity of such termination and specifying the effective date thereof at least ninety (90) days before the effective date of such termination. Such termination will not entitle the Entity to a refund of any portion of the participation fee paid to the City under this Agreement. Notwithstanding the above, the Entity shall not be relieved of liability to the City for damages sustained by the City by virtue of any breach of this Agreement by the Entity.

23. **Termination for Convenience**. Either the City or the Entity may terminate this Agreement at any time by giving at least ninety (90) days notice in writing to the other party. Such termination will not entitle the Entity to a refund of any portion of the participation fee paid to the City under this Agreement.

24. **Construction and Severability**. If any part of this Agreement is held to be invalid or unenforceable, such holding will not affect the validity or enforceability of any other part of this Agreement so long as the remainder of the Agreement is reasonably capable of completion.

25. **Enforcement**. The Entity agrees to pay to the City all costs and expenses including reasonable attorney's fees incurred by the City in exercising any of its rights or remedies in connection with the enforcement of this Agreement.

26. **Entire Agreement.** This Agreement contains the entire agreement of the parties and supersedes any and all other agreements or understandings, oral or written, whether previous to the execution hereof or contemporaneous herewith.

27. **Applicable Law and Venue.** This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of New Mexico, and the laws, rules and regulations of the City of Albuquerque. The venue for actions arising out of this Agreement is Bernalillo County, New Mexico.

28. **Binding Agreement.** This Agreement shall not become binding upon the City until approved by the highest approval authority of the City required under this Agreement.

IN WITNESS WHEREOF, the City and the Entity have executed this Agreement as of the date first above written.

CITY OF ALBUQUERQUE

Approved By:

Mary L. Scott, Director
Human Resources Department

B. Jesse Muñiz, MBA
Acting Chief Procurement Officer

ENTITY: Water Utility Authority

By: _____