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Anthem

New York State Department of Civil Service

Technical Proposal - Redacted

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Dental Plan Services RFP - FINAL

Section 5: Technical Proposal Requirements

The purpose of Section 5 of the RFP is to set forth the submissions required as part of the Offeror bid proposal. The Offeror's Technical Proposal must contain responses to all required submissions from the Offeror in the format requested. Each Offeror may submit only one Technical Proposal. Each Offeror's Technical Proposal will be evaluated based on the responses to the required submissions contained in Section 5 of this RFP. An Offeror must not include any cost information in the Technical Proposal, including attachments. Specific savings estimates (dollars or percentages) must not be quoted in the Technical Proposal or in any attachments submitted with the Technical Proposal.

Acknowledged.

Since the New York State Health Insurance Program was established in 1957, we have proudly served as a trusted partner of the New York State Department of Civil Service (the Department). Throughout the years, we have stood by your side as the administrator of the Empire Plan Hospital Program, including the Excelsior Plan and the Student Employee Health Plan. The experience we have drawn from this long-term relationship will be invaluable and directly applied to our administration of the Dental Plan.

On January 1, 2024, our name will evolve from Empire HealthChoice Assurance, Inc. dba Empire BlueCross to Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross (Anthem). This change symbolizes more than a new name; it represents our renewed commitment to championing whole health for you and your members.

Our dedication to providing you with a best-in-class healthcare experience remains unwavering. As we embrace this new chapter, we are honored to have this opportunity to build on our partnership and serve the New York State Dental Plan's members and their families with experience and innovation.

Anthem as the offeror has responded to the below items related to our Technical Proposal. Anthem is presenting our Essential Choice dental plan to meet the Department's needs. The proposed plan delivers cost-effective and inclusive benefits. With one of the largest local and national dental networks, your members will have access to quality care wherever they are. In New York alone, we have 9,091 unique dentists at 26,273 locations. A larger network means greater access — driving network utilization, stronger network savings, and greater access to care. The plan is designed to be user-friendly and aims to provide predictable, sustainable savings for the Department and members alike.

The importance of dental benefits as part of caring for the whole body cannot be overstated. Regular dental exams not only help to decrease a patient's risk for oral diseases, such as cavities and periodontal (gum) disease but may also help diagnose other, sometimes life-threatening medical conditions. Early detection can help avoid more serious problems and reduce healthcare costs for the Department.

We understand the significance of administering the benefit design in a manner consistent with your collectively bargained benefit structure and developed both systematic and administrative flexibility to align with your union-negotiated benefit designs. We can deliver best-in-class dental benefits for healthier outcomes and are uniquely positioned as the leading partner to achieve these results based on our existing relationship as the Hospital Program administrator, our unique capabilities and provider collaborations, unmatched technology and data, and a member-centric view known as the Whole Health Connection.

Our unique capabilities include real-time claim processing and the use of artificial intelligence in collaboration with providers to quantify disease against clinical processing guidelines to ensure adherence with benefit plan coverage while reducing unnecessary costs. Our technology and data allow us to consult and advance evidence-based dentistry, plan design, and network optimization. We do this while keeping members' oral and overall health front of mind by offering our Whole Health Connection suite of tools and resources. Whole Health Connection includes the option to administer clinically enhanced dental benefits for members with high-cost, chronic health conditions, the ability to administer claim files for care coordination programs, and digital tools and resources that support your members in real-time, at the point dental care is needed. This includes unique provider collaborations supporting care opportunities for at-home dentures and orthodontia as well as emergent care leveraging the use of teledentistry.

With more than 50 years of experience, Anthem is a leader in administering dental benefits for a diverse range of clients, including local and state governments. Our broad portfolio speaks to our expertise and capacity to handle large dental plans and complex requirements. Anthem serves more than six million members and administers dental benefits for nearly 100,000 employer groups. We administer multiple states' dental benefits, each with unique benefits and nuanced plan administration requirements. These numbers represent our steadfast commitment and proven ability to fulfill the requirements outlined in your RFP. We will leverage all this experience to ensure a seamless transition for the Department and New York State Dental Plan members and their families to Anthem's dental plan.

5.1 Executive Summary

1. In an Executive Summary, the Offeror must describe its capacity and proposed approach to administering the Dental Plan, which covers over 234,000 lives and incurs claims costs of over $70 million annually. The Offeror must have the ability, experience, reliability, and integrity to fulfill the requirements of this RFP. As such, the Executive Summary must include:
   a. A description of the Offeror's understanding of the requirements presented in the RFP and how the Offeror can assist the Department in accomplishing its objectives;

   b. A statement explaining the Offeror's experience managing the dental plans of other state or local government employers, including at least one large client. A large client is considered any employer with at least 50,000 covered lives. In determining covered lives, the Offeror should count all lives (i.e., an employee, a spouse, and two eligible dependents counts as four covered lives). The Offeror should include details on how its experience qualifies them to undertake the functions and activities as required by this RFP.

   Confirmed. We proudly have been serving New York families and businesses since 1934. As a local partner in the New York community, with 5,007 locally based employees living and working in several locations across the state, we offer the strength, experience, reliability, and integrity of a nationwide company with local access to care for the Department's members.

   Please refer to our Executive Summary located in Section 2, which describes our ability to fulfill your RFP requirements with proactive and innovative services.

5.2 Account Team

The Offeror must complete the Biographical Sketch Form (Attachment 14) for all key personnel including Subcontractor key staff, if any, of the proposed Account Team. Where individuals are not named, include qualifications of the individuals that will fill the positions. The Offeror must provide:

1. The name and address of the Offeror's main and branch offices, and the name of the senior officer(s) who will be responsible for this account.

   The Department's Account Team is located at Anthem's office at 15 and 17 Plaza Drive, Latham, New York 12110. The senior officers responsible for the administration of the Plan are:

Victor DeStefano, President, New York Commercial Business

Victor will have responsibility for senior-level oversight of the New York State Dental Plan of the Department's account and is located at our office at One Penn Plaza, 36th Floor, New York, New York 10119.

Scott Towers, President, Specialty Business

Scott will have overall accountability for operations, underwriting, network development, and strategy. He is located at 1285 Northland Drive, Mendota Heights, Minnesota 55120.

Jason O'Malley, Regional Vice President, Upstate Sales and Account Management

Jason will continue to provide leadership and direction in all account management activities for the Department. He maintains the authority to command the appropriate resources necessary to deliver program services. Jason is located at 15 Plaza Drive, Latham, New York 12110.

Please refer to Section 3 for the completed *Biographical Sketch Forms (Attachment 14)* for all key personnel of the Account Team.

2. An organizational and staffing plan that includes the roles and responsibilities of key personnel involved in administering the Dental Plan, their planned level of effort, their anticipated duration of involvement, and their daily level of availability. An organizational chart must be included in the proposal which identifies the Offeror's staff and staff from any Subcontractor, including their name and title, to be used in delivering the Project Services.

   Anthem's relationship with the Department is our top priority and one we never take for granted. Our focus has always been and will continue to be, to consistently serve you and your Plan members and provide the highest level of service every day.

   Accordingly, we will provide the Department with an expansive cross-functional Sales and Operational Team above and beyond what we typically offer. Victor DeStefano, President, New York Commercial Business, and Scott Towers, President, Specialty Business have overall accountability for the administration of Anthem's dental plan. Victor and Scott's leadership involvement exemplifies our commitment to the success of the New York State Dental Plan and provides the Department with the exceptional service you deserve as our largest client. With millions of members and tens of millions of claims processed over the past five decades, we are experts at dental plan administration and delivering a program that surpasses the Department's expectations. Our cross-functional team will work side by side with the Department to ensure your Dental Plan meets all your specifications as required.

Below are the members of your Anthem Account Team who will work directly with the Department:

Your Leadership Team		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Victor DeStefano President, New York Commercial Business	Responsible for the overall operations and administrative management of client contracts in New York, including the New York State Dental Plan contract.	[redacted]	[redacted]	[redacted]
Scott Towers President, Specialty Business	Responsible for overall accountability for the Dental business in New York as well as the other 13 states we have licenses to operate. Responsibilities include overall accountability for product development, operations, underwriting, network development, and strategy.	[redacted]	[redacted]	[redacted]

Your Anthem Team		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Jason O'Malley Regional Vice President of Sales	Executive responsible for leadership, direction, and oversight responsibility for all account management activities.	[redacted]	[redacted]	[redacted]
Angela Blessing Strategic Account Executive	Account Team leader responsible for ensuring all Plan expectations are being met or exceeded. Angela will also formulate strategies to improve Plan administration, control or reduce costs, and ensure member satisfaction.	[redacted]	[redacted]	[redacted]
Tony Harper Staff Vice President, Dental Account Management	Executive responsible for leadership, direction, and oversight responsibility for all Dental account management activities.	[redacted]	[redacted]	[redacted]

Your Anthem Team (continued)		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Sandy Bogen Strategic Account Consultant	Sandy will work collaboratively with Angela to provide dental-specific account management expertise, which encompasses reporting, renewal strategies, and member communications support.	[redacted]	[redacted]	[redacted]
Brenda McCumber Account Service Manager	Day-to-day operation contact with primary responsibility for all benefit changes, membership inquiries, and issues involving claims processes to ensure the account is being administered correctly.	[redacted]	[redacted]	[redacted]
Asea Safgren Director, Specialty Administration	Responsible for leading and oversight of Specialty account service associates, which includes Shawna Brodeur, Specialty Account Service Manager, Sr.	[redacted]	[redacted]	[redacted]

Your Anthem Team (continued)		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Shawna Brodeur Specialty Account Service Manager, Sr.	Shawna will partner with Sandy Bogen and Brenda McCumber to deliver exceptional service support. She will act as a point of contact and liaison for the dental plan.	[redacted]	[redacted]	[redacted]
Your Anthem Implementation Team		**Planned Level of Effort**	**Anticipated Duration of Involvement**	**Daily Level of Availability**
Julie Kloncz Manager, Specialty Implementation	Oversees Large Group Dental Implementation Team.	[redacted]	[redacted]	[redacted]
Abbey Thornton Senior Client Success Advisor	Serves as an expert resource in managing all post-sale implementation activities.	[redacted]	[redacted]	[redacted]

Your Anthem Financial Team		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
ReNae Lynch Regional Vice President, Specialty Underwriting	Executive responsible for overseeing underwriting policies and procedures, development of the Plan's ASO fee, and renewals.	[redacted]	[redacted]	[redacted]
Derek Schutz Director and Actuary, Specialty Finance and Actuarial	Executive responsible for overseeing Actuarial functions including development of pricing and plan impact factors, forecast modeling, and reserve setting.	[redacted]	[redacted]	[redacted]

Your Anthem Networks Team		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Travis Weir Staff Vice President, Dental Network Solutions, Analytics, and Reporting	Executive accountable for developing dental network solutions, client reporting, credentialing, fraud, waste, and abuse, and maintaining our leading PPO network.	[redacted]	[redacted]	[redacted]
Dr. Stewart Balikov National Dental Director, SIU, and Clinical Utilization Review	Responsible for Utilization Management oversight for clinical claims and appeals review, process improvements, and evidence-based dental clinical policies. Directs the Dental Special Investigations Unit (SIU) responsible for Fraud, Waste, and Abuse detection, prevention, and recovery. Provides clinical proficiency as the chief dental clinical expert.	[redacted]	[redacted]	[redacted]
Lorie Ellis Manager, Utilization Management	Manages our Utilization Review Team including predeterminations, claims review, grievances and appeals, process improvements, and clinical staff education and training.	[redacted]	[redacted]	[redacted]

Your Anthem Networks Team (continued)		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Neil Goldberg Director, Network Management	Oversees the Network Development and Management Team and national recruitment call center. Additional functions include contractual modifications to maintain and support state or federal law requirements and product introductions, network data integrity for provider directories, and accuracy of claim processing, servicing, and provider education to the provider network.	[redacted]	[redacted]	[redacted]
Jennifer McMorrow Manager, Network Management Senior	Collaborates with internal partners to determine and execute continued expansion and retention strategies — ensuring our networks meet and exceed access standards for current and future membership.	[redacted]	[redacted]	[redacted]
Tiffannie Saueressig Manager, Reporting and Data Analysis	Oversees the dental research and analytics area. She has accountability for provider, network, and client reporting, along with managing provider reimbursement and developing rating and renewal tools for pricing.	[redacted]	[redacted]	[redacted]
Lynn Cascino Provider Network Manager	Serves as the lead project network recruiter in New York.	[redacted]	[redacted]	[redacted]

Your Anthem Operations Team		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Suzanne Woodring Staff Vice President, Dental Operations	Executive accountable for the end-to-end Operations functions for the Dental plan including: o Group case installation and benefit coding o Membership and enrollment o Claims o Grievance and appeals o Member and provider customer service	[redacted]	[redacted]	[redacted]
Margaret Pates Director, Service Operations	Oversees the Claims Administration Team. She creates, prioritizes, and drives claims strategy and initiatives to improve quality and timeliness that surpass service expectations.	[redacted]	[redacted]	[redacted]
Kim Neuttila Manager, Claims	Manages our special claims and orthodontia claims analysts and support unit.	[redacted]	[redacted]	[redacted]
Jane Tessmann Director of Customer Care, Dental Operations	Oversees all call center activity for members and providers, and its overall quality, performance, and success.	[redacted]	[redacted]	[redacted]
Dan Larsen Dental, Customer Care Manager	As the site lead, he guides our Customer Service Teams to ensure a consistently high level of service is provided to members and providers.	[redacted]	[redacted]	[redacted]

Your Anthem Operations Team (continued)		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Rochelle Wright Director, Customer Experience	Oversees Grievance and Appeals, Employer Services, and Training and Case Implementation. These areas provide support to our customers in researching grievances, appeal determinations, employer support of claims and benefit escalations, training, and implementation/maintenance of plan benefits.	[redacted]	[redacted]	[redacted]
Sheng Xiong Manager, Grievance and Appeals	Manages our Grievance and Appeals unit including escalated issues and process improvement.	[redacted]	[redacted]	[redacted]
Shana Siebrands Dental Operational Expert	Accountable for providing technical direction, guidance, and resources to customer service, on a day-to-day basis.	[redacted]	[redacted]	[redacted]
Jennifer Hollers Dental Employer Services Representative	Serves as a direct contact and liaison for the Plan and handles any escalated service and claims issues. They assist the Account Team with claims and enrollment, escalated adjustments, and act as the seamless link between the Account and Operations Teams.	[redacted]	[redacted]	[redacted]

Your Anthem Contract and Quality Assurance Team		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Thomas Manor Director, Quality Assurance	Oversees Specialty Quality Oversight and Controls including performance quality audit.	[redacted]	[redacted]	[redacted]
Lisa Kubasch Manager, Dental Contract Administration	Oversees Dental Contract Administration including dental group contracts and dental evidence of coverage issuance.	[redacted]	[redacted]	[redacted]
Your Anthem IT Team		**Planned Level of Effort**	**Anticipated Duration of Involvement**	**Daily Level of Availability**
Derek Lindberg Staff Vice President, Technology Member Management	Executive accountable for Specialty IT solutions.	[redacted]	[redacted]	[redacted]
Kathryn Ansley Developer Advisor	Serves as the technical advisor and dental claims system expert.	[redacted]	[redacted]	[redacted]
Your Anthem Products Team		**Planned Level of Effort**	**Anticipated Duration of Involvement**	**Daily Level of Availability**
Lucas Bitzan Staff Vice President, Dental Product Development	Executive accountable for Dental Product Management, and monitoring industry and competitive trends alongside regulatory and public affairs, to develop market-leading and competitive product solutions.	[redacted]	[redacted]	[redacted]
Regina Hopkins Dental Product Management Director	Assists in dental group benefit design consultation within New York.	[redacted]	[redacted]	[redacted]

Your Anthem Billing and Enrollment Team		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
David Lawrence Vice President, Enrollment and Benefit Administration	Executive with leadership oversight across the medical Benefit Configuration and Case Installation Teams performing installation activities.	[redacted]	[redacted]	[redacted]
Danielle Casanova-Cruz Director, Market Experience	Maintains oversight of the Case Install and Membership organization. Responsible for a dedicated team for NY clients that will partner with both Account and Strategic Implementations Teams, to ensure the account structure and eligibility are successfully established.	[redacted]	[redacted]	[redacted]
John Lacognata Manager, Installation and Eligibility	Oversees all New York membership, including the dedicated New York City Eligibility Team, the dedicated New York State Eligibility Team, and all New York group installations.	[redacted]	[redacted]	[redacted]
Michelle Diebold Manager, ASO Billing	Manages the billing functions for large National and New York local accounts.	[redacted]	[redacted]	[redacted]
Rahul Kaushal Senior Director, Digital Operations	Responsible for Electronic Enrollment Transaction (EET) functions and monitoring to ensure that files are successfully received and loaded.	[redacted]	[redacted]	[redacted]

Your Anthem Billing and Enrollment Team (continued)		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Janna Liberty Business Analyst	Tracks and monitors all aspects of audits in process and ensures the required reporting is provided to the Department or the Office of the State Comptroller in a timely manner; Compiles audit supporting documentation requested by the Department or the Office of the State Comptroller; Serves as the primary reporting contact and ensures monthly, quarterly, and annual reports are accurate and on time.	[redacted]	[redacted]	[redacted]
Your Anthem Marketing, Communications, and Digital Team		**Planned Level of Effort**	**Anticipated Duration of Involvement**	**Daily Level of Availability**
Allison Austin Staff Vice President, Marketing Strategy and Insights	Executive responsible for strategic marketing leadership who will support the Account Team with the dental plan.	[redacted]	[redacted]	[redacted]
Jill Atwood Director, Marketing	Responsible for member marketing and communication support.	[redacted]	[redacted]	[redacted]
Amanda Wauthier Marketing Manager, Sr.	Accountable for an integrated marketing strategy and analytics.	[redacted]	[redacted]	[redacted]
Josh Kahn Staff Vice President, Digital	Executive responsible for digital client and member communication support leadership.	[redacted]	[redacted]	[redacted]

Your Anthem Marketing, Communications, and Digital Team (continued)		Planned Level of Effort	Anticipated Duration of Involvement	Daily Level of Availability
Kate Otto Director, Digital Product	Responsible for overseeing the development of a custom dental microsite.	[redacted]	[redacted]	[redacted]
Christine Leko Manager, Product Development	Responsible for overseeing the development of a custom dental microsite.	[redacted]	[redacted]	[redacted]

Please refer to Section 11 for Anthem's Organizational Chart and Staffing Plan.

3. A description on how the Account Team interfaces with senior management and ultimate decision-makers within Offeror's organization; and how the Account Team will interact with other departments such as the call center, quality assurance, reporting, and network management within Offeror's organization.

The organizational model we are proposing capitalizes on our current structure for the Hospital Program and integrates numerous operational areas and key individuals into a dedicated model for the Dental Plan. We are expanding the current team structure to provide you with additional resources to reduce administrative burdens for the Department. The Account Team reports to Anthem's President, New York Commercial Business Victor DeStefano, and Scott Towers, President, Specialty Business. The Account Team will have direct access to Victor and Scott to ensure we are providing excellent service that meets or exceeds the Department's expectations.

Our proposed extended Account Team includes cross-functional leadership support and expert resources for the Department. Angela Blessing, Jason O'Malley, and Sandy Bogen will have daily access to these resources and will meet with them regularly to ensure all lines of communication are open. This model will ensure Anthem maintains the superior level of service you have become accustomed to while easing administration for the Department through a single point of contact for the Anthem Plan Hospital Program and the New York State Dental Plan. The Account Team will respond quickly and accurately to inquiries and act in a consultative manner with the Department of Civil Service, the Office of Employee Relations, and other New York State entities involved in the administration of the Plan.

The Account Team will have access to, and cooperation with, all operational areas, including the dedicated call center, Reporting, Auditing, Compliance, Claims, and Network Management Teams. In keeping with our existing process for the Hospital Program, Anthem will facilitate monthly meetings with leaders from our operational areas. The objective of these meetings is to review current service levels, discuss areas of concern and mitigation strategies, and identify enhancements or process improvements, trends, and any topic that could potentially impact the Plan. These meetings ensure visibility, accountability, and support within the organization, from executive management to our extended Account Team.

This structure ensures a top-to-bottom understanding of your Plan and promotes immediate, proactive resolution to any issues that may arise during the contract. This includes collaborative, innovative investments that promote seamless administration of the Plan.

We recognize and value the importance of our relationship and understand what is required at all levels of our organization. We are committed to meeting your expectations and all requirements outlined in your RFP.

4. An explanation of how the Offeror's Account Team will be prepared to administer the operational and clinical aspects of the Dental Plan.

Anthem has been administering benefits for the State of New York for nearly 65 years. The experience we have drawn from this long-term relationship will be invaluable and directly applied to our administration of the Dental Plan. We recognize the importance of having the State of New York as a client and are fully committed to meeting your expectations. The Account Team will meet the requirements for deliverables, act consultatively, and engage senior management as needed to ensure the Department's expectations are met. The Operational and Clinical Teams will be accountable to the Account Team, who will be responsible for oversight of the entire Plan. All key account areas will participate in regularly scheduled meetings with the Department, with the understanding that they are accountable for their various areas of operation. Providing direct access and interaction with the operational leadership creates a collaborative environment and open communication resulting in higher client satisfaction.

We will outline in detail throughout the proposal our approach to actively manage all aspects of the program but some of these activities include:

- Regular discussions to explore coverage options and their impact on costs, quality, outcomes, and the overall best use of healthcare dollars
- Continued review of member and provider experiences to identify opportunities for service improvement and Plan development
- Clinical program oversight and policy development
- Communicating performance measures
- Fully cooperating in any program audits
- Review of utilization trends through claims data to evaluate program performance
- Collaborating on member communications

We acknowledge there are unique aspects to the Department's Dental Plan and that union contracts require the plan to be administered exactly as stated within the RFP. Anthem has experience in administering similar requirements for other State dental plans. We are committed to the overall satisfaction of the Department and have proposed the resources and administrative model that best accomplishes this goal.

5. A description of how the Offeror proposes to ensure that responses to administrative concerns and inquiries posed by the Department, members of the Council on Employee Health Insurance, or union representatives regarding member-specific claims issues for the duration of the Contract, will be provided within one Business Day.

   Strategic Account Executive Angela Blessing has nearly 15 years of experience supporting the Department on the Empire Plan Hospital Program and over 30 years in the healthcare industry. She has the necessary institutional knowledge across all areas of operation, direct access to senior-level management, and the authority to command the resources necessary to respond to administrative concerns and inquiries promptly on the same day.

   Sandy Bogen, Strategic Account Consultant has more than 30 years of industry experience. She has in-depth knowledge of dental plan benefit design and administration. Sandy will support Angela as necessary to ensure dental administrative concerns and inquiries are responded to quickly and with the same authority granted to Angela.

6. A description of the protocols that will be put into place to ensure the Department will be kept updated on actual or anticipated events impacting costs and/or delivery of services to Enrollees, including a representative scenario.

   We propose establishing monthly meetings with the Department to discuss various topics and deliverables associated with administering the Plan. Some topics and deliverables that may be discussed include:

   - Utilization and Operational trends and patterns including the potential impact on the Plan and Plan members
   - Recommendations to better serve Plan members and/or ways to control spend
   - Dental trends across the industry and our book of business
   - Proposed state and federal legislation that could potentially impact the Plan
   - Provider network trends
   - Emerging treatments and services

   In addition, we will conduct an in-depth Plan review annually. During this meeting, the following will be provided:

   - Year in review of Plan performance, experience, and emerging trends
   - Roll-up analysis of the Plan's utilization compared to the book of business results
   - Benchmark analysis comparing your program against other State clients and/or clients with similar plan designs and membership demographics
   - Discussion of upcoming key events for the Department and how we can support you in those endeavors

Over the last few years, the following specific example stands out where we proactively communicated time-sensitive information to our members:

During the COVID Public Health Emergency (PHE), the federal government required every state, including Medicaid payors, to pause their annual Medicaid eligibility reviews and disenrollments. Once the PHE ended, millions of Americans faced losing their benefits once the Medicaid eligibility process began again. Anthem quickly and proactively developed tools to educate members on the redetermination process. These tools allow members to receive instant, personalized guidance on their current health plan eligibility — whether a Medicaid, Medicare, or commercial plan — along with resources to help them learn more and enroll in the right plan for their needs. Beyond health insurance members are also using the tools to see if they qualify for food assistance, housing, childcare, and other programs, that support whole health outside of the doctor's office. More than 90,000 members from all 50 states and Washington, D.C. have received instant, personalized guidance.

We were recognized in the Health Category of Fast Company's Innovation by Design Awards for 2023. This award honors designers and businesses solving the most crucial problems of today and anticipating the pressing issues of tomorrow. It is one of the most sought-after design awards in the industry. This honor places us alongside other game-changing healthcare innovations from emerging startups and leading companies. This is the first time a health plan solution has earned this recognition.

7. A description of the corporate resources that will be available to the Account Team to ensure compliance with all legislative and statutory requirements.

Our Public Affairs Team monitors proposed and actual legislation on a state and federal level. The Account Team along with our Legal Team works in conjunction with Public Affairs to analyze new laws and regulations that affect or could potentially affect our customers. The Account Team meets routinely with the Public Affairs and Legal Teams and actively participates in discussions to identify the potential impact to the Plan. In addition, our internal Compliance Team who is responsible for making sure we are compliant with all applicable legislative and statutory requirements today on the Empire Plan Hospital Program will have oversight responsibility for the Dental Program as well. The Account Team will ensure the Department is kept fully abreast of potential or actual operational, procedural, and/or financial impact on the Plan.

In addition, the Account Team closely monitors impacted business areas to ensure timely and accurate implementation of any operational, procedural, and/or system changes required to make sure we are compliant with all legislative and statutory requirements. As a true benefits partner, we will proactively schedule meetings as needed or at the Department's request to discuss pending or proposed legislation and regulations with potential impact on the Plan and ways we can work together to shape public policy.

5.3 Preliminary Implementation Plan

The Offeror must provide as part of its proposal a preliminary Implementation Plan in narrative, diagram, and timeline formats, designed to meet the implementation requirements by the specified completion dates.

1. The preliminary Implementation Plan must include estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. It must include key activities such as:
   a. Training of call center staff;
   b. Website development;
   c. Network development;
   d. Transition of benefits; and
   e. Testing of eligibility files and claims processing.

Confirmed. Anthem will implement the Plan on the same enterprise eligibility processing platform as the existing Hospital Program. Our eligibility platform leverages the latest technology and enhancements to bring you and Plan members an experience that will continue to evolve in anticipation of your needs and the needs of Plan members. Our longstanding relationship with the Department administering the Hospital Program provides a solid foundation for our mutual ongoing success — one that engages Plan members and eases the administrative burdens of the Department's staff.

Our Preliminary Implementation Plan addresses the key activities referenced above as well as all other key deliverables to ensure a smooth transition to our dental plan. We remain committed to ensuring Plan members receive the level of service they have come to expect from Anthem and will leverage our experience and expertise in implementing large, complex clients to ensure success. Comprehensive testing will occur before the effective date and is an integral part of the overall implementation plan.

The following items can create complications when changing dental carriers. These items will be addressed during weekly implementation calls:

- Receiving history files from the previous carrier
- Predetermination reviews from the prior carrier
- Educating members on the new network

Educational meetings will also be offered for members to address upcoming plan changes. We understand the expectation of having certain aspects of the Plan (e.g., custom website and Sydney Health mobile app) available in advance of the effective date, as well as the importance of member communication and education. We have incorporated these requirements into our Preliminary Implementation Plan documents provided in Section 4.

Team Approach

A dedicated Implementation Team will manage all implementation activities and be comprised of resources from various areas including but not limited to Account Management, Operations, Eligibility and Billing, Underwriting, Reporting, Marketing, Communications, and Network Teams. These areas will work together and directly with you to ensure a seamless implementation. Anthem commits to having a contracted network, customer service, and claims processing fully functioning 45 days before the September 1, 2024, effective date.

The assigned dedicated implementation coordinator will work closely with the Account Team to lead a cross-functional Implementation Team that will include resources such as:

- A technical project manager to coordinate all IT and website development activities
- A dedicated marketing manager to assist in the development and creation of member communication materials
- A dedicated call center manager to support scripting, workflow development, and training
- A network manager to oversee custom network implementation

This cross-functional team will work closely with the Department to ensure that we complete all implementation activities according to plan and will be available to address ongoing needs and issue resolution.

Implementation Plan, Tools, and Data Requirements

An experienced project leader will be assigned and responsible for developing an implementation plan and managing the team through the implementation activities. Our Implementation Team will meet with the Department several times throughout the implementation process.

Implementation activities include:

- Third-party vendor interfaces, if applicable
- Website and Sydney Health mobile app
- Financial and backend reporting requirements
- Acclimation of Claims, and Customer Service representatives in Plan-specific workflows

Our team will use the following implementation tools:

- Formal project plan
- Group structure document
- Benefit summaries
- Communication deliverables/issues document
- Formal meeting and reporting structure

Operational Readiness

We will be prepared for an operational readiness review with the Department 45 days before opening the dedicated call center and activating the custom microsite as well as 45 days before the contract effective date and will make our policy and procedures available to you for review. This will provide the Department with the opportunity to conduct a review of the documentation required to assess call center readiness, IT systems connectivity, website/microsite development, and claims processing. Following the readiness review, we will provide a timeline and correction plan if any issues are identified. We will provide the Department with ongoing reviews at an agreed-upon frequency, which can be bi-weekly, weekly, and then daily as we near the effective date.

Our Management Approach Ensures Success

With our seasoned team, knowledge of the Department's requirements, proven processes, and experience with many successful implementations, we are confident in our ability to develop and execute an implementation plan that meets with the Department's approval. With our extensive track record as a reliable and committed benefits administrator, not only for the Department but also for many state health plans, which extends back decades, we have proven experience implementing complex dental programs.

Please refer to Section 4 for the Preliminary Implementation Plan documents, which include the requested timeline and diagram.

2. Implementation Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that all of the Implementation requirements listed in Section 3.3 will be in place on or before the Services Start Date following completion of the Implementation Period, with the exception of opening the Dedicated Call Center and completing work on the customized website. The Dedicated Call Center must be opened at least 30 calendar days prior to the Services Start Date. The customized website must be live and operational at least 30 calendar days prior to the Services Start Date. This guarantee is not subject to the limitation of liability provisions of the Contract.

   Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount for each Calendar day or part thereof, that all Implementation requirements are not met. The forfeited amount (Standard Credit Amount) is $1,500 a day for each Calendar day the guarantee is not met. However, an Offeror may propose higher amounts.

[redacted] Please refer to Section 5 for the completed Attachment 6.

5.4 Participating Provider Network

At least thirty calendar days prior to the Services Start Date, and throughout the term of the Contract, the Offeror must possess a Participating Provider network that meets or exceeds the accessibility standards set forth in Section 3.3 of this RFP. To demonstrate satisfaction of this requirement, the Offeror must submit all information required below based on the Geo-Coded Census file provided by the Department in Enrollment by ZIP Code & Geo Access Network Report File (Attachment 21).

Confirmed.

An Offeror will need to obtain sensitive information from the Department. Upon receipt of a completed, notarized Confidentiality and Non-Disclosure Agreement (Attachment 16), the Department shall provide the Offeror with Enrollment by ZIP Code and Geo Access Network Report File (Attachment 21), containing the NYBEAS enrollment file that will ensure that all Offerors perform their analyses consistently. This confidentiality and non-disclosure agreement governs through the solicitation process.

Confirmed. The signed *Confidentiality and Non-Disclosure Agreement (ATTACHMENT 16)* was submitted by Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross on May 23, 2023.

The Offeror may execute custom Dental Provider contracts contingent on award of a Contract or utilize existing agreements that can be made applicable to the Plan or a combination thereof. All Dental Providers in the network must be credentialed by the Offeror. The Offeror must agree to provide documentation, including unredacted Dental Provider contracts, to the Department upon request to demonstrate satisfaction of this requirement. No Enrollee may be excluded from the Offeror's Geo network analysis, even if no Dental Provider is located within the pre-defined access standards.

1. To fulfill the requirements of this Section and Section 3.3 of the RFP, the Offeror must:
    a. Submit their proposed Dental Provider network using the Offeror's Proposed Provider Network Files form (Attachment 22). An Offeror is required to submit its proposed Dental Provider network in two separate files: one for General Dentistry; and one for Specialists.

        Confirmed. Anthem's completed *Offeror's Proposed Provider Network Files (Attachment 22)* are in Section 7.

    b. Perform a GeoAccess analysis based on the Access Standards as referenced in Section 3.3 of this RFP. The Offeror should submit the complete Geo network reports in a searchable PDF and the GeoAccess Accessibility Summaries in copies in both searchable PDFs and hard copies. These analyses should include every ZIP Code that is in the demographic file; even ZIP Codes with no access should be included. The Offeror should use Estimated Driving Distance from the employee's home ZIP Code for calculating distance. The most current version of Quest Analytics software must be used to create these reports. See Offeror's Participating Provider Quest Analytics Report (Attachment 31) for instructions.

        Confirmed. Anthem's completed *Offeror's Participating Provider Quest Analytic Report (Attachment 31)* is in Section 8.

        We used the most recent version of Quest Analytics, a GeoAccess analysis program, to determine how many members will have access to our providers within a certain distance. All calculations were based on estimated driving distance calculations as requested.

Our network accessibility results for the Department are as follows:

Provider Type	Urban	Suburban	Rural
General Dentist	[redacted] (98% required) 2 within 5 miles	[redacted] (98% required) 2 within 10 miles	[redacted] (95% required) 2 within 20 miles
Pedodontist	[redacted] (91% required) 1 within 5 miles	[redacted] (95% required) 1 within 15 miles	[redacted] (70% required) 1 within 25 miles
Orthodontist	[redacted] (91% required) 1 within 5 miles	[redacted] (95% required) 1 within 15 miles	[redacted] (65% required) 1 within 25 miles
Periodontist	[redacted] (91% required) 1 within 5 miles	[redacted] (95% required) 1 within 15 miles	[redacted] (50% required) 1 within 25 miles
Oral Surgeon	[redacted] (91% required) 1 within 5 miles	[redacted] (95% required) 1 within 15 miles	[redacted] (90% required) 1 within 25 miles
Endodontist	[redacted] (91% required) 1 within 5 miles	[redacted] (95% required) 1 within 15 miles	[redacted] (80% required) 1 within 25 miles

c. Submit the Offeror's Proposed Provider Network Summary Worksheet (Attachment 27), which indicates fulfillment of Urban, Suburban, and Rural network Access requirements as outlined in 3.3 of this RFP.

Confirmed. Our network meets or exceeds all access requirements. Anthem's completed *Proposed Provider Network Summary Worksheet (Attachment 27)* is in Section 9.

d. Carefully read the instructions in Comparison of Current Dental Plan Network to Offeror's Proposed Network (Attachment 29) and complete the Attachment. To do this, identify whether each of the Plan's current Network Providers (from Attachment 30 Utilized Provider Files) will or will not participate in the Offeror's proposed Provider network. Please submit a match and match criteria for every provider listed in Attachment 30.

Confirmed. [redacted]

[redacted]

[redacted]

Anthem followed the instructions in the *Comparison of Current Dental Plan Network and the Offeror's Proposed Provider Network (Attachment 29)* to complete the disruption of the *Utilized Provider File (Attachment 30)* in Section 10.

e. Describe how the Offeror monitors whether network Dental Providers are accepting new patients into their practices, including how the Offeror's proposed access standards consider Dental Provider availability.

[redacted] Our directory is updated daily, and network adequacy is assessed annually. If any gaps or enhancements are identified, additional recruitment efforts are made to ensure future and existing members have appropriate access to care.

We also track and assess the accessibility of care more broadly through quality assurance reviews, member satisfaction surveys, and member requests. If a member is unable to get an appointment with a network dentist, we will reach out directly to the dentist's office to assist with scheduling the member's appointment.

f. Describe the Offeror's process for verifying accuracy of all provider demographic data; including how often the Offeror outreaches to providers, the methods of outreach, and when the updated information is then available on the online provider directory.

Anthem takes directory accuracy seriously and has a dedicated unit whose sole focus is to perform directory accuracy confirmation and outreach ensuring compliance with all state and federal regulations. Our online search tool, Find Care, is updated daily. We use a variety of resources to update and verify provider demographic data including:

- State regulatory agency
- Provider supplied data
- Returned mail
- Provider response to an active mailing

All participating providers are required to complete an initial, rigorous credentialing process to ensure a quality network for our clients. Each prospective dentist must complete a uniform credentialing application. All elements of the credentialing or recredentialing process are managed by our Networks Team; no subcontractors are used. We leverage NCQA credentialing standards and ask each dentist to submit the following:

- A copy of a valid state license to practice dentistry for each state in which the dentist can practice (Primary Source Verified)
- The dentist's Specialty certificate if the dentist declares a specialty - if applicable (Primary Source Verified)
- A copy of a valid Drug Enforcement Agency certificate for each state in which the dentist practices - if applicable (Primary Source Verified)
- The declaration page of the dentist's current malpractice insurance
- Answers to disclosure questions, including malpractice history, provider disciplinary action, and any pending litigation.

Our Credentialing committee reviews all affirmative answers, which meet established review criteria.

We also query the following for all dentists:

- National Practitioner Data Bank (for the history of reported outliers such as malpractice claims, state dental board actions, etc.)
- Office of Inspector General
- System for Award Management

We perform recredentialing every three years consistent with NCQA standards or at a secondary level of credentialing according to the contract and specialty of the dentist. During recredentialing, we require each dentist to verify existing data on file and to send copies of their current license, DEA Controlled Substance Registration Certificate, malpractice insurance documentation, and answers to disclosure questions. We complete website validation at recredentialing similar to our initial credentialing process.

In addition to our robust credentialing process, we continuously reach out to our providers telephonically every 90 days. This is done to verify key data elements in our directories are accurate and up to date, with an exhaustive data confirmation of every single element in our directory confirmed on an annual basis. Any changes identified during that outreach will be updated in our directories within two business days of receipt.

g. Detail those areas, if any, within New York State and outside of New York State where the Offeror's network does not meet or exceed the access guarantees as detailed in Section 3.3 of this RFP.

Even though Anthem's network exceeds all access requirements as outlined in section 3.3, there are Limited Access Service Areas where requirements are not met or may not be possible if no providers are practicing within the required driving distance. All areas with and without access are detailed in the *Offeror's Participating Provider Quest Analytics Report (Attachment 31)* in Section 8. Below are summaries of our accessibility analysis:

Urban

Provider Type	Number of Members	Percentage Without Access
General Dentist	[redacted]	[redacted]
Pedodontist	[redacted]	[redacted]
Orthodontist	[redacted]	[redacted]
Periodontist	[redacted]	[redacted]
Oral Surgeon	[redacted]	[redacted]
Endodontist	[redacted]	[redacted]

Suburban

Provider Type	Number of Members	Percentage Without Access
General Dentist	[redacted]	[redacted]
Pedodontist	[redacted]	[redacted]
Orthodontist	[redacted]	[redacted]
Periodontist	[redacted]	[redacted]
Oral Surgeon	[redacted]	[redacted]
Endodontist	[redacted]	[redacted]

Rural

Provider Type	Number of Members	Percentage Without Access
General Dentist	[redacted]	[redacted]
Pedodontist	[redacted]	[redacted]
Orthodontist	[redacted]	[redacted]
Periodontist	[redacted]	[redacted]
Oral Surgeon	[redacted]	[redacted]
Endodontist	[redacted]	[redacted]

Less than [redacted] of members do not have access to a network provider in urban and suburban areas. We will conduct targeted provider recruitment in rural areas with 10% or greater limited access. This includes focused recruiting of specialists in the following top New York cities:

Periodontists

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Endodontists

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

The top cities outside of New York where we will focus on recruiting specialists include:

Periodontists

- [redacted]
- [redacted]
- [redacted]

Orthodontists

- [redacted]
- [redacted]
- [redacted]

Our focus is to ensure Plan members have continuous access to quality network providers through the term of the Agreement. While Anthem exceeds all access requirements as outlined in Section 3.3, there are Limited Access Service Areas where the requirement is not met or is not possible to be met if no providers are practicing within the required driving distance. We are committed to targeting those areas as part of our Network Recruitment Plan and Guarantee outlined in our response for Section 5.4, item 1h.

Further, if the Department chooses, Anthem will also offer Plan members other options for accessing care beyond services provided in a dentist's office such as:

- Ortho@Home Program - Through our partnership with byte® and SmileDirectClub™, members can receive clear orthodontic aligners from the comfort of their homes.
- Virtual Network Providers - Through our partnership with The TeleDentists®, members can access dental care 24/7/365 for emergencies as well as first-time dental consultations or second opinions.
- Mobile Dental Solution - In areas with high to moderate levels of membership with fewer numbers of network providers, we partner with Jet Dental which provides common dental services such as exams, X-rays, cleanings, and fillings in workplaces and other locations.
- International Emergency Dental Program - Members can receive emergency dental care from our network of credentialed English-speaking dentists while traveling or working in approximately 100 countries throughout the world. Emergency dental care received through this program is reimbursed in full and is not included in the member's annual plan maximums.

h. Outline a plan to address areas within the proposed network that don't have any, or have a limited number of, licensed providers or network providers.

Upon award of the dental contract, we will mobilize a team to identify the top utilized dentists who do not participate in our network and initiate recruitment efforts. A focused component of our recruitment guarantee will be to target Limited Access Service Areas where we are not meeting overall access standards outlined in Section 3.3.

Target Recruitment Plan

We will invest in a targeted and ongoing dentist recruitment campaign as outlined below:

[redacted]

- [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]

  [redacted]
- [redacted]
  - [redacted]
    - [redacted]
      - [redacted]
      - [redacted]
      - [redacted]
    - [redacted]
    - [redacted]
- [redacted]

- [redacted]
- [redacted]

Ongoing Recruitment Plan

- [redacted]
- [redacted]
- [redacted]

Typical Success of Recruitment

Based on our experience, we recommend the Department allow us to include references to the New York State Dental Plan in our recruitment materials. The name recognition of your Plan and the number of Plan members will make a significant difference in bringing additional providers into the network.

Our network recruitment is contingent upon the Department allowing us to use the New York State Dental Plan's name in our recruitment materials, in addition to receiving the necessary data elements to initiate our recruitment efforts.

The Plan's benefit design also directly impacts the dentists' willingness to participate in the dental network. Plan members may receive the best benefit from network providers, which is also extremely helpful in our messaging and recruitment success.

Continuous Network Analysis, Recruiting and Retention

Anthem participates in multiple network studies, which compare non-network usage to industry benchmarks and standards. We use this information when developing detailed and targeted recruitment strategies to maintain robust access to network providers.

We also contract with a third-party vendor to identify all dental providers, the current carriers with which they participate, and whether they participate with Anthem. These studies and resources provide Anthem with the data necessary to recruit dentists and maintain one of the largest dental networks in the nation. We are confident that this data-driven approach will lead to successful recruitment and expansion of our robust network which already exceeds all access requirements.

As part of our reporting package, we will monitor provider retention and employ retention activities including, but not limited to:

- Provider education
- Deployment of special offers
- Fee negotiation
- Enhanced provider service capabilities such as the ability to communicate electronically to minimize provider administrative burden

2. Dental Provider Network Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following program service level standards:
   a. Network Access Urban Areas Guarantee: The Offeror's network cannot provide less than the required network Access-Urban requirements as outlined in Section 3.3.

      Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a single forfeiture amount for each quarter in which urban Enrollees do not have Dental Provider access that meets the network Access-Urban Areas requirements as outlined in Section 3.3. The amount quoted by the Offeror shall be applied only once per quarter for General Dentistry and for each of the individual Specialist types if the Offeror fails to maintain required access in Urban Areas. The quoted access standard is not an overall aggregate of Dental Provider access in Urban Areas (i.e., there is one standard for General Dentists and a standard for each of the individual Specialty types as outlined in Section 3.3). The forfeited amount (Standard Credit Amount) is $15,000.00 for any Dental Provider type, calculated quarterly. An Offeror may propose a higher amount.

      Confirmed. We are exceeding your expectations by increasing our accessibility requirements to the following:

Provider Type	Access Requirement	Urban Required Access	Anthem's Proposed Access
General Dentist	2 within 5 miles	98%	[redacted]
Pedodontist	1 within 5 miles	91%	[redacted]
Orthodontist	1 within 5 miles	91%	[redacted]
Periodontist	1 within 5 miles	91%	[redacted]
Oral Surgeon	1 within 5 miles	91%	[redacted]
Endodontist	1 within 5 miles	91%	[redacted]

[redacted] Please refer to Section 5 for the completed Attachment 6.

b. Network Access Suburban Areas Guarantee: The Offeror's network cannot provide less than the required network Access-Suburban requirements as outlined in Section 3.3.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a single forfeiture amount for each quarter in which suburban Enrollees do not have Dental Provider access that meets any network Access-Suburban Areas requirements as outlined in Section 3.3. The amount quoted by the Offeror shall be applied only once per quarter for General Dentistry and for each individual Specialist types if the Offeror fails to maintain required access for any Dental Provider type in Suburban Areas. The quoted access standard is not an overall aggregate of Dental Provider access in Suburban Areas (i.e., there is one standard for General Dentists and a standard for each of the individual Specialty types as outlined in Section 3.3). The forfeited amount (Standard Credit Amount) is $15,000.00 for any Dental Provider type, calculated quarterly. An Offeror may propose a higher amount.

Confirmed. We are exceeding your expectations by increasing our accessibility requirements to the following:

Provider Type	Access Requirement	Suburban Required Access	Anthem's Proposed Access
General Dentist	2 within 10 miles	98%	[redacted]
Pedodontist	1 within 15 miles	95%	[redacted]
Orthodontist	1 within 15 miles	95%	[redacted]
Periodontist	1 within 15 miles	95%	[redacted]
Oral Surgeon	1 within 15 miles	95%	[redacted]
Endodontist	1 within 15 miles	95%	[redacted]

[redacted] Please refer to Section 5 for the completed Attachment 6.

c. Network Access Rural Areas Guarantee: The Offeror's network cannot provide less than the required network Access-Rural requirements as outlined in Section 3.3 .

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a single forfeiture amount for each quarter in which rural Enrollees do not have Dental Provider access that meets any network Access-Rural Areas requirements as outlined in Section 3.3. The amount quoted by the Offeror shall be applied only once per quarter for General Dentistry and for each Specialty type if the Offeror fails to maintain required access for any Dental Provider type in Rural Areas. The quoted access standard is not an overall aggregate of Dental Provider access in Rural Areas (i.e., there is one standard for General Dentists and a standard for each of the individual Specialty types as outlined in Section 3.3). The forfeited amount (Standard Credit Amount) is $15,000.00 for any Dental Provider type, calculated quarterly. An Offeror may propose a higher amount.

Confirmed. We are exceeding your expectations by increasing our accessibility requirements to the following:

Provider Type	Access Requirement	Rural Required Access	Anthem's Proposed Access
General Dentist	2 within 20 miles	95%	[redacted]
Pedodontist	1 within 25 miles	70%	[redacted]
Orthodontist	1 within 25 miles	65%	[redacted]
Periodontist	1 within 25 miles	50%	[redacted]
Oral Surgeon	1 within 25 miles	90%	[redacted]
Endodontist	1 within 25 miles	80%	[redacted]

[redacted] Please refer to Section 5 for the completed Attachment 6.

5.5 Customer Service

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to meet the Customer Service requirements specified in Section 3.4 of this RFP, including the following:

Our approach to serving members is based on a "one call, one contact, one solution" philosophy. Members can reach the Plan's dedicated Customer Service call center via voice call or by using our online chat feature via anthembluecross.com or the Sydney Health mobile app. We staff our dental Customer Service call center with associates dedicated 100% to dental benefits and claims and will offer a team within this call center that will be 100% dedicated to Plan members. This includes specialized training in dental benefits, claims processing, grievances and appeals, and troubleshooting methods for members experiencing concerns with web access, log-in issues, and provider searches.

Each dental Customer Service representative (CSR) will have real-time access to the Department's overall program structure and benefit details as well as member claims and details through our online customer relationship management (CRM) system.

While staffed with dedicated CSRs to handle member and provider calls, your dedicated team will be supported by designated resources including an aligned manager, employer service representative (ESR), and operations experts (OEs) in partnership with your Account Team to ensure seamless day-to-day service for Plan members. This may include supporting training activities, ongoing review and revisions of policies and procedures, or assisting with member inquiries.

Your ESR will act as a supervisory level, direct contact serving the dedicated team with day-to-day questions and inquiries. The ESR will collaborate with the dedicated Enrollment, Claims, and Customer Service Teams, the Account Team, and any other support staff necessary to resolve escalated service and claims matters.

Our OEs will be readily available to offer technical direction, guidance, and resources on a day-to-day basis for the dedicated CSRs. This assistance includes complex case research and resolution. They will review, interpret, and maintain records of service level, quality, accuracy, and productivity.

a. Summarize how Offeror will comply with federal and State law to assist Members who need translation services.

Services for Hearing Impaired Members

Our Customer Service Center meets all standards for the Americans with Disabilities Act. To assist the hearing and speech impaired we utilize the 711 telecommunications relay service.

Language Translation Services

Anthem is compliant with all state and federal language assistance mandates. If a member is requesting support in a different language, our dental CSRs can communicate with members in more than 200 languages. Some of the languages include Cantonese, Japanese, Korean, Mandarin, Portuguese, Russian, Spanish, and Vietnamese. We also have dental CSRs who are Berlitz-certified in Spanish to assist in translation and interpretation requirements as needed for members.

Translation services are also available for our dental network providers who may be serving non-English speaking members.

b. Summarize how Offeror will track calls for reporting and change phone prompts and voice recordings as needed, without an additional charge to the State.

Our CRM tracking system is used to document all calls and chats, which ensures timely response and follow-up for members. Calls and chats will be tracked at a granular level including member complaints, requests for provider directories, benefit booklets, dental office selection, claims adjustments made, and more for proactive trend analysis that enhances service and satisfaction.

The call tracking system generates open inquiry reports, and we can sort the data to identify specific populations' open inquiries. We log 100% of all incoming and outbound calls in our CRM tool. Calls are available in the Verint recording system for immediate retrieval for 180 days. Calls are also archived for 10 years using a different protocol.

All calls to our Customer Service Center will be routed to our interactive voice response (IVR) system. Upon entering the IVR system, callers will be asked to identify if they are a member, health benefit administrator, or provider. If the caller is a member, the system will ask for information from the member's ID card for verification purposes. Once this information is entered, the member can either be transferred to a live CSR or remain on the line to access self-service options. Live CSRs are available Monday through Friday from 8 a.m. to 8 p.m. ET. Through our IVR, members can access eligibility, benefits, deductibles, coverage, and claims processed information. Members can also request assistance to find a provider.

We will collaborate with the Department regarding the IVR and phone prompt customizations. Customizations are included in our fee and will be shared with the Department before use. Should a customization not be supported by our CRM we will discuss viable alternatives to avoid additional charges to the Department.

At no additional charge, we will also provide a custom toll-free number for the Department and work with you to create a custom greeting for the Plan. Custom greetings may be changed throughout the year to address items such as open enrollment messaging or promotion of benefits to improve members' oral health.

c. Indicate the hours the Call Center will be available to members and staffed with CSRs in compliance with Section 3.4.

The dedicated Customer Service department will be staffed and available to take calls Monday through Friday from 8 a.m. to 8 p.m. ET (except for the legal holidays observed by the Department). These hours can be adjusted to align with other components of the Department's health plans, such as the Hospital Program, upon request.

The dental telephone line will be operational and available to members and providers equal to or better than the [redacted] required uptime and [redacted] blockage rate.

d. Describe the Call Center technology that will be utilized for the Dental Plan, and a description of customizable options, if any, Offeror proposes for the Dental Plan.

We designed our systems to anticipate members' needs and to continually exceed your service expectations. As part of our commitment to delivering excellent service, we consistently monitor all our systems and look for areas of improvement to serve our clients better.

We enhance the member experience by using these fully automated interfaces:

- A proprietary CRM tracking system gives our team of dental CSRs and claims analysts the most up-to-date claims information as well as historical call data to respond to members' inquiries quickly and efficiently. Unlike third-party software, our proprietary CRM is seamlessly integrated with our eligibility, claims, grievances and appeals, and related modules for real-time access to member information.
- Our proprietary Sydney Health desktop and mobile app gives our members direct access to dental CSRs through a live chat feature Monday through Friday from 8 a.m. to 5 p.m. ET while also offering the most up-to-date claims information to resolve members' inquiries quickly and effectively. Members may also view benefits, and fully engage in their oral health with our dental cost estimator and dental health assessment tools.
- Members can contact Anthem through the Support page on the Plan's custom website. Once members register on the website, this feature will simplify service, and offers the following benefits:
  - Quick access
  - Intuitive navigation
  - A secure message center to communicate with the Customer Service Team
  - Links to common information and services

Quick Access

Members can quickly and easily access the Support page anywhere within the secure website, simplifying the online experience for members.

Intuitive Navigation

The Support page allows members to view important information such as:

- FAQs
- A thorough glossary of common health terms
- Contact information for our Customer Service unit and technical support
- Secure Message Center

Within the secure online experience, we know each member's state of residence and members can view telephone numbers and contact information specific to their state.

Secure Message Center

Members can use the Message Center functionality to send and receive secure messages directly with our Customer Service unit. They will also see alerts specific to them via the secure Message Center. When not logged in to our website, users can submit questions through an email form.

Our website is an essential component of the consumer experience with Anthem. The Support page makes it simple for members to find important information and contact us. Members will benefit from our commitment to putting members first, as well as continuous improvement, which is exemplified in our member website strategy.

- An IVR system that prompts members to either continue through the IVR for self-service or speak with a live dental CSR. Members can access our IVR system 24/7 for help finding a provider, and accessing eligibility, benefits, and claims information.

Our proposal includes no-cost, customizable solutions to Call Center technology including:

- Custom toll-free number
- Customized greetings for members and providers
- IVR call prompts for call routing
- Access to our unique Open Enrollment Solutions Team with a dedicated toll-free member and tailored open enrollment support designed for member open enrollment questions about benefits, and everyday questions specific to members' unique circumstances

Our Open Enrollment Solutions Team will support the Department by hosting both virtual and onsite open enrollment meetings using leading technology tools. These tools include Brain Shark videos, the use of webinars, and even gamification to help connect with members during open enrollment to learn more about the benefits available to them.

e. Provide a narrative on the Call Center which describes the information and resources that will be available to CSRs to assist them in addressing and resolving inquiries; the internal controls and reviews that will be performed to ensure quality service is being provided to Members; including outlining if there is a Quality Assurance team of representatives to monitor and develop the CSR staff; the first call resolution rate for the proposed call center; Offeror's company-wide average staff and turnover rate for call center employees; the proposed staffing levels; and how Offeror will ensure adequate staffing during call volume peaks. Explain the logic used to arrive at the proposed staffing levels, including the ratio of management to CSR staff.

Your dedicated dental Customer Service Team will assist callers with the following:

- Verification of coverage
- Provider status and information
- Claim status and benefit information
- Facilitate service requests for provider listings, benefit books, member ID cards, duplicate explanation of benefits (EOBs), re-adjudication, reconsideration of claims, and simple claim adjustments

Call Center Resources

If a CSR is unable to resolve a member issue, we seamlessly incorporate the following resources:

- OEs with an extensive background in escalated customer services and claims processing procedures, guidelines, and application of benefits
- Employer service representatives for direct contact and a liaison for the Account Team who will work directly with the Department on any escalated service and claims issues

Call Quality

A total of six calls per month per dental CSR will be audited by the Performance Quality Audit department. Two calls per month are audited for soft skill utilization as well as four call audits per month for call accuracy.

The Performance Quality Audit department audits CSR calls for accuracy. Calls are digitally recorded to audio video files, reviewed, and feedback is shared with CSRs. After being randomly selected from the current month file universe the call audio samples are available to the audit staff via a Verint 15.2 Quality Management (QM) program. The calls are audited within the QM application, and the call audit results are provided as audited to the CSRs, OEs, and Customer Service managers. Each month Performance Audit is responsible for listening to and scoring a minimum of four accuracy calls per CSR.

Customer Service Soft Skill Call Auditing

The Performance Audit department also performs Soft Skill audits. The results are shared with the dental CSR and Customer Service management as indicated above to provide feedback for training and coaching purposes. Performance Audit evaluates the following six main categories within each call:

- Introduction
- Communication
- Attitude
- Proactive response
- Complete/correct information
- Closing of the call

Each main category above also includes several subcategories we monitor.

First Call Resolution

We resolved an average of [redacted] of issues during the first call for the past five years. Year to date, we have a first-call resolution rate of [redacted].

Turnover Rate

In 2022, we had a turnover rate of [redacted] for CSRs, which was greatly influenced by the abatement of the COVID-19 epidemic and robust job prospects. Year to date, we had a [redacted] turnover rate as the job market has begun to cool and we continue our investments in CSR retention and career progression.

Proposed Staffing Levels and Logic

We propose a dedicated team of [redacted] CSRs to handle the Plan's calls. Our ratio of manager to call center associates is [redacted] and we staff [redacted] This team will be fully trained on your account and available to take calls 45 days before the contract's effective date. Each representative will have real-time access to your overall program structure and benefit details through our CRM system.

This staffing model is based on leveraging analysis and the use of a workforce management platform that controls team caseloads through a performance and capacity matrix that includes:

- Expected service level performance such as "average speed of answer" of all inbound service demand channels
- Analysis of the "arrival time" and frequency of service demand by channel
- Daily reporting and aging assessment (timeliness) of interaction inventory, by agent, and by team using similarly situated clients
- Schedule adherence, availability, and forecast measures to ensure our CSRs are efficient and scheduled at the appropriate times

The Department can be confident in our proposed staffing model as the collaboration with our Workforce Management Team ensures appropriate staffing levels, including during peak periods such as open enrollment and holidays. Weekly meetings with the Workforce Management Team will be held to ensure adequate staffing and discuss call center performance and staffing. Our staffing requirement projections are based on factors such as historical data and scheduled growth as well as actual performance.

Call Volume Peaks and Backup Support

To ensure adherence to performance metrics and member satisfaction, we will also train an additional pool of dental CSRs for backup support to assist members during peak call volumes, which typically occur during open enrollment. Should a dental CSR from your dedicated team leave, we will advance a dental CSR from this pool of backup support to fill the position.

The Department's dedicated team of CSRs, as well as the Account Team, will provide culture training to ensure the backup CSRs are fully knowledgeable of the Department's standards and expectations.

f. Describe the back-up systems for Offeror's primary telephone system which would be used in the event the primary telephone system fails, is unavailable or at maximum capacity. If a backup system is activated, explain how and in what order calls from Members will be handled. Confirm whether backup staff will have Dental Plan specific training. Indicate the number of times a backup system has been utilized over the past two years. Confirm that calls will be handled exclusively by Offeror's Call Center and that the backup call center would only be used in case of system failure or call overflow.

As part of our Business Continuity Program, the Disaster Recovery Plan provides for the recovery of system infrastructure, data, and applications. In the event we need to implement our disaster recovery plan for the telephone system, you can rest assured Dental CSRs will be ready and available to take your calls. A seamless continuation of service includes the following safeguards:

Contingency

We maintain a documented and tested Disaster Recovery Plan for our IT infrastructure for both voice and data center services. We have an owned, remotely located disaster recovery "hot site" data center with implemented remote data replication and redundant high-availability network capabilities. This data center is geographically isolated and capable of supporting the full workload of any corporate production data center. This state-of-the-art recovery facility has been certified by the Uptime Institute as a Tier III data center. The recovery facility does not rely on third-party vendors for hot sites for our corporate production data centers. Our Corporate Data Centers and networks have been designed to provide high levels of security and availability. In the event a backup system is needed, this would be our first line of defense and would be a relatively seamless solution without a need to prioritize member calls — it becomes a turnkey solution with rapid deployment to ensure member call center availability and service standards.

In the event the first line of defense does not adequately serve as a backup solution, Anthem has implemented and maintains a substantial workspace recovery capability utilizing a combination of resources, including network redirection of work, Anthem-owned worksite recovery capacity, and mobile recovery resources with secure satellite connectivity for voice and data.

The "Mobile Recovery Strategy Solution" provides for up to 500 call center seats on a scaled basis within 96 hours following an unplanned event. Solution components include — two owned technology vans (satellite connectivity for voice and data with bandwidth equivalent to two DS-3s), VOIP phone switch (ACD) for 500 seats/1,000 lines, servers, data switches, on-board generator, and HVAC, two satellite ground stations, two mobile satellite units (data connectivity for 1,000 seats each including servers, data switches, on-board generator and HVAC, and PCs to use with mobile recovery seats for scaled delivery within 96 hours following declaration.

If this second line of defense gets deployed, Anthem will prioritize member calls before provider calls and give precedence to members with access to care and emergency treatment inquiries using our CRM solutions that include IVR prompts. Any remaining calls will be triaged based on volume and staffing.

Our backup systems have not been used over the past two years; however, we test our business continuity plan semi-annually to ensure readiness in the event a backup system is ever warranted due to unforeseen circumstances including natural disasters.

Staffing

With our sizable work-at-home population, we are less reliant upon on-premises infrastructure to support our call centers. Back-up call center capabilities for the Plan will include the availability of experienced dental CSRs who are fully trained to provide backup support for your members and their families as needed. In the event of a system failure or the need for overflow call support, our backup solutions will only use Anthem CSRs trained to support the Plan. Backup support will never be outsourced to third parties.

g. Define how frequently Offeror conducts customer satisfaction surveys for large clients as defined above. Include whether the Offeror conducts a customer satisfaction survey or if surveys are performed by an independent third party. Please provide a sample of a survey Offeror used for a large client and advise of the typical response rate for a large client.

Plan members will be put first in everything we do. We measure satisfaction through our member satisfaction survey, which is designed to gauge general satisfaction with the plan, customer service interactions, and overall call experiences. The focus of the survey is to pinpoint what is most important to members.

Surveys are conducted monthly by Anthem via U.S. mail. We draw members from an aggregate list of claimants with recently adjudicated claims, giving us a standard sample size that typically equates to [redacted] of the overall membership. This is a statistically relevant sample size balanced against average response rates.

To provide a more convenient means of collecting feedback from members, we continue to evaluate other methodologies including telephonic and email-based survey options. We are open to discussing specific survey methodologies, including third-party vendor solutions, with the Department. Surveys can be issued and tracked specifically to Plan members. In 2022, we mailed out roughly [redacted] surveys to our large clients. The [redacted] respondents scored us favorably, with [redacted] providing Anthem with a positive rating for overall service quality.

Please refer to Section 12 for the sample survey.

h. Detailed information about the physical location(s) where call center and customer service work shall be performed. [Note: In accordance with New York State Labor Law section 773, the head of each State agency is required to use reasonable best efforts to ensure that all state-business-related contracts for call centers and customer service work be performed by contractors, agents, or subcontractors entirely within the State of New York.]

Our dental headquarters and primary operations center is located in Mendota Heights, Minnesota. As a result of the pandemic, we instituted a hybrid workforce model whereby associates may choose a mix of remote and in-office work schedules. This hybrid workforce model provides robust business continuity planning in the event of unforeseen circumstances by enabling work in various locations, with strong checks and balances to ensure HIPAA compliance and secure data exchanges.

We expect the hybrid workforce model to continue into 2024 - 2025 and anticipate the majority of our associates will continue working remotely. We are committed to providing a more flexible, supportive, and productive environment for all associates which in turn enables us to deliver strong performance outcomes to our partners and the Plan. Our office locations are equipped with tools and technology to support both in-person and virtual collaboration.

As part of our proposal, the entire team of dedicated CSRs will be hired and located in New York to serve the Plan's members. We will also assess our remaining customer service staffing models and upon award of the contract, we will make a good faith commitment to hire a hybrid workforce located in New York to perform claims processing, grievances and appeals, and related customer service functions as appropriate.

2. Call Center Telephone Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following four plan service level standards:

In 2022, we met [redacted] of our dental performance guarantees and are on track to meet [redacted] of our dental performance guarantees in 2023.

a. Call Center Response Time Guarantee: 90% of incoming calls to the Offeror's telephone line must be answered by a CSR within thirty seconds.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which the number of phone calls answered within thirty seconds falls below 90% of all incoming calls. The forfeited amount (Standard Credit Amount) is $15,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

[redacted] Please refer to Section 5 for the completed Attachment 6.

b. Availability Guarantee: The Offeror's telephone line must be operational and available to Members and Providers equal to or better than 99.5% percent of the Offeror's required up-time from 8:00 am through 5:00 p.m. ET, Monday through Friday, except on legal holidays observed by the State.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which the Offeror's telephone line is not operational and available to Members and Providers 99.5% percent of the time. The forfeited amount (Standard Credit Amount) is $15,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

[redacted]

- [redacted]

[redacted]. Please refer to Section 5 for the completed Attachment 6.

c. Telephone Abandonment Rate Guarantee: No more than 3% of callers to the Offeror's telephone line will disconnect a call prior to the call being answered by a CSR.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which more than 3% of callers disconnect a call prior to the call being answered by a CSR. The forfeited amount (Standard Credit Amount) is $15,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

[redacted]

[redacted] Please refer to Section 5 for the completed Attachment 6.

d. Telephone Blockage Rate Guarantee: No more than 0% of incoming calls to the Offeror's telephone line shall be blocked by a busy signal.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which more than 0% of incoming calls to the Offeror's telephone line are blocked by a busy signal. The forfeited amount (Standard Credit Amount) is $15,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

[redacted]. Please refer to Section 5 for the completed Attachment 6.

5.6 Member Communication Support

The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to develop Member communications specified in Section 3.5 of this RFP, including the following:

1. Describe the role of the Offeror's legal department as it relates to the preparation of Communication materials and ensuring that materials accurately reflect any benefit changes required by law or regulation.

   We have a rigorous legal and compliance review process as part of our standard operating procedure. This process ensures communications adhere to state and federal law and any CMS requirements when appropriate. Our Marketing managers will submit materials for review by our Marketing Compliance, New York Local Compliance, and Local Legal Team before final release. The reviews and approvals are then documented within our project management system.

2. Provide two examples of recent (within the last three years) communications the Offeror has developed and distributed on behalf of other clients.

   Confirmed. Anthem has extensive experience developing and customizing a full spectrum of communications materials designed to drive unique messaging. Please refer to Section 13 for sample communications we have developed and distributed on behalf of other clients within the last three years.

3. Describe the Offeror's approach to developing appropriate customized forms, letters, and SBCs for the Dental Plan Services, incorporating the Department's feedback.

   The Marketing Team will work with the Account Team to determine the scope of needs and the timing of each request. We will seek to understand the Department's goals and objectives for each customized form or letter and SBCs. We will leverage available material where and when appropriate. A creative brief will be developed for complex projects and the Department's approval before kickoff. Marketing will then establish rounds of reviews and feedback with collaboration from the Account Team for quality control and accuracy. Timelines will be developed to support each project and communicated to all stakeholders to ensure alignment and accountability for associated tasks. Marketing will ensure legal reviews are completed before the release of materials. A final draft of materials will be provided to the Account Team for distribution to the Department. Once approved, a final version will be sent to the Department.

4. Provide information about how the Offeror has worked with other large clients to produce customized communications. A large client is defined as an entity with over 50,000 or more covered lives.

   Anthem has deep expertise with focused communication plans for large clients that allow us to develop a communications experience that will resonate with members. We have decades of experience partnering with large clients to create a holistic and unified plan that can be delivered through your existing communication channels.

   The key to a successful enrollment is the ability for Plan members to view their dental plan details and make an informed plan selection leading into the open enrollment period.

   When it is determined custom communications are needed, we start by collaborating with the client to fully understand the client's goals and objectives. With that information in hand, we can develop a communications plan, using data and metrics, to drive the desired targeted outcomes.

   ### Timing

   When possible, it is best to create an annual member communications plan for a client, but when a specific need comes up, the Account Team will engage with Marketing as quickly as possible to ensure we have the time to develop and deploy a custom communication plan.

   If a more robust campaign is needed, development may take 4 to 6 weeks.

   - Request and receive employee data files (10-days).
   - Customize content/design and layout, as well as proofing, brand review, and client approval (2 to 3 weeks).
   - Set up print/digital deployment (2 weeks).

5. Describe the resources that will be available to the Department to support the Department's development of various Enrollee communications and the ability to provide input into such communications process quickly.

   The Account Team will have direct access to the Marketing Team and will serve as the liaison between the Department and the Marketing Team. The Account Team will ensure that adequate marketing resources are available to develop or provide input back to the Department promptly.

   The Marketing Team consists of a director and three marketing managers who will be available to assist with the development of the Plan's custom communications. They are supported by an in-house creative studio, project managers, and a member engagement Marketing Team that is focused on driving member engagement through data-driven insights. When appropriate, the New York Marketing Team will engage with the appropriate areas to ensure timely reviews and input are provided to the Department to support their goals.

6. Confirm the commitment to work with the Department to develop appropriate customized forms and letters for the Programs. Provide examples of how the Offeror has worked with other large clients to produce customized communications.

   Confirmed. The Marketing Team will work with the Account Team to determine the scope of needs and timing of each request. We will seek to understand the Department's goals and objectives for each customized form and letter and will leverage available material where and when appropriate. A project plan will be established to ensure alignment before work begins. For larger projects and programs, we will develop a creative brief for the Department's approval. Marketing will then establish the rounds of reviews and feedback and work hand-in-hand with your Account Team for quality control and accuracy. Marketing will ensure legal reviews are completed before the release of materials. Final materials will be provided to the Account Team for distribution to the Department and filed within our database.

   Through our customized communications efforts and strategies for other large clients, the following comprehensive communications materials have been created and distributed:

   - Welcome brochures
   - Posters
   - Direct mail campaigns
   - Flyers
   - Postcards
   - General health and wellness communications
   - Reference guides and frequently asked questions (FAQ)
   - Videos and demos

7. Describe how dependents will be notified of their upcoming ineligibility for dental services due to age and the requirement of providing a full-time student attestation form to maintain eligibility. Please provide examples of the proposed attestation form.

   Full-time student attestation forms will be sent to subscribers 60 days, and if necessary due to no response, 30 days before their dependent reaches age 19 and before the expiration of a dependent's full-time student status. We will also post full-time student eligibility requirements on the Plan's custom website along with the attestation form. We will accept completed forms via mail, email, or fax.

   Please refer to Section 14 for the sample proposed attestation form.

8. Confirm that staff will be available to attend Health Benefit Fairs, select conferences, and benefit design information sessions, in New York State and elsewhere in the United States. Describe the experience and qualifications of staff that will be attending these events.

   Confirmed.

   Sandy Bogen, Strategic Account Consultant has more than 30 years of industry experience. She has in-depth knowledge of dental plan benefit design and administration and will support the Department with benefit fairs, conferences, and benefit design information sessions.

   As we want your members to understand the benefits and the power of keeping up with dental checkups, we will offer additional support during open enrollment periods through event representation and customized, educational materials.

9. Describe how the online directory will be available to Members 24 hours a day, 7 days a week, 365 days a year and the anticipated protocol for updating the site for regular maintenance; the amount of time it will take Offeror to add or remove Dental Providers from the directory upon joining or leaving the network; and what controls will be in place to ensure the listed information is accurate and up to date.

   Our online provider directory is available to members 24 hours a day, 7 days a week, 365 days a year with minimal downtime for routine maintenance. The maintenance process is transparent and done behind the scenes so members will have access to the online Find Care tool without disruption. The Directory Accuracy Team is dedicated to the integrity of our provider data. They ensure we comply with New York state and federal directory accuracy requirements, including those associated with the Consolidated Appropriations Act (CAA).

   We have an auditable process to demonstrate compliance status, our progress, and action items. These are in addition to our standard protocols relating to quality audit controls for provider data integrity and entry. With continuous telephonic outreach to our providers required every 90 days, we verify key data elements in our directories to ensure the information is accurate and up to date. These elements include:

   - Provider name
   - Specialty
   - Office locations
   - Telephone number
   - Email address

We also perform exhaustive confirmation of every data element in our directory on an annual basis such as:

- Certifications
- Languages spoken by staff
- License number
- Type of license
- National Provider Identifier (NPI)
- Handicap accessibility
- Wheelchair accessibility
- TIN
- Office hours

Any changes identified during provider outreach efforts are updated in our directories within two business days of receipt, or according to contractual obligations depending on the type of update. Our Dentist Provider Agreements include language that requires the dentist to notify us at least seven calendar days before any demographic changes to assist with keeping their information current for claims and directory updates.

10. Detail the Offeror's experience in working with large clients (defined above) who have required customized websites or web portals for benefits information. Offerors who can provide links to those customized websites for the Department's review will be scored more favorably.

We have extensive experience developing customized websites for large clients. Anthem can create a custom-built website for the Plan similar to what we designed for the Hospital Program. The dental website can include access to benefits-related information, services, and forms. We will collaborate with the Department to update content as required. The website can be accessed without a password during open enrollment and remains open all year. Once a member becomes active with coverage, they can register for secure account services on the dedicated website that will be developed for the Plan.

The link to the existing custom website for the Hospital Program is empireblue.com/nys. The following are some links for other examples of custom sites we have created for large clients:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

11. Complete a second Biographical Sketch Form (Attachment 14), for all staff proposed for involvement in the Member Communication Support process.

    Confirmed. The following members of the Department's Account Team will be involved in the member communication support process:

    - Jill Atwood, Director, Marketing
    - Sandy Bogen, Strategic Account Consultant
    - Josh Kahn, Staff VP, Digital
    - Asea Safgren, Director, Specialty Administration

    Please refer to Section 3 for their completed Biographical Sketch Forms (Attachment 14).

5.7 Reporting Services

The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in the Reporting Services as specified in Section 3.6 of this RFP, including the following:

1. The Offeror must submit examples of the financial and utilization reports that have been listed without a specified format in the reporting requirements above as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the Dental Plan. Provide an overview of the reporting capabilities with the value it is believed the reporting capabilities will bring to the Dental Plan, including:

    Confirmed. Please refer to Section 15 for the sample reports available.

    In-depth, dental-specific reporting is a vital core component of our dental systems, not an add-on or patch to the medical system as some carriers do. This allows us to deliver a comprehensive suite of meaningful management reports that will help the Department evaluate plan performance and manage costs, including dental utilization analysis and network detail.

    Simply stated, our detailed reports will give the Department a clear picture of how efficiently the Plan is operating and what benefits members are accessing — measuring the true and overall value you and your members are receiving. Our proposal of a well-run dental benefits plan will provide members with access to see the dentist regularly, which is by the far most important factor in long-term oral and overall health.

The Department will be provided with the following standard reports:

- Enrollment and Paid Claims provides an at-a-glance look at your claims and enrollment experience. It identifies the number of claims processed and the claims dollars paid by the month and also includes the number of subscribers enrolled for each coverage type.
- Payment by Benefit Level includes a split of paid claims by benefit level, coverage type, relationship type, or network (in-network versus out-of-network).
- Cost Containment Summary identifies network savings, but also breaks down the contracts/history savings category into two areas: plan design savings and plan administration. We include additional detail in each area to easily identify exactly where savings are derived. For example, the report details the dollars saved by using our dental contracted network dentists versus out-of-network dentists, thus capturing the value our dental network brings to you and your members.
- Provider Network Utilization identifies the number of patients, providers, claims, and claims dollars by network and out-of-network providers.

The following reports are nonstandard but available to the Department upon request:

- Claim Turnaround Time captures the percent of claims paid within 0-14 days and 0-30 days for the current period and prior period.
- Top 25 Providers recaps the top 25 providers including the number of paid claims, paid claims amounts, and network status (in-network or out-of-network) for each provider.
- Annual Maximum Summary provides the number of members and the percentage of the total members who have met the annual maximum.
- Average Claim Cost identifies the average claims cost by relationship type (subscriber, spouse, dependent) and the total number of claims and procedures during a given timeframe.
- Lag shows, by month, the date the claims were incurred and the date the claims were paid.
- Membership Demographics show the average number of members by coverage and relationship type, as well as membership by age bands and the number of females versus males, and the claims paid for these categories.
- Top Three Procedure Codes provides the top three ADA procedure codes per dental category by paid claims dollars.
- Paid Claims by State shows claims paid based on the state.

a. How reports will be provided in the specified format (paper and/or electronic Microsoft Access, Excel, Word), as determined by the Department;

We can provide our reports in the Department's specified format and preferred frequency. Our Financial, Survey, Service Benefit, and Performance Guarantee reports are typically provided in an Excel or PDF file format and will be emailed to the Department by the Account Team.

b. Confirm that the ability and willingness to provide ad hoc Reports and other Data analysis. Provide examples of ad hoc reporting that have been performed for other large clients.

Confirmed. We will produce ad hoc reports as requested by the Department.

As one of our most valued customers, we will also produce comprehensive Dental Whole Health reporting for the Department. This specialized reporting includes access to members' utilization and experience information and improves your ability to make plan design enhancements focused on specific challenges and opportunities. Reports will be emailed to the Department by the Account Team annually. This type of reporting will prove most beneficial after accumulating trended years of data.

The following personalized reports will help the Department see trends and gain new insights into your Plan:

- Dental Financial and Utilization Summary displays the paid amount by employee trend and peer group comparison, and the factors driving changes or differences.
- Enrolled Member and Benefit shows the demographic distribution, dental benefits, and members' benefit plan selections over the years.
- Members Receiving Dental Care demonstrates the prevalence of using dental care or routine/preventive dental care, stratified by member demography, dental coverage type, etc.
- Dental Services Received breaks out the differences in dental services utilization at different age levels.
- Cost Containment segments the total cost contained (administrative plan savings and benefit plan savings) by provider network savings, UCR, alternative benefit, eligibility, duplicate bills, frequency limits, missing information, contracts and history, COB, deductible, coinsurance, annual maximum, and utilization review, etc.
- Preventive Dental Care Visits illustrate the importance of routine diagnostic and preventive services and the impact to follow-up services.
- Sealant or Fluoride Visits illustrate the specific preventive services rendered for children and their impact on follow-up costs.

Benchmark data can also be included in your monthly, quarterly, or annual reports. The benchmark data will only change annually.

Please refer to Section 15 for sample reports.

2. Reporting Services Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that all Dental Plan management reports and claim files listed in Program Reporting (Attachment 17) will be accurate and delivered to the Department no later than their respective due dates. The Offeror shall propose the forfeiture of a specific dollar amount of the Offeror's Administrative Fee for failure to meet this guarantee.

   Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each Calendar day the Department has not received the Dental Plan management report and claims file by their respective due date. The forfeited amount (Standard Credit Amount) for each management report or claim file that is not received by its respective due date is $100 per calendar day per report. However, an Offeror may propose a higher amount.

   [redacted]

   Please refer to Section 5 for the completed Attachment 6.

5.8 Enrollment Management

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to manage enrollment Data as specified in Section 3.7 of this RFP, including the following:
   a. Offeror's testing plan to ensure that the initial enrollment load and daily enrollment transition files for the Plan are accurately updated to Offeror's system and that such files interface correctly with Offeror's claims system.

      As Anthem already takes in a daily Electronic Enrollment Transaction (EET) file for the Hospital Program, we will leverage our existing procedures to establish the Dental Plan's eligibility file process. The EET Team will work with the Department to ensure enrollment files are uploaded to our system timely and accurately. We will review the test files and provide feedback to the Department during the development of the enrollment file. We perform full production parallel testing to ensure data accuracy, comparing each member's record against membership data to determine if it is an add, change, or termination of coverage (terminations by omission are identified in the case of full population files). We will send unresolved discrepancies to the Department. Once file feeds are signed off by both parties, the file feed settings will be changed to allow production files.

      Making sure the initial enrollment is loaded and previous service dates are added to our claims system are some of the most important items we will address during implementation. We have provided dates for testing eligibility files as well as receiving and loading prior service from the incumbent carrier. After testing, an error report will be created and discussed as needed to ensure operational readiness. Knowing the incumbent carrier will be processing claims beyond the contract effective date, we will schedule times to receive additional claims files to ensure all utilization of the dental benefit is captured.

Our claims system is fully integrated with all cross-functional departments, providing checks and balances to ensure only eligible members receive verification for service and that correct reimbursement is sent to providers and members. It is designed to process claims from initial submission, either electronically or by mail, through payment to the provider or member, and billing to the Department.

The system has been modified over time to support detailed business needs. It enables network providers to submit claims electronically through a dedicated web portal. Providers must register and create a secure account using their unique provider ID assigned by Anthem. All information is password-protected. It is key to note that in 2022, [redacted] of in-network claims were submitted electronically ensuring that claims are processed quickly and accurately.

The testing plan must include:

i. The quality controls that are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system.

   In the production environment, there will be tolerances based on activity levels (percentage limit of adds, terms, errors, etc.), which if not met will require an Anthem EET resource to review the results and determine if the file can be run. This occurs the same day for change files and within 24 hours for full population files.

   In addition, we schedule future expected file dates. If we do not receive a file when expected, the EET Team will receive an alert and follow up with the Department. We will also accept and process a quarterly reconciliation file to ensure the enrollment in Anthem's system is accurate and up to date. Any discrepancies between Anthem's system and the reconciliation files will be reported back to the Department for review and guidance.

   We have noted key milestones in our implementation plan which includes auditing plan set up. We conduct internal audits and system testing to ensure plans are set up accurately and claims payments are processing accurately. In addition to our internal audit, we can coordinate with the Department to schedule a virtual meeting so we can share our screen showing sample claims processed based on the dental benefits coded in our system.

ii. How the Offeror's system identifies transactions that will not load into Offeror's enrollment system. How exceptions are identified that will cause enrollment transactions to fail to load into Offeror's enrollment system. What steps are taken to resolve the exceptions, and the turnaround time for the exception records to be added to Offeror's enrollment file.

   We currently process an average of 1,500 eligibility transactions per day for the Hospital Program and more than 100,000 daily enrollment transactions enterprisewide, most of which are processed systematically. Any membership transactions that do not meet quality standards or fall out based on other factors will be reviewed and updated manually by a team of associates dedicated specifically to the Plan. These associates will compare our eligibility records with New York Benefits Eligibility and Account System (NYBEAS) records to ensure accuracy. We load most manual transactions within one business day.

Claims System

Our goal is to identify and correct any errors that may keep eligible members from loading into the system during implementation testing. However, to ensure data integrity and overall quality, the dental system reviews the load results before updating the eligibility records in the system. This ensures if there is a significant discrepancy, the file will not be applied to avoid potentially disrupting eligible members' coverage. After every file load, the system generates a suite of post-processing reports including a summary, any exceptions, the terminations, and adds. Some common file errors include a missing termination date or a date of birth that has been transposed. If there are minimal errors on a report, the Data Team will review it against NYBEAS and make the appropriate corrections. For members that may be left off a file or do not load, we will manually enter them into the system based on eligibility information in NYBEAS, and they will be immediately eligible. For manual edits, we will request the change be shown on the next electronic file unless a change is needed to ensure timely access to benefits for eligible members.

iii. How the Offeror will ensure that enrollment and eligibility transactions that do not load into the Offeror's system will be manually reviewed and reported back to the Department within one Business Day.

Anthem will process enrollment transactions that do not load into our system manually. Failed transactions will be reviewed by a dedicated team that will compare the data on the file with the data on NYBEAS. Manual enrollment updates are generally made within one business day. If we are unable to manually update the enrollment transaction due to a discrepancy between the information on the eligibility transaction versus the eligibility information, we will notify the Department within one business day requesting clarification and direction.

b. Offeror's capabilities for retrieving and maintaining enrollment information within twenty-four hours of its release by the Department as well as:

i. How Offeror's enrollment system maintains a history of enrollment transactions and how long enrollment history is kept online. As part of this requirement, identify any limits in the Offeror's enrollment system to the number of historical transactions that can be kept online;

We maintain enrollment file transaction history for six months. Online transactions are retained indefinitely.

If the Department chooses, we can send a system-generated email confirming the file has been loaded into our eligibility system along with the reports mentioned above.

ii. How Offeror's enrollment system handles retroactive changes and corrections to enrollment Data, and how retroactive enrollment changes adjust previously paid claims;

Retroactive enrollment transactions are processed systematically as part of the normal eligibility file process. Reports for these types of transactions are generated weekly. Claims for services rendered beyond the date a member is eligible for coverage will be sent to our Recovery Team. The Recovery Team will initiate the recovery process and ensure payment amounts are credited back to the Plan when recovered.

iii. How Offeror's enrollment system captures the information necessary to produce the reports entitled "Claims and Credits Paid by Agency" and "Quarterly Participating Employer Claims" required in the Reporting Section of this RFP; and

As we do for the Hospital Program, Anthem will develop custom reporting to ensure the Department receives "Claims and Credits Paid by Agency' and "Quarterly Employer Claims" specific to the Dental Plan. Data elements supplied by the Department on the eligibility file such as agency code and Benefit Program code will be used to develop these required reports. We can supply these reports in the format that works best for the Plan.

iv. How Dependents are linked to the Enrollee in the Offeror's enrollment system and claims processing system, including a description on how Offeror's enrollment and claims processing system can administer a social security number, Employee identification number, and an alternate identification number assigned by the Department; and any special requirements to accommodate these three identification numbers.

Dependents are linked to the enrollee in our enrollment and claims processing system by the employee ID number and the Department-assigned Health Care Identification (HCID) number. We also capture dependent Social Security numbers (SSNs) when they are present on the Department's eligibility files, however, our dental claims system does not capture and store the SSNs for dependents. There are no special requirements to accommodate three identification numbers, and this is a common requirement from other Plans. Our claims system only maintains the subscriber's ID numbers.

Claims

Our system can accommodate unique identification numbers provided by the Department or can automatically generate them. The use of unique member ID numbers in place of using SSNs is encouraged. Anthem can accept any 9-digit numeric identifier from the Department to tie subscribers to their dependents. However, they do ask that the last four digits of Social Security numbers continue to be submitted in the appropriate field on the enrollment file, as this is an additional way for members to identify themselves at the point of sale and when calling the Customer Service Center. Members can obtain services using only their name and date of birth.

c. How Offeror's enrollment system and claims processing systems are HIPAA compliant.

To ensure HIPAA compliance, Anthem uses only the minimum required data. We will communicate using HCIDs unless specifically approved. The file feeds will be set up with unique and secure login and password information; only designated Department resources and the Anthem EDI Team will know the password.

We have adopted a number of policies and procedures to ensure the sensitive information received is protected at all times, both at rest and in motion. Only associates with a need to know are provided access to systems that house PHI, and password controls ensure only those associates can access their systems. All policies, procedures, and systems comply with HIPAA and applicable state privacy laws. These actions include:

- Modified existing computer system to be compliant with national code sets to transmit, receive, and process HIPAA-compliant EDI files
- Implemented software for HIPAA EDI compliance
- Contracted with a clearinghouse to provide transaction brokering services between Anthem, payers, and providers for the 27X transactions and the 837/835 transactions
- Distributed a Notice of Privacy Practices (NPP) to all enrollees. The NPP is also available on anthembluecross.com
- Completed mandatory company-wide training regarding HIPAA and refreshed HIPAA rules through annual training
- Increased member website security, including password protection for member benefits information
- Tailored claims system security to restrict access to member data
- Aligned written information security program with ISO 27001 to meet all applicable legal and regulatory requirements including HIPAA, PCI, and state privacy laws

d. Describe how Offeror will administer full-time student verification on behalf of the Department, make eligibility determinations as a result of this review, and provide the Department, in a file of its specification, eligibility determinations that can be loaded into NYBEAS. Please also outline any past experience in administering eligibility determinations for full-time students.

Anthem will send full-time student attestation forms to subscribers 60 days, and if necessary due to no response, 30 days before their dependent reaches age 19 and before the expiration of a dependent's full-time student status.

We will accept completed forms via mail, email, and fax. Once received and information reviewed, if student-dependent eligibility requirements are met, we will notify the Department via an outbound readable file in the format provided in Attachment 33 labeled Outbound File Layouts. As required, we will send this file to the Department on a weekly basis. We will also send a weekly file of enrollment changes to the Department in a readable file according to the Department's specifications as provided in Attachment 33

Before the passage of the Affordable Care Act required dependent coverage to age 26, we had a standard workflow for all clients who extended dental coverage beyond age 19 to full-time student dependents. We will leverage that method to develop a process that aligns with the Plan's student-dependent eligibility requirements.

2. Enrollment Management Guarantee: The Offeror must guarantee 100% of all Dental Plan Services enrollment records that meet the quality standard for loading, will be loaded into the Offeror's enrollment system within twenty-four hours of release by the Department.

   Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount for each twenty-four-hour period or part thereof in which enrollment records that meet the quality standards for loading are not loaded in the Offeror's enrollment system after such enrollment records have been released by the Department. The forfeited amount (Standard Credit Amount) is $1,000.00 for each twenty-four-hour period or part thereof in which this guarantee is not met. However, an Offeror may propose higher amounts.

   [redacted] Please refer to Section 5 for the completed Attachment 6.

5.9 Direct-Pay Enrollment Option

The Offeror must confirm there will be a Direct-Pay Dental Plan for our retirees or enrollees who become no longer eligible for the NYS Dental Plan.

Confirmed. Members who become no longer eligible for the Plan will receive information on our dental plan options. If the Department chooses, we can also include a link to our Online Shopper website on the Department's custom dental plan website, which will provide these members with an easy and convenient way to shop for a dental plan that meets their family's needs, enroll, and remit payment all in one place. Members can enroll using our online shopping website at the following link Online Shopper or a paper enrollment form, which we will post on the Department's custom website.

5.10 Claims Processing

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in claims processing as specified in Section 3.9 of this RFP, including the following:

   We will serve the Department's claims processing needs using dental-specific systems and more than 600 associates who are focused 100% on the dental business. To deliver the greatest expertise in claims processing, we will staff the Plan's Claims Team using a mix of [redacted] dedicated and dedicated flex claims processing specialists and a dedicated OE to ensure we are meeting the Plan's service standards while operating at optimal efficiency. We anticipate approximately [redacted] data entry and claims processing specialists will spend 100% of their time processing the Plan's claims. Claim processing specialists will also have real-time access to your overall Plan structure and benefit details through our CRM system.

The Plan's claims processing center, claims processors and support staff will be located in the Continental United States.

Training

The Claims Team is required to complete an internally developed clinical education overview program and six modules on dental procedures, practices, and terminology. New claims processors/data entry operators participate in approximately one week of formal classroom training. After this classroom instruction, a trainer shadows the new hire while processing claims for 3 to 5 days. All new processors' work is audited at 100% until quality metrics are met.

Specific training on the Plan's unique benefit design will include the distribution of the Plan's benefits. Key points or distinctive aspects will be highlighted and discussed with the Claims Team for full understanding.

Ongoing training classes are held quarterly to keep associates informed of new processes and policies. Operations experts create a reference guide, which is approved by the claims managers, outlining the new processes. The changes are also applied to processing manuals used for training, and team meetings will be held as needed to review the new workflow processes and any new functionality.

Additionally, while all Anthem associates are trained and regularly updated on internal and state requirements regarding fraud and abuse prevention and detection, claim processors receive additional claims-specific training.

Benefit Readiness and Testing

We manage the implementation process through the checks and balances of a detailed implementation schedule, which includes careful attention to loading the Plan's benefit design into our system. Our internal Benefit Setup Audit compares the system setup and rules to your approved benefit schedule after receipt of your approved final benefit schedule and before the contract effective date.

System and Retention

Claim processing speed is combined with accuracy using a sophisticated analytic system with preprogrammed edits, rules, and claims experience. Claims are automatically adjudicated when they pass through system edits for member and dependent eligibility, provider status, group record setup, duplicate claims, scheduled benefits, time limitations, and exclusions — ensuring payments are only made for authorized services for eligible members. Any claims that do not pass our system-based checks and edits are manually reviewed by our experienced staff or denied pending further information.

Records retention periods are based on regulatory requirements and all claims information is maintained for a minimum of 10 years. All items are archived and accessible within 24 hours. Claims information is also saved in our data warehouse which we operate for reporting and analysis needs. Claims data will be made available no later than 12 calendar days following the end of each calendar month, including the month following the contract termination.

All systems are maintained and upgraded regularly to deliver greater efficiencies and features. System backups are performed daily in our data center and all backups are also replicated and stored offsite at our disaster recovery data center site.

Cost Control

Our internal audit controls are in place, which ensure data integrity and successful claims processing. The audits are performed by audit staff, the Performance Audit Team, and the Quality department.

Each month a random sampling of claims for each product is extracted based on the volume of claims processed in each month. For the Department, a statistically valid sample of claims per month will be audited. Our auditor will review claims and check for financial and processing accuracy — flagging any non-critical, potentially critical, or critical errors.

Furthermore, our Performance Audit Team performs an annual audit of all the Current Dental Terminology (CDT) code changes and updates for the following year. They verify our systems are updated with the most current information to ensure claims are processed correctly.

Our analytically driven prepayment review program focuses utilization review on dentists who are practicing in a way that is an outlier in comparison with their peers. This program improves savings, streamlines resources to keep administrative costs in control, and improves claim turnaround times. We also use our analytics for dentist education based on outlier practice patterns. The analytically driven prepayment review program has yielded more than $15 million in cost-of-care savings since its inception in 2018.

Explanation of Benefits

We send EOBs via U.S. mail and provide all information per New York state insurance laws. We will suppress the distribution of any EOBs where the member's responsibility is zero. Members may also elect to receive EOBs electronically via our Sydney Health mobile app and online through the Plan's custom website.

A HIPAA-compliant paper or electronic EOB will also be sent to the provider based on how the claim was submitted. If the claim was submitted by the provider via mail, we will mail the EOB. If the claim was submitted by the provider via electronic data interchange (EDI), the EOB will be sent electronically.

Coordination of Benefits

When we are considered the primary carrier, we process the claim as normal. When we are considered the secondary carrier, and primary payment information is present with the claim, benefits are coordinated so that no more than 100% of the Plan's payment obligation is made. The Plan's payment obligation is determined before calculating all percentages, deductibles, and benefit maximums.

a. Describe how any changes to the Offeror's benefit design would be monitored, verified, and tested, to guarantee that changes to other client benefit plans do not impact the Dental Plan.

We share the Department's expectation for the delivery of a timely implementation with precise execution when setting up your dental benefits. We will work with you to set up the plans and divisions as needed to build a Plan-specific group and benefit construct that segregates your benefit design from that of all other clients. This ensures changes to other client accounts will never impact the Department's benefit programs. We will actively monitor and review plan design elements with each renewal or benefit change as part of the Account Team's due diligence.

Our internal Performance Audit Team will conduct an overall assessment audit to ensure all benefits and aspects of each of the Plan's benefits are set up accurately in the claims system. This is a multifaceted, 360-degree review. If the Audit Team finds an error, we will coordinate any updates before conducting another audit to confirm the successful resolution of the error.

In the event a contract setup error is identified during implementation, a quality control review will be performed with all impacted procedure codes and subgroups to identify the level for correction. If an error is identified post-implementation, a claims query will be run to identify all claims impacted, followed by adjustments of impacted claims.

The Performance Audit Team will also perform an annual audit of all CDT code changes and updates for the following year. Our systems are updated with the most current information to ensure the claims are processed correctly.

b. Describe how Offeror's claims processing system collects overpayments from Offeror's Dental Plan.

We identify and control overpayments through our audit processes and in response to inquiries and/or additional information received from members or providers. These processes ensure the Department will only be charged for accurate claims payments for covered expenses.

Both underpayments and overpayments will be considered as errors. Anthem takes responsibility for the recovery of overpaid dollars to members or providers and is accountable for the claims' financial risk. If we determine the claims payment error is attributable to late reporting of eligibility changes, in particular retroactive terminations by the Department, then the Department will be financially responsible for the premium amount due for the period(s) in question or the amount of the claim paid. We base funding reimbursements on a claims-paid basis. We will make every attempt to recover dollars associated with claims paid for retroactively terminated members beyond their coverage eligibility date.

If we identify funds as overpaid, our system automatically initiates collection activity and tracks it in our database.

Our internal team sends up to three collection letters to the provider to recover overpaid funds. If collection letters are unsuccessful, we send recoveries above $75 to a contracted external collection agency. For participating providers, we can activate an internal automated withholding process to extract and recover unpaid balances from future provider claim payments.

c. Describe how the Offeror will analyze and monitor claim submissions to promptly identify errors, fraud, and abuse, and report such information in a timely fashion to the State in accordance with a State-approved process. Confirm the Dental Plan shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses.

Our sophisticated analytic system combines claims processing speed with accuracy using preprogrammed edits, rules, and claims experience. Claims are automatically adjudicated when they pass through system edits for member and dependent eligibility, provider status, group record setup, duplicate claims, scheduled benefits, time limitations, and exclusions. The dental claims processing system monitors and flags claims for apparent overcharging, unbundling, upcoding, inappropriate care, and other forms of abuse or fraud.

Using evidence-based processing policies that align system edits and provider contracts, we ensure quality and cost control through our system, edits, and a Claims Team focused exclusively on the dental business. This ensures the Department will only be responsible for accurate claims payments of covered expenses.

All claims are tracked from the time we receive them through the issuance of EOBs and payments. Any claims that do not pass our system-based checks and edits are manually reviewed by our experienced staff or denied pending further information. Claims are adjudicated in near real-time.

Using our more than 50 years of experience managing and processing dental claims, we have developed robust fraud-prevention system capabilities. System triggers can indicate potential fraud or abuse by providers and Plan members on specific claims. All associates are required to complete an annual Fraud, Waste, and Abuse (FWA) training program. Processed claim payments are audited both systematically and manually by Claims supervisors and our Finance department to provide additional protection against fraud or abuse by our associates, providers, and Plan members.

We audit the handling of each member and provider claim from electronic submission or data entry through the adjudication process. Additionally, we continuously audit each provider's claim patterns through analytic comparison of the provider's treatment decisions and claim submissions in comparison to:

- Peers
- Their practice history
- Scientific clinical literature regarding best practices

This analytic comparison is in addition to the hands-on review of any claims flagged by our system for clinical or other review.

If Anthem suspects fraud or abuse, we will automatically suspend the claim for review by trained claims personnel and potential escalation to Compliance or our Special Investigations Unit (SIU). If the SIU determines there is an issue, a member of the unit may contact the dental office for clarification.

We can report any identified errors, fraud, and/or abuse of significant impact to the Department and are required by law to report as appropriate to the authorities. We can also analyze and measure across several parameters the historical claim submission patterns of every dentist submitting claims to us.

Both our contracts with providers and the conditions of employment for our associates give us the right and the means to perform investigations and act upon the results. Our investigation policies also have a strong preventive sentinel effect. Focused audits of dental offices and/or employees are conducted as warranted.

d. Describe the process by which Department Staff will be provided access to the Offeror's claims system and any online and web-based reporting tools necessary to fulfill the requirements of the Contract.

All claims data is the sole property of the Department. We will send detailed claim files via secure FTP to the Department's Decision Support System vendor no later than 12 calendar days following the end of each calendar month, including the month following contract termination and/or upon request to aid in claim and eligibility audits.

The Department will have access to view members' claim information via a web-based reporting tool. The EmployerAccess online tool and app is your one-stop destination for news and plan administration. Our EmployerAccess application offers the following claim information:

- Claim number
- Member name
- Relationship to subscriber
- Claim type
- Provider name
- Date received
- Date paid
- Payee
- Status
- Service dates
- Total charges / allowed amount
- Denied amount
- Deductible
- Co-insurance
- Co-pay

- Paid amount
- CPT code
- Patient responsibility

The Account Team will provide the Department with reports that include dashboard reporting containing high-level key indicators about the most significant cost drivers and standard reports to help the Department monitor plan trends and dive deeper to address questions about cost, utilization, or chronic conditions.

If needed, the EmployerAccess tool includes the Employer AI Assistant — a continually trained support chatbot for support and an integrated switch to live-person accessibility.

Additionally, the Account Team is readily available to help with any account maintenance or custom reporting needs. A designated, dental ESR will be also available as a direct contact for your staff with real-time access to your claims and enrollment information.

2. Claims Processing Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following two plan service level standards:

   In 2022, we met [redacted] of our dental performance guarantees and are on track to meet [redacted] of our dental performance guarantees in 2023.

   a. Claims Payment Accuracy Guarantee: Claims payment accuracy must be achieved for a minimum of 98% of all claims processed and paid each calendar year.

      Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount for each year in which 98% of claims payment accuracy is not achieved as determined based on an annual audit conducted by the Department. The forfeited amount (Standard Credit Amount) is $60,000.00 for each year this guarantee is not met. However, an Offeror may propose higher amounts.

      [redacted]

      [redacted] Please refer to Section 5 for the completed Attachment 6.

b. Claims Processing Guarantee – Twenty-Four (24) Calendar Days Turnaround Time: No less than 99.5% of submitted claims received by the Offeror that require no additional information in order to be correctly processed shall be processed within twenty-four (24) calendar days from the date the claim is received electronically or in the Offeror's designated post office box to the date of Claim Adjudication.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which less than 99.5% of claims that require no additional information in order to be correctly processed, are not processed within twenty four calendar days from either the date the claim is received electronically or in the Offeror's designated post office box to the date the payment is transmitted to the Provider or mailed to the Member as calculated on a quarterly basis. The forfeited amount (Standard Credit Amount) is $15,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

[redacted] Please refer to Section 5 for the completed Attachment 6.

5.11 Plan Audit and Fraud Protection

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in plan audit and fraud protection as specified in Section 3.10 of this RFP, including the following:

Plan Audits

We ensure quality and cost control using system edits and a Claims Team focused exclusively on dental claims. Our evidence-based processing policies align with system edits and provider contracts for cost savings and better oral health for Plan members. Our advanced analytical capabilities compare dentists' claim submission patterns to their peers, their practice history, and scientific research regarding clinical best practices. This gives us unparalleled capabilities for analyzing cost trends and detecting subtle forms of fraud and abuse that traditional methods alone cannot detect.

Our quality assurance program incorporates system-based and human audit controls to ensure data integrity and successful claims processing, including role-based assignments for the review of high-dollar and complex claims. Claim audits are conducted on a daily, monthly, and quarterly basis depending upon the type of audit. The various audits are focused on the quality, speed, and accuracy of claim handling including:

- Opening, sorting, and scanning of claims
- Data entry of claims
- Handling of suspended claims
- System adjudication
- Processing and financial accuracy

The comprehensive internal audit controls include:

- A daily random audit of Claims staff performed by the Audit staff
- Reaudit of claims auditors performed by the auditor's supervisor
- Monthly audits performed by the Quality department

Enrollment Audits

We employ several checks and balances to ensure the integrity of our eligibility file processing for both initial and subsequent data submissions. We will conduct an initial review of the submission to ensure that the data meets the required specifications. Upon processing the eligibility file, we will notify the Department of any specific membership errors within two business days after processing is complete.

External Audits

We also engage in independent external audits of our systems, performance, security, and financial controls that include:

- Annual independent external audit
- Customer-requested claims audits
- Annual SOC-1 (SSAE16) report*

*We can provide our SOC report to the Department annually.

We will cooperate and provide sufficient resources to assist with Department and/or the Office of the State Comptroller (OSC) audits whether conducted by State staff or by a third party on the Department's or OSC's behalf, responding to audit requests within 15 business days. The auditor will have access to all documentation needed to conduct the audit. We will provide feedback and applicable action items for any audit report prepared by the Department within 30 calendar days of receipt.

The Department will only be charged for accurate claims payments for covered expenses. Anthem will accept responsibility for the recovery of overpaid dollars to members or providers and is accountable for the claims' financial risk. We issue the determined (processed) credit on the Department's next scheduled (subsequent) claims invoice.

The use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. Root cause analysis of extrapolated findings will then be used to pinpoint all claim errors by cause for the next best actions in collaboration with the Department.

Fraud Protection

We identify, investigate, and deter Fraud, Waste, and Abuse (FWA) by providers, our associates, and Plan members via an integrated program combining system-based checks, routine and targeted auditing, and role-based access to information.

Our proven fraud-prevention capabilities include system triggers, which can indicate potential fraud or abuse by providers and/or Plan members on specific claims. Processed claim payments are audited both systematically and manually by Claims supervisors and our Finance department to provide additional protection against fraud or abuse by associates, providers, and/or plan participants. As a control measure, we engage our Special Investigation Unit (SIU), when fraud or abuse is suspected. We can also analyze and measure the historical claim submission patterns of every dentist submitting claims to us across several parameters.

Focused audits of dental offices and employees are conducted as warranted. These are typically desktop-based. If an onsite audit is required, or if the Department requests an onsite audit, we will work with you to determine mutually acceptable requirements including:

- Providing sufficient resources whether the audit is conducted by the Department or by a third party on the Department's or the Office of the State Comptroller's behalf.
- Available documentary evidence necessary to perform the review including but not limited to claim documentation, provider agreements, and correspondence.

We will report any third-party documented and identified allegations and/or errors that may result in FWA specific to the Department's benefit plan within seven business days.

Your Account Team will formally relay to the Department any significant modifications to the processes outlined within our responses and those mutually developed with the Department in writing. This includes our onsite audit process mutually developed with the Department.

a. Describe the audit program Offeror would conduct for the Dental Plan including a description of the criteria Offeror uses to select Providers to audit and a description of the policy that Offeror follows when an audit detects possible fraudulent activity by a Provider.

We have developed robust fraud-prevention system capabilities using our more than 50 years of experience managing and processing dental claims. This includes analytics-based utilization monitoring, which is unique in the marketplace. Our proactive, multi-faceted approach includes:

Internal Audit Controls

Internal audit controls are in place, which ensure data integrity and successful claims processing. The audits are performed by audit staff, the Performance Audit Team, and the Quality department.

Each month a random sampling of claims is extracted based on the volume of claims processed in each month. For the Department, a statistically valid sample of claims per month will be audited. Our auditor reviews claims and checks for financial and processing accuracy — flagging any noncritical, potentially critical, or critical errors.

Furthermore, our Performance Audit Team performs an annual audit of all CDT code changes and updates for the following year. This team also verifies our systems are updated with the most current information to ensure claims are processed correctly.

System-Based Edits

Our sophisticated adjudication system performs an analysis of all claims. The system software can:

- Identify erroneous submissions such as misreporting, unbundling, or aberrant charge levels.
- Flag claims for treatment that may not have been appropriate. When a claim is flagged, the appropriate review is performed by a licensed professional.

Clinical Utilization Review Team

Review is performed by our Clinical Utilization Review Team, which is led by a Manager of Utilization Review and comprised of analysts including actively licensed dental professionals. They review supporting clinical treatment documentation to determine dental appropriateness, as well as the application of coverage rules according to the Plan's benefits. All Clinical Utilization Review staff are required to complete annual training on FWA. Observations by the Clinical Utilization Review Team f may result in referrals to the Special Investigations Unit.

Special Investigations Unit

Indications of fraudulent, abusive, or inappropriate treatment are investigated, and appropriate follow-up actions are taken. Under the direction of our National Dental Director, our clinical investigators partner with our Analytic-Based Systems reporting experts. The range of actions may include provider education, placing the provider on focused review, conducting an audit, and reporting findings to authorities (outside agencies).

Indications of fraudulent, abusive, or inappropriate treatment are investigated, and appropriate follow-up actions are taken. Under the direction of our Nation Dental Director, our investigators review referrals from the Clinical Utilization Review Team. The SIU also reviews abnormal or questionable billing patterns identified by reporting available from our Analytic-Based Systems. The range of actions may include provider education, placing the provider on focused review, conducting an audit, and reporting findings to law enforcement or other authorities (outside agencies) as appropriate.

Analytic-Based Systems

We analytically monitor the claim submission patterns of each dentist who submits claims to us. If providers appear to be outliers in any claim category, we can place additional clinically focused reviews on those providers with a special focus on the dental procedures billed where additional utilization monitoring is appropriate. This program goes beyond single-case clinical review to continuously monitor and measure each dentist's claim submissions and the related treatment patterns for consistency with:

- Their peers
- Their practice history
- Scientific clinical literature regarding best practices

Augmented Intelligence

Augmented intelligence (AI) will enable us to integrate real-time imaging (X-ray) qualifications in up to 100% of dental procedures including complex, high-cost restorative care (bridges, crowns, root canals), oral surgical and periodontal (gum) care, and even medically necessary orthodontics. This technology will enhance the speed and accuracy of claims processing while refining the consistency and predictability of a quantitative claims review and administration, improving outcomes for and interactions with members, clients, and dental providers.

The standard process of an investigation involves an analytical evaluation of claims submissions and patterns along with files of associated claims data to conduct provider desk or on-site office and member audits. Dental records are requested, and evaluated against the files and claims data, and findings are documented. Once completed, the results are discussed between the assigned SIU analyst and our national dental director, who is certified as an Accredited Healthcare Fraud Investigator by the National Healthcare Anti-Fraud Association. Upon completion of the case, the results are shared with the outlier dentist. Practice behavior is monitored for a period of time to ensure the provider's behavior conforms with the peer group.

b. Provide examples of how Offeror's payment integrity algorithms and software have prevented or detected major cases of fraud, waste, and abuse for other large clients.

Anthem's internally developed FWA algorithms ensure the highest level of payment integrity for the Department's plan as described above. During the first six months of 2023, we opened [redacted] cases of suspected FWA, and we closed [redacted] of those cases at an average settlement figure of over [redacted] and [redacted] in total recoveries. Our algorithm is highly effective in identifying potential cases and recoveries, but the power of prevention is even more impactful from a financial and appropriateness of care perspective. Anthem's provider education effort identified dentists that exhibited outlier activity in comparison to their peers and visually highlighted their practice pattern differences. By working with our network providers and having an informed discussion together, we educated them on these differences and significantly improved utilization rates that saved our clients and members more than $7 million annually.

c. Describe the corrective action, monitoring, and recovery efforts that take place when Offeror finds that a Provider is billing incorrectly or otherwise acting against the interests of Offeror's clients. Please indicate whether Offeror has a fraud and abuse unit within Offeror's organization and describe its role. In the extreme case of potentially illegal activity, identify procedures that the Offeror has in place to address illegal or criminal activities by a Provider or Facility and confirm Offeror will pursue litigation on the Department's behalf when necessary.

Fraud Protection

Dr. Stewart Balikov leads the unit responsible for Fraud, Waste, and Abuse (FWA) detection and recovery. Dr. Balikov is an Accredited Health Care Fraud Investigator (AHFI®) through the National Health Care Anti-Fraud Association (NHCAA).

The FWA team identifies, investigates, and deters FWA not only by providers but also by our associates, and Plan members using an integrated program combining system-based checks, routine and targeted auditing, and role-based access to information. In addition, individuals may report suspected FWA either named or anonymously by calling our dedicated dental FWA toll-free hotline number or by submitting their concerns to our dedicated dental email address.

Our Special Investigations Unit (SIU) maintains a case management system for all FWA cases. The case management system stores the relevant basic attributes for reporting purposes. SIU staff members receive regular, recurring training from the NHCAA. The Director of the SIU and the Senior Clinical Investigator are also Accredited Health Care Fraud Investigators.

Provider Oversight

We take provider oversight seriously. Our multi-pronged solution to provider oversight consists of:

- Provider contracting and credentialing
- Provider audits and monitoring (e.g., member complaints)
- Internal monitoring and reporting (practice trends, anomalies)
- Analytic Based Systems reporting
- Special Investigations
- Law enforcement and regulatory referrals

Our first line of provider monitoring is rooted in a robust review of each provider including the use of best-in-class credentialing standards from the National Committee for Quality Assurance (NCQA). This third-party private organization sets forth standards for provider data verification including active provider licensure using third-party resources such as government databases. NCQA also outlines organizational requirements we meet including items such as a credentialing committee to review provider credentials and resolve disputes regarding network participation. Further, we recredential and monitor these components every three years to ensure continuous oversight and monitoring.

We use member and provider data and feedback to monitor provider performance against recognized clinical practice standards and compliance with relevant contractual, legal, and regulatory requirements regardless of network participation. This includes adherence to benefit plan administration including claims processing rules and clinical policies. Our systems aggregate this feedback in conjunction with grievance and appeals so we can complement our next line of defense, internal monitoring, and reporting.

Internal monitoring and reporting leverages data analytics and artificial intelligence. Data analytics monitors claims trends and outlier behavior by providers prompting a review of their practice patterns. Artificial intelligence is used in claim reviews to help detect FWA among individual claims. If we find provider practice patterns and behavior to be outside recognized norms, we proactively educate providers and notify them of enhanced reviews. These enhanced reviews include analytics-based claim reviews as well as focused reviews. We will manually review all their claims for adherence to relevant contractual, legal, and regulatory requirements including benefit plan administration as well as claims processing rules and clinical policies.

To the extent our provider audits and internal monitoring and reporting mechanisms justify further provider oversight, we will refer individual providers and/or their offices to the SIU. This unit will request detailed records from a provider to justify their claims and practice patterns and we augment their records with ad hoc internal reports to ensure what we receive is accurate and verifiable to the extent possible. This includes the engagement of our Analytics, Claims, Clinical, and Legal Teams to ensure our investigation is thorough and prompt.

Corrective Actions

Upon receipt of a member's complaint about a provider, we enter the grievance into a confidential database for trending quality of care issues, which aids in establishing quality improvement activities. This process is the same for all member grievances or complaints.

Treatment and other billing, financial, or administrative records may also be requested from the provider documenting the sequence of dental care, the dental care delivered, and the dental services billed. The case is reviewed by a qualified Network representative. We communicate the determination to the member and dentist as appropriate.

Upon resolution, members receive written notification of the outcome, and providers receive written notification of one or more of the following:

- Resolution of the quality-of-care grievance
- Request for corrective action

We track and report quality of care grievances and associated resolutions. We maintain a record of all complaints and grievances filed for seven years. This information may be used in the recredentialing process of a participating dentist.

Pending any special investigation findings, our final line of defense is the removal of a provider from our network and referral of our investigative findings to appropriate law enforcement or regulatory agencies for potential judicial action. We may also pursue monetary financial recovery as well as pursue civil litigation pending an internal legal assessment (in conjunction with clients as appropriate).

Our responses are consistent with all New York and federal regulations, and we cite those regulations when appropriate.

5.12 Appeals Process

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in the appeal process as specified in Section 3.11 of this RFP, including the following:

   As part of our commitment to member satisfaction and access to quality care for the Plan's members and their families, we monitor our ability to address members' concerns through our formal, written grievance resolution process. Complaints, grievances, and Level 1 and Level 2 appeals are tracked through our CRM system. The information Anthem tracks includes claim numbers, the person submitting the grievance (provider or member), issue or category, resolution status (open or closed), and other details. This process ensures the member has opportunities to receive an equitable resolution for complaints or grievances. We confidentially maintain documentation of all quality-of-care grievances in compliance with the Data Practices Act as applicable.

Expedited/Urgent Grievance and Appeals Criteria

Expedited/urgent grievances are defined as cases involving an imminent and serious threat to the health of the member, including but not limited to, loss of life, limb, or major bodily function including acute pain, facial edema, or uncontrollable bleeding (hemorrhaging). Expedited grievances must be resolved within 72 hours of receipt. Expedited/urgent appeals are defined as an appeal where a delay in treatment could significantly increase the health risk, the ability to regain maximum function or cause severe pain.

If a dentist requests an expedited grievance, it will be handled using our expedited grievance process and processed within 72 hours. If a member or the member's representative other than the member's dentist requests an expedited grievance, it will be evaluated by one of our licensed dentists to see if it meets the criteria of an expedited grievance.

Additionally, we may also request that a case be expedited even if it was not initially requested as an expedited case. Our licensed dentist will review using the expedited criteria.

If our licensed dentist determines that an expedited request does not meet the expedited criteria, our Grievance/Appeals analyst will call the member or provider (if submitted by the provider) to explain the request will be processed as a standard grievance request rather than an expedited grievance. A letter is also mailed within three calendar days of the receipt date of the grievance. All verbal and voicemail messages are documented in the case notes in our CRM.

Expedited grievances will be resolved as quickly as dental circumstances require. Anthem will provide verbal notification to the requesting party within 72 hours, followed by written notification to the member and the provider within three calendar days of receipt of the grievance.

a. Describe in detail how the Offeror proposes to notify Members of their right to appeal and the steps to file an appeal. Specify the process and turnaround time for appeals and their conformance to state regulations.

   If we deny a pre-determination of benefits request or a dated claim, members have the right to a full and fair review of our determination. Members are proactively notified of these rights and the steps to conduct an appeal with each Adverse Determination letter or EOB they receive. Requests to review an Adverse Determination or claim denial can be submitted by members by mail, by calling our Customer Service Team, or online through the custom website. Members must submit their appeal request within 180 days from the claim denial and include the name, identification number, group number, claim number, and provider's name as shown on the EOB. They can mail their appeal to the address shown on the EOB.

   The member may submit written comments, documents, or other information in support of the appeal. Upon request from the member and at no charge, we will provide copies of all relevant records we used to make our decision. The review will factor in all new information we receive regarding the denied or reduced claim, even if we did not have the information when we made our initial determination. The original decision-maker(s) will not conduct the new review, and the new reviewer will not base the decision on any prior decision.

We base all benefit determinations on a preset schedule of dental services eligible under the plan and process claims according to contract agreements. In all cases where a professional must determine coverage for a procedure under the plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. If this professional rendered advice in connection with the initial adverse benefit determination, we will select a different professional to review. The original professional's staff members or subordinates also are ineligible to serve as new reviewers. We will identify any dental professional consulted on our behalf.

Generally, members will receive an acknowledgment of receipt of the appeal within five business days. Anthem will make a benefit determination within 30 days following receipt of an appeal. Our appeal responses comply with state and federal regulations, and we cite those regulations as appropriate. If we continue to deny a claim after reviewing an appeal, we will notify the member in writing.

b. Please provide for the Offeror's book of business the final determinations of internal and external appeal for plan years 2021 and 2022

Our percent of appeals upheld by year are as follows:

2021	2022	YTD 2023
[redacted]	[redacted]	[redacted]

5.13 Pre-Determination of Benefits

Pre-determination of benefits as specified in Section 3.12 of this RFP. Describe the process and procedure the Offeror proposes to use for making predeterminations of benefits including what information will be required of the Member and how this information can be submitted (i.e., facsimile, telephone, electronically).

The predetermination of benefits includes the following process, staff, and determination mechanisms:

Process

Most providers submit predeterminations as a courtesy for their patients regardless of network participation, however, network providers will manage this on behalf of the member in all circumstances. In the rare event, members need to file a predetermination, our dedicated Customer Service Teams will assist members with initiating this process. Predeterminations can be submitted via mail or fax. Members can also submit predetermination requests through the member website anthembluecross.com or our Sydney Health mobile app via their message center by uploading the form.

Staff

The Pretreatment Review Team is comprised of in-house actively licensed dental professionals and contracted dental consultants. Our dental Utilization Management (UM) Team is led by our national dental director who combines experience as a practicing dentist with business management principles in overseeing trained analysts, statisticians, and licensed dental professionals.

Approximately 30 full-time associates work on our UM Team. We train all UM staff on our claims systems and clinical claim review criteria. When changes to the review criteria are made or in the rare instance that the UM staff does not meet performance standards, additional training is provided, and a review of all criteria is completed. Routine annual training also includes topics such as:

- Courses required by the State Boards of Dentistry for clinical licensure
- Ethics and compliance
- Fraud, waste, and abuse

A policies and procedures manual is maintained and the contents are reviewed annually. The manual is used as part of our training program for consistency among our staff. Monthly audits are conducted on a random sample of claims (approximately 20 claims per dental hygienist and dental assistant). We compile results, and the UM manager performs monthly reviews to establish additional training needs, policy updates, or workflow enhancements.

Future audit enhancements will include sending a sample of claims to our licensed dentists for review. We will review outcomes to find inconsistencies among the dentists. Our national dental director will then review the audit results for necessary enhancements or changes.

Determination

Our pretreatment review includes an assessment of submitted claim information from participating and nonparticipating providers to determine medical necessity and appropriateness of care based on established clinical policies and contractual guidelines. It also provides valuable information related to the approval or denial of a claim, which defines out-of-pocket expenses for members and payments to providers. Depending on the procedures reviewed, our UM staff determines coverage based on the appropriateness of the dental procedure and the Plan benefits available to the member. Upon determination, a notice will be mailed to the member and provider within one business day. The provider may also receive our decision electronically within 24 hours if the predetermination request was submitted via EDI.

We determine payable benefits at the time of claim submission. Claims payments will be based on the benefits available under the contract, the member's eligibility at the time of the service, and the remaining annual benefits accessible.

5.14 Transition and Termination of Contract

The Offeror must provide a narrative describing in detail:

1. The process and level of customer service and clinical management that Offeror will provide in Phase One and Phase Two of the Transition Services, as specified in Section 3.13 of this RFP.

   While we do not like to see clients leave, we understand it does happen. We agree to the reasons for termination and timelines listed within Appendix B. Uninterrupted Transition Services to the Dental Plan will be executed until the final plan claim incurred during the contract term is submitted to the Department for payment.

Phase One

We commit to continuing the administration of the program as we have committed to in this proposal and to aid the Department in the transition process, including transmitting electronic files to the new carrier so previous claims activity can be captured. The Account Team will monitor all aspects of the transition to safeguard against any interruption in service. We will continue all contractual obligations set forth in the Contract. This includes ensuring all service levels and performance guarantees are executed to maintain the Department's expectations.

During Phase One, we will continue to monitor all service levels as agreed upon. This includes:

- Supporting all customer service functions: dedicated phone line, custom website, mobile app, and EmployerAccess site
- Transferring calls to the successor if needed
- Applying enrollment updates
- Collaborating with our Workforce Management Team ensures appropriate staffing levels
- Providing monthly financial reports and all other required Program Reporting as identified in Attachment 17
- Performing all audit activities as determined within the contract and remitting reimbursement due to the Plan upon final audit determination

Transition Plan

We will create an Anthem Oversight Team led by your Account Team and meet weekly with the Department's project manager. Calls may include a third party or the successor entity. They will propose our Transition Plan with no additional costs within 30 calendar days of receipt of the Department's termination notice. The Transition Plan for Phase One and Phase Two activities will include tasks, milestones, and deliverables associated with the Project Services to the Department, a third party, or the successor entity. We will work with the Department to reach a mutually agreed upon plan signed off by the Department. Each task assigned to Anthem will have the functional area identified as well as a responsible individual to lead from that area.

To ensure a smooth transition to the successor entity, we will develop a written plan for transferring knowledge. We will work with the Department's project manager to identify relevant processes, procedures, methods, tools, and techniques of its personnel with special skills or responsibilities performed during the Contract.

Benefits

Our standard benefit provides a period of up to 60 days for treatment in progress prior to a member's termination date to be completed following their termination. This applies to the installation of new appliances and modifications to appliances including crowns, root canals, bridges, or cast restorations for which the tooth was prepared prior to the benefit termination date. The timeframe can be customized during implementation at the Department's direction.

The industry standard is to forgo an extension of benefits for orthodontia treatment in progress. We follow this standard. Orthodontic benefits are prearranged with members and providers with claims payment plans pre-determined and agreed upon between members and providers at the start of treatment. Further, it is industry standard to honor orthodontia treatment in progress when members switch from one dental benefits plan to another. For example, if treatment was started with one benefit plan A but a member transitioned to benefit plan B, then benefit plan B would honor orthodontia treatment in progress making extension of benefits unnecessary.

The Department can customize the timeframe (up to 60 days) for which an extension of benefits may apply or exclude the provision with prior consultation with your Implementation and/or Account Team.

For the first year of the Contract, per New York State Guidelines, we will work with the successor entity to promptly notify members in care with a network provider before the end date of our contract of their rights to continue to receive a network level of benefits if their provider is not in the successor entity's network.

Phase Two

To finalize the transition of your Plan, we will transfer your data to another organization in the format acceptable to the Department to the extent our current solution can support, ensuring all enrollment and claims details are received. This process can begin 22 weeks in advance with a test file or as the Department desires. We can provide one or more pre-production files at least twelve weeks prior to the end date with a production file six weeks prior to the successor entity's Implementation Date. A second production can be sent to the successor entity by the close of business three days prior to the End Date.

We will send data files including, but not limited to:

- Utilized and high-volume provider data file
- COB data
- Predeterminations with approved-through dates
- Reporting formats

The Department will still receive service for:

- Anthem's EmployerAccess site
- Updates on pending litigation and settlements
- NYBEAS access
- Processing and reimbursement on late-files claims as warranted
- Management reports

Upon contract termination, we will process claims submitted with service dates within the contract period but received after the termination date, billable to the Department for up to six months for provider claims, 12 months for a provider Medicare claim, and 15 months for member claims.

We will continue to provide the Department standard reports when paying runout claims.

Anthem understands the importance of uninterrupted dental care. Should you choose to leave Anthem's dental program, we know the experience you have during implementation may directly impact our opportunity to earn your business back.

Please refer to Section 16 for Anthem's Transition and Termination of Contract Diagram.

2. Transition and Termination Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee all Transition Plan requirements outlined in Section 3.13 of this RFP will be completed in the required time frames to the satisfaction of the Department.

   Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each day or part thereof that the Transition Plan requirements are not met. The forfeited amount (Standard Credit Amount) is $1,000.00 for each day this guarantee is not met. However, an Offeror may propose higher amounts.

   [redacted] Please refer to Section 5 for the completed Attachment 6.

Building on our past, elevating the future

Administering the New York State Dental Plan with experience and innovation

Anthem

Since the New York State Health Insurance Program was established in 1957, we have proudly served as a trusted partner of the New York State Department of Civil Service (the Department). The experience we have drawn from this long-term relationship will be invaluable and directly applied to our administration of the Dental Plan.

Throughout the years, we have stood by your side as the administrator of the Empire Plan Hospital Program, including the Excelsior Plan and the Student Employee Health Plan. On January 1, 2024, our name will evolve from Empire BlueCross to Anthem Blue Cross. This change symbolizes more than a new name; it represents our renewed commitment to you and your members.

Rest assured, the transition will be smooth, with no disruption in service, ensuring that what remains constant is our dedication to providing you with a best-in-class healthcare experience.

As we embrace this new chapter, we are honored to have this opportunity to build on our partnership and serve the New York State Dental Plan's members and their families.

With an in-depth understanding of the Department's needs and long-term experience administering benefits for your 1.1 million Hospital Program members, we have the expertise to ensure a successful transition. We also understand the importance of aligning benefit designs with collectively bargained structures, offering the flexibility necessary to accommodate your union-negotiated plans.

We have reviewed the Request for Proposal (RFP) thoroughly and are well-equipped to help you achieve your Dental Plan objectives, built upon:

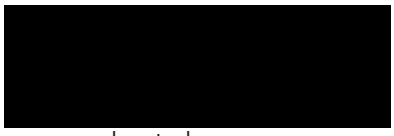
Extensive experience with large, complex clients, including those with varying collectively bargained benefit designs.

A robust local and national network with access to quality care that includes deep in-network discounts.

Proven first-class service across all areas of plan administration, delivering satisfaction, confidence, and peace of mind.

Expertise in managing large, complex clients

With more than 50 year's experience and tens of millions of claims processed, Anthem is a leader in administering dental benefits and surpassing service expectations for a diverse range of clients, including local and state governments. Our broad portfolio speaks to our expertise and capacity to handle large dental plans and complex requirements. Our current dental portfolio includes:



dental groups

dental plan members

groups, each with more than 10,000 members

We administer dental benefits for [redacted] large groups, each with more than **50,000 members** and totaling [redacted] **members**, including two state government groups.

Over the past year, **we have successfully implemented** [redacted] **large labor groups in New York, totaling** [redacted] **members.**

In 2022, we met [redacted] **of our dental performance guarantees** and are on track to meet [redacted] **of our guarantees in 2023.**

These figures are more than just numbers — they represent our steadfast commitment and proven capability to fulfill the requirements outlined in your RFP. We will leverage all of this experience to ensure a seamless transition for the Department and New York State Dental Plan members and their families.

With over 25 years of experience, Anthem has become a trusted leader in administering dental benefits for even the largest and most intricate groups. Not only are we capable of expertly managing large local and national accounts, but our customers are highly satisfied and continue to renew with us year after year:

- Our persistency rate for national accounts is [redacted], demonstrating that large employers recognize our expertise and choose to remain with Anthem.
- Additionally, among our Labor Market customers, [redacted] report being satisfied with our overall service.

We are committed to delivering best-in-class member service across all our dental plans. This dedication to customer satisfaction is why employers of all sizes continue to trust Anthem as their dental benefits administrator.

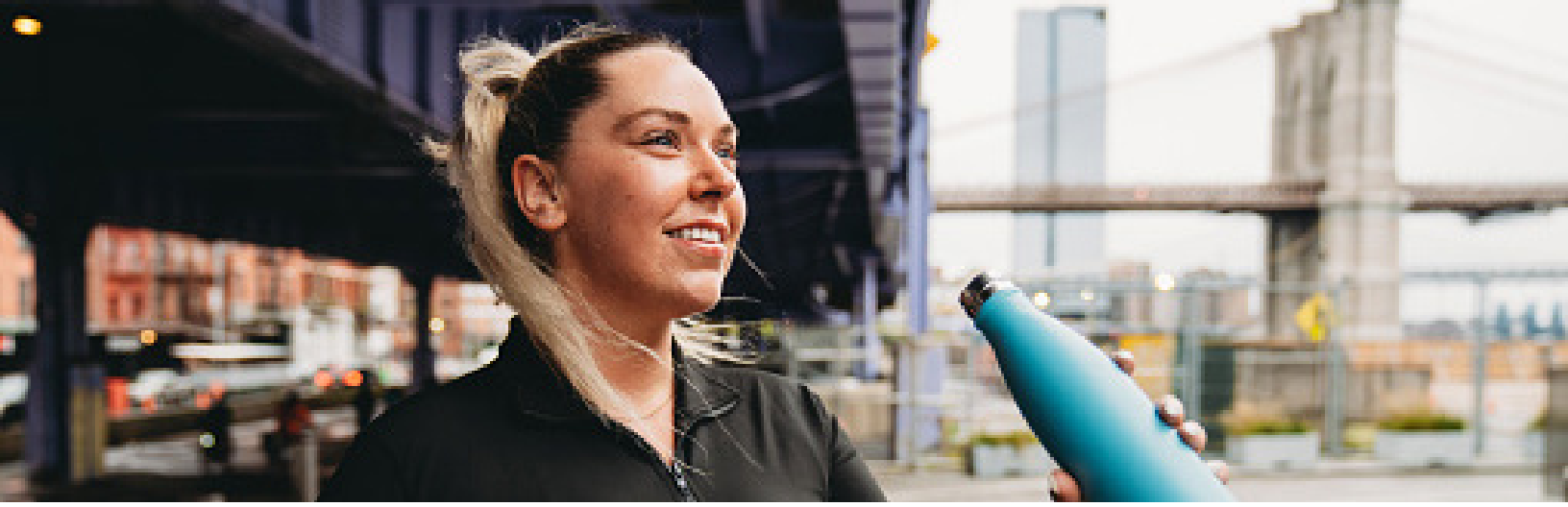
Strong network access, combining choice, convenience, and quality

We know network access and savings alone are not the only factors in choosing a dental plan. Convenient access to quality providers together with a strong member experience is paramount to a well-functioning dental plan. To ensure Anthem supports the Department with these needs, we are committed to building a turnkey custom network solution exclusively available to New York State Dental Plan members.

Supporting both the Student Employee Health Plan population along with the other populations in the Plan, this custom network will blend a unique set of providers to fit the needs of all your members — from deep discounts for Student Employee Health Plan members accessing their Discounted Dental Access Program benefits to other Plan members who may already have a dentist and value access and convenience.

Through one of the largest local and national dental networks, your members will have access to quality care wherever they are. In New York alone, we have [redacted]. A larger network means greater access, driving better network utilization, stronger network savings, and greater access to care.

Beyond traditional network options, we also offer teledentistry for virtual consultations and innovative in-home dental solutions like Ortho@Home and Dentures@Home. We're committed to helping your members feel covered and confident in their dental care — when and where they need it.



High-quality dental care, anywhere

[redacted]
unique dentists at
[redacted]
nationwide

[redacted]
unique dentists at
[redacted]
locations
in New York

Strong network utilization and deep network discounts on covered services, averaging:

Up to [redacted]
New York XPO Dental Complete Network

Up to [redacted]
National XPO Dental Network Complete Network

[redacted] of members have access to two general dentists within a 5-mile radius (urban)

[redacted] of members have access to two general dentists within a 10-mile radius (suburban)

[redacted] of members have access to two general dentists within a 20-mile radius (rural)

[redacted] at risk for recruitment of the Department's top utilized providers

[redacted]

[redacted]

[redacted]

Enhancing the member and client experience

Anthem has invested heavily in hiring and training top talent, supported by robust digital tools, creating a simpler, more proactive experience for our members and clients and driving higher satisfaction, better value, and enhanced oral health.

Responsive, efficient service you can rely on

We are committed to results and plan excellence, demonstrated by:

- Delivering **responsive service to millions** of members and processing tens of millions of claims.
- Paying the **average claim in approximately three business days with nearly 100% accuracy.**
- Responding to member calls promptly, **with more than [redacted] of inquiries resolved during the first interaction** with our Member Services team.
- Answering [redacted] **of calls in 30 seconds or less.**

Streamlined eligibility

Leveraging our existing infrastructure and established workflows with the Department, we are fully capable of accepting and processing your member eligibility files in the same data layout.

Insightful reporting

You will receive detailed, sophisticated, and timely reporting to monitor plan performance. This includes enrollment and paid claims, cost containment, payment by benefit level, and dental provider network utilization.

Additional specialized Dental Whole Health reporting focuses on members' utilization and experience information to improve your ability to make plan design enhancements focused on specific challenges and opportunities. These will prove most beneficial after accumulating three years of data.

We provide a comprehensive selection of detailed, actionable reports:

- **Dental Financial and Utilization Summary** displays the paid amount by employee trend and peer group comparison, and the factors driving changes or differences.
- **Enrolled Member and Benefit Report** shows demographic distribution, dental benefit, and members' benefit plan selections over the years.
- **Members Receiving Dental Care Report** demonstrates the prevalence of using dental care or routine/preventive dental care, stratified by criteria such as member demography or dental coverage type.
- **Dental Services Received Report** breaks out the differences in dental services utilization at different age levels.
- **Cost Containment** segments the total cost contained (administrative plan savings and benefit plan savings) by provider network savings, usual and customary rates, alternative benefit, eligibility, duplicate bills, frequency limits, missing information, contracts and history, COB, deductible, coinsurance, annual maximum, and utilization review.
- **Preventive Services Report** measures the impact on cost and care for services like sealants and fluoride on your child population in follow-up years.

One integrated, digital tool for better health

Our Sydney[SM] Health app delivers personalized engagement and real-time access to health plan information. Members will enjoy an easier, more connected healthcare experience.

With Sydney, your members can:

- Use Care Finder to locate nearby dental providers in-network and compare costs by procedure, specialty, or provider.
- Access MyHealth Dashboard for personalized health and wellness information.
- Receive personalized care reminders and tips.
- Send emails to our team of licensed dental professionals through **Ask a Hygienist** for answers to dental questions, quickly and privately.
- Complete a dental health risk assessment to better understand oral health and risks.
- Add providers to the My Care Team list for easier access to information.

Sydney Health

4.8 ★★★★★

iOS App Store rating
(ranked top ten in the medical category)*

+131% utilization
increase in app utilization of health and wellness tools*

>40% of care searches
completed through our mobile experience*

* Apple App Store and Anthem Internal Data, September 2020. App store is a ® registered trademark.

Dedicated Account Management

Angela Blessing, Strategic Account Executive, will continue to be responsible for all aspects of account management, including overseeing the day-to-day management of the Dental Plan, monitoring account performance, and undertaking strategic planning. She will serve as the single point of contact for the Department. Angela will have direct access to senior management across functional areas, including clinical, operational, financial, and network.

Jason O'Malley, Regional Vice President, Sales, will continue to hold overall accountability for managing the State of New York account. He will provide account management oversight for the Dental Plan and work with the Anthem team to ensure we meet the Department's expectations. Jason has the authority to secure necessary resources and champion the Department's objectives for senior leadership.

Sandy Bogen, Strategic Account Consultant, will bring her extensive experience with large local dental clients to collaborate strategically with the Account Management team. She will support renewals, deliver comprehensive reports, and devise client-focused strategies to ensure the best solutions for the Department.

We will also assign **additional dental account management resources and clinical experts** to support your goals for the Dental Plan every step of the way.

Overall, we know you deserve our best resources to save time, money, and effort, and your members deserve personalized, whole-person care. To ensure we are meeting the Department's expectations, we propose monthly meetings to discuss various topics of interest and to serve as a consultative partner in the overall administration of your Dental Plan.

Whole Health Connection: the power of integration

Anthem Whole Health Connection® integrates dental, behavioral health, pharmacy, and medical data to provide a complete view of the whole person and drive better outcomes through coordinated care. This approach produces insights to improve overall population health.

Our integration identifies oral health signs early to close gaps and enable better treatment by providing care management and collaborating with network dentists. We focus on high-risk, high-cost conditions impacted by oral health, like pregnancy, diabetes, and heart disease. This coordination allows us to engage members holistically and promote better whole health.

Benefit integration also enhances the member experience, reduces costs, and simplifies administration. Specifically, Anthem's 2020 Dental Value study revealed that integrated benefits:

Reduced inpatient admissions by [redacted]

Reduced emergency room visits by [redacted]

Reduced medical/pharmacy spend by [redacted]

Through Whole Health Connection, Anthem can provide an integrated healthcare approach for the Department. We look forward to collaborating with you to obtain the necessary data across your benefit partners to deliver the best possible member experience.

Shaping a healthier future together

We're excited about the potential to build on our shared history with the New York State Department of Civil Service, while constantly seeking avenues for proactive improvement and innovation. Our proposal isn't merely about continuing the status quo; it's about elevating and reimagining what's possible for the future of the New York State Dental Plan. This commitment ensures we deliver superior, forward-thinking services that prioritize the oral health and overall satisfaction of your members, now and in the future.

Thank you.

1055172NYEENABC 06/23

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form
RFP entitled:
"Dental Plan Services"

Prepare this form for each key staff individual, including subcontractor-provided key staff, if any, of the Offeror's proposed Account Team (RFP Section 5.2). Where individuals are not named, please include qualifications that will be sought to fill the positions. If additional space is needed you may add additional sheets.

Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Victor DeStefano

Job Title: Chairman, President, and CEO

Relationship to Project: Victor is responsible for the overall operations and administrative management of client contracts in New York, including the New York State Dental Plan contract.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Binghamton University Binghamton, NY	B.S.	2007	Finance & Management
Columbia University New York, NY	MPH	2015	Health Policy

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2023 - Present	Empire BlueCross	Interim President, New York Commercial Business
2019 - 2023	Empire BlueCross	Regional Vice President and General Manager
2008 - 2018	United Healthcare	Executive Director of Medicare and Retirement

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form
RFP entitled:
"Dental Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Victor DeStefano is a dynamic healthcare executive with deep roots in New York. Born and raised in Staten Island, educated in Binghamton and Washington Heights, and now residing in Nassau County, Long Island. Victor's life and career are steeped in the New York spirit.

Victor joined the organization in 2019 as regional vice president and general manager of Empire BlueCross Blue Shield and now serves as Interim President, New York Commercial Business. He oversees an impressive $3 billion in revenue, serving over 3.5 million health insurance members, remaining steadfast in Empire's mission to improve the lives of all New Yorkers.

Guided by a patient-first approach, Victor fosters a culture of high performance within his team of over 240 associates, driving strategic business development and nurturing the company's growth. His leadership style, reflecting his profound understanding of patients' unique needs, has been a major factor in driving the New York commercial market's community-focused initiatives.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form
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"Dental Plan Services"

Prepare this form for each key staff individual, including subcontractor-provided key staff, if any, of the Offeror's proposed Account Team (RFP Section 5.2). Where individuals are not named, please include qualifications that will be sought to fill the positions. If additional space is needed you may add additional sheets.

Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Scott William Towers

Job Title: President, Specialty Business (President, Anthem Dental)

Relationship to Project: Scott is responsible for overall accountability for the Dental business in New York as well as the other 13 states we have licenses to operate. In addition to strategy, departments include Product Development, Operations, Underwriting, and Network Development.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Minnesota Minneapolis, MN	BA of Arts-Mathematics	1994	Actuarial Science
Carlson School of Management, U of MN Minneapolis, MN	MBA	2001	Finance, Strategy

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2016 - Present	Elevance Health	President, Specialty Business/Products
2009 - 2016	Anthem, Inc.	Staff Vice President/Director
1996 - 2009	DeCare Dental/Delta Dental of MN	Vice President/Director/various others

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form
RFP entitled:
"Dental Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Scott has more than 26 years of Dental Administration in several leadership roles with full responsibilities for P&L, network development and management, product development and innovation, clinical management, clinical integration, and all aspects of operations performance and service delivery.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form
RFP entitled:
"Dental Plan Services"

Prepare this form for each key staff individual, including subcontractor-provided key staff, if any, of the Offeror's proposed Account Team (RFP Section 5.2). Where individuals are not named, please include qualifications that will be sought to fill the positions. If additional space is needed you may add additional sheets.

Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Jason O'Malley

Job Title: Regional Vice President, Sales

Relationship to Project: Jason has overall accountability for the management of the State of New York account. As such, Jason is responsible for the leadership and direction of all account management activities associated with the Dental Plan along with working collaboratively with the Anthem Blue Cross team to provide oversight and support to ensure we meet the Department's expectations. Jason has the authority to command the resources necessary, and access to senior level management within the organization, to ensure flawless execution of the Dental Plan.

As the current Regional Vice President over the Anthem Plan Hospital Program, the Department will have an accountable, experienced team leader with in-depth knowledge of the State's benefit programs and strong relationships with key government and labor contacts. Jason is committed to maintaining our strong partnership and ensuring that Anthem continues to serve as a trusted and effective partner, providing the Department with the expertise and dedicated resources required to administer the Dental Plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
State University at Albany School of Business Albany, NY	MBA	1995	Business

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Biographical Sketch Form** **RFP entitled:** **"Dental Plan Services"**

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2019 - Present	Empire BlueCross	RVP, Sales
2008 - 2019	Empire BlueCross	Director, NYS Account
2005 - 2008	Empire BlueCross	Account Executive, NYS Account
1997 - 2005	Empire BlueCross	Account Manager
1995 - 1997	Empire BlueCross	Implementation Analyst
1993 - 1995	Empire BlueCross	Claims Adjuster

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Reporting directly to the President and CEO, Jason leads the Upstate Sales and Account Management team for Anthem Blue Cross. He is responsible for overseeing the growth and profitability of the Upstate market, ensuring successful long-term relationships with client and brokers, as well as setting direction on product development, advertising, and community relations.

Jason has been with the company since 1993 with more than 20 years of account management experience at Anthem, and has prior experience in operational and analytical roles within our account implementation and claims areas.

As the current Regional Vice President over the Hospital Program, Jason works with the account team to develop recommendations on ways to improve Plan administration, benefit design, and various approaches to control cost.

Jason earned his master's degree in business administration from the State University at Albany School of Business. He is also a licensed life and health insurance agent in New York.

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Prepare this form for each key staff individual, including subcontractor-provided key staff, if any, of the Offeror's proposed Account Team (RFP Section 5.2). Where individuals are not named, please include qualifications that will be sought to fill the positions. If additional space is needed you may add additional sheets.

Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Angela Blessing

Job Title: _Strategic Account Executive

Relationship to Project: Angela will be responsible for all aspects of account management including overseeing the day-to-day management of the Dental Plan, monitoring account performance, and strategic planning. She will serve as the single point of contact for the Department. Angela will have direct access to senior management across multi-functional clinical, operational, and financial areas.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Southern New Hampshire University Manchester, NH	AA	2017	General Studies Business Concentration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2008 - Present	Empire BlueCross	Strategic Account Executive
2007 - 2009	Empire BlueCross	Provider Network Business Analyst
2004 - 2007	Empire BlueCross	Manager, Provider Data
2000 - 2004	Empire BlueCross	Manager, Provider Service

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Angela has over 30 years of experience in healthcare, working at the forefront to address the challenges of an ever-evolving industry. During her tenure with our company, she has advanced to positions of increasing responsibility, with specialized experience in areas relating to Provider Contracting, Claims, Customer Service, and Account Management.

Angela has been the Strategic Account Executive since 2008 for the Empire Plan Hospital Program, Student Employee Health Plan, and the Excelsior Plan. She routinely collaborates with the Department and the Office of Employee Relations and provides recommendations on ways to improve Plan administration, benefit design, and various approaches to control cost. She also provides recommendations and/or insight on developments in the healthcare industry, legislative and regulatory requirements, and their financial and/or procedural impact to the Program.

As the current Strategic Account Executive, the Department will have an accountable, experienced team leader with in-depth knowledge of the State's benefit designs, strong familiarity with key government and labor contacts, and a proven track record to build upon our longstanding relationship. With her in-depth knowledge and experience, combined with her direct access to leaders across multi-functional operational, clinical, and finance areas, Angela will ensure the same efficient and exceptional administration of the Dental Plan as experienced on the Hospital Program. She is well known by the Department, the Office of Employee Relations, and key union contacts. These long-standing collaborative relationships, prior operational and provider contracting experience, and longevity serving the State of New York uniquely qualifies Angela to oversee administration of the Dental Plan.

Angela holds a Life, Accident, and Health license in New York.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Tony Harper

Job Title: Staff VP Specialty Business & Sales

Relationship to Project: As specialty senior leadership sponsor, Tony will be responsible for the leadership and oversight of the strategic account management staff handling the servicing, reporting, administration, and retention of the Dental Plan program. His oversight includes overall account management of the Department's Dental Plan upon conclusion of the implementation phase. Tony will also oversee the transition process if the Department terminates the dental coverage with Anthem in the future.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
South Cobb High School	High School Diploma		

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2011 - Present	Anthem Blue Cross and Blue Shield	Staff VP Specialty Business & Sales

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Since joining Anthem, Tony has served in roles as underwriting consultant, member services team leader, and director of Specialty Account Management. He has also worked for such companies as Prudential, Canada Life, Delta Dental, and Confederation Life. Tony has held positions as executive director, manager of disability claims, sales executive, account manager, and underwriter. He has experience working in the following Operations areas: Implementation, Underwriting, Service, and Sales. Tony holds the LOMA ACS designation.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Sandy Bogen

Job Title: Strategic Account Consultant

Relationship to Project: Sandy will be part of the account management team with responsibility for reporting, renewals, and overall strategies for the Dental Plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Richmond Richmond, VA	Bachelors		Human Resource Mgt.

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2018 - Present	Anthem Blue Cross and Blue Shield	Strategic Account Consultant
2005 - 2018	Anthem Blue Cross and Blue Shield	Sales Account Representative

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Sandy began her career with Anthem in September 2005 as a Sales Account Representative for large local medical/pharmacy clients. In March 2018, she joined the Specialty Sales team as a Strategic Account Consultant to support our clients who offer Anthem's specialty products.

Prior to joining Anthem, she worked for two other national health care companies in a variety of roles including marketing communications, sales, and client service.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Brenda McCumber

Job Title: Account Service Manager

Relationship to Project: Brenda is involved in many aspects of the day-to-day operation of the State of New York account with primary responsibility for all benefit changes, membership inquires, and issues involving claims processes to ensure the account is being administered correctly. In addition, Brenda is a direct point of contact for the Department of Civil Service and the Department of Employee Benefits for urgent member situations and benefit questions.

As the current Account Service Manager for the Hospital Program for the past nine years, the Department will have an accountable and experienced team member who strives to ensure all inquiries are handled thoroughly, accurately, and timely. She is constantly looking for ways to enhance the member's overall experience through internal process improvements and plan coordination. Brenda also has a close working relationship with external business partners to ensure plan administration and benefit changes are coded timely and accurately.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Hudson Valley Community College Troy, NY	Associates Degree	2003	Physical Education

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PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2015 - Present	Empire BlueCross	Account Service Manager
2010 - 2015	Empire BlueCross	Operations Expert
2003 - 2010	Empire BlueCross	Mentor/Customer Service Rep

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Brenda has over 25 years of customer service experience, including 20 years at Empire BlueCross. During Brenda's tenure, she has developed a strong working knowledge of benefits, membership, and claims processing. She has worked with several "white glove" accounts and has been in her current role on the Account Team for nine years. She has experience handling escalated inquiries and requests.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Asea Safgren

Job Title: Director, Specialty Administration

Relationship to Project: Asea will be responsible for leading and overseeing Specialty account service associates, which includes Shawna Brodeur, Specialty Account Service Manager, Sr.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Northern State University Aberdeen, SD			General

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2011 - Present	Elevance Health	Director, Specialty Administration
2001 - 2011	DeCare Dental	Director, Specialty Administration
1989 - 2001	Medica Health Plans	Manager

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Prior to joining Anthem, Asea worked in leadership overseeing a team of dental account managers and account support for Delta Dental of Minnesota. Before joining Delta Dental of MN, she worked for Medica Health Plans, a medical carrier in Minneapolis, Minnesota. During this time Asea led multiple teams including small group renewals, small group account service, and regional large group account service.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Shawna Brodeur

Job Title: _Specialty Account Service Manager, Sr.

Relationship to Project: Shawna will partner with Sandy Bogen and Brenda McCumber to deliver exceptional service support. She will act as a point of contact and liaison for the Dental Plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
N/A			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2008 - Present	Empire BlueCross	Strategic Account Executive
2007 - 2009	Empire BlueCross	Provider Network Business Analyst
2004 - 2007	Empire BlueCross	Manager, Provider Data
2000 - 2004	Empire BlueCross	Manager, Provider Service

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Shawna has been with Empire for 15 years. She has held multiple positions including within the Enrollment, Audit, Implementation, and Business Analyst departments. Shawna also spent two years as a manager for our Specialty Account Service team.

Shawna now serves as an Account Service Manager, Sr. In this role, she provides dedicated service support for our large group specialty products, acting as a point of contact and liaison for our clients and brokers.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Julie Kloncz

Job Title: Manager, Specialty Implementation

Relationship to Project: Julie oversees the Large Group Dental Implementation team.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Normandale Community College Bloomington, MN			Continuing Education
Kaplan Insurance, Inc. Plymouth, MN		2019	MN Resident Insurance Producer Accident & Health, Life

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PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2018 - Present	Anthem Blue Cross and Blue Shield	Manager, Specialty Implementation
2017 - 2018	Anthem Blue Cross and Blue Shield	Specialty Account Manager
2015 - 2017	Assured Partners of MN	Benefits Manager
2015 - 2015	Cigna	Client Manager

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Julie is the manager of Dental Implementation, where she has been in role since 2018. Prior to assuming this role, she led the Employee Client Management team with AssuredPartners of Minnesota providing superior leadership in client engagement and new business development. Julie has also served as Client Manager with Cigna where she managed and serviced Cigna's middle-market employer group Life, Accident, Disability, FML and Voluntary products. In addition, Julie held a Marketing Director position for Kemper Dental where she was a member of the sales development and marketing team for group dental and vision products. She was also a Regional Sales Director with The IHC Group and Senior Distribution Relations Executive with Securian Dental.

Julie is a results-oriented leader and strategic business partner with over 20 years in the dental benefits industry; she is recognized for her strong business acumen, ability to manage multiple priorities as well as effectively lead a team of implementation coordinators.

As a result of Julie's robust hands on implementation experience with employers with at least 50,000 covered lives and her ability to effectively lead and develop a team of professionals – you can be confident in a smooth and efficient implementation experience with Anthem.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Abbey Thornton

Job Title: Senior Client Success Advisor

Relationship to Project: Abbey serves as an expert resource in managing all post-sale implementation activities.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Minnesota – Carlson School of Management Minneapolis, MN	Bachelor of Science in Business	2010	Human Resources & Industrial Relations

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
March 2023-Present	Anthem Blue Cross and Blue Shield	Sr. Client Success Advisor
July 2021-March 2023	Anthem Blue Cross and Blue Shield	Specialty Implementation Coordinator Lead
January 2019-July 2021	Anthem Blue Cross and Blue Shield	Implementation Coordinator
May 2014-December 2016	AssuredPartners of MN	Account Executive

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Abbey has worked in the insurance industry for over a decade and has a wide range of experience with both Medical and Ancillary products, including project management, account management, and process improvement work. She has experience on both the broker and carrier side, and values a collaborative partnership between all stakeholders. Abbey leads large, complex implementations for our Strategic and National accounts, including an employer with at least 50,000 covered lives.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: ReNae Lynch

Job Title: RVP CSBD Underwriting Specialty

Relationship to Project: ReNae is the executive responsible for overseeing underwriting policies and procedures, development of the Dental Plan's ASO fee, and renewals.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Iowa State University Ames, IA	Bachelor of Science	1991	Business Administration-Finance

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2022 - Present	Elevance Health	RVP CSBD Underwriting Specialty
2011 - 2022	Elevance Health	Director Group Underwriting
2007 - 2011	Cigna Healthcare	Medical Underwriting Specialist
2004 - 2007	DeCare Dental	Underwriting Manager
2000 - 2004	DeCare Dental	Senior Underwriter
1999 - 1999	Towers Perrin	Health & Welfare Associate
1996 - 1998	MetLife	Group Underwriter/Account Specialist

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

ReNae is a results-oriented leader with over 25 years of group underwriting experience including medical, dental, vision, life and disability products. She has spent the last 15+ years in a leadership role in Specialty Underwriting, managing large group local and national customers up to 200,000 employees.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Derek Schutz

Job Title: Director & Actuary III

Relationship to Project: Derek is the executive responsible for overseeing Actuarial functions including development of pricing and plan impact factors, forecast modeling, and reserve setting.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Saint John's University Collegeville, MN	Bachelor of Arts	2008	Applied Physics

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2020 - Present	Elevance Health	Director & Actuary III
2017 - 2020	Elevance Health	Actuarial Director
2008 - 2017	Elevance Health	Various

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Derek is a member of the American Academy of Actuaries (2014) and has a fellowship with the Society of Actuaries (2017).

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Travis Weir

Job Title: Staff VP Network Optimization

Relationship to Project: Travis is responsible for the Anthem business unit providing dental networks administration, analytics, client reporting, and fraud, waste, and abuse detection.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Minnesota State University at Mankato Mankato, MN	B.A.	1996	Mathematics w/Econ & Bus. Admin. concentration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2023 - Present	Elevance Health	Staff VP Network Optimization
2017 - 2022	Elevance Health	Staff VP of Dental, Vision, Life & Disability UW and Analytics
2013 - 2016	Anthem, Inc.	Director of Dental Analytics, FW&A and Client Reporting
1999 - 2012	DeCare Dental/Delta Dental of MN	Director of Dental Actuarial and other actuarial roles

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Travis has 24 years of experience in Dental administration including multiple state employer groups, constructing customized networks, national accounts, small group and individual segments. Held leadership roles in Actuarial, Underwriting, Analytics and Fraud, Waste & Abuse with currently responsibility and oversight for the development, strategy, growth, retention and FW&A monitoring of dental network solutions in a data driven manner.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Stewart R, Balikov, DDS

Job Title: _National Dental Director, Director, Clinical Utilization Review

Relationship to Project: Dr. Balikov oversees the Utilization Management team as the principal clinical resource for utilization management, claims review, grievances and appeals, process improvements, and clinical staff education and training. He also directs the Dental Special Investigations unit responsible for fraud and/or abuse detection and recovery.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
USC School of Dentistry Los Angeles, CA	D.D.S.	1983	Dentistry
University of California, Irvine Irvine, CA	Bachelors	1978	Biological Sciences
Los Angeles Pierce College Los Angeles, CA	A.A.	1984	General Sciences

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PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2017 - Present	Anthem Blue Cross and Blue Shield	National Dental Director, Director Clinical Utilization Review
2004 – 2017	Aetna, Inc.	National Dental Director, Utilization Management
2004 - 2004	GE Consumer Finance	Operations Team Lead
2001 - 2004	GE Consumer Finance	Compliance Manager
2001 – Present	Self	Private Practice General Dentist (part time)
1983 - 2001	Self	Private Practice General Dentist (full time)

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Stewart R, Balikov, DDS, is a 1983 graduate from the University of Southern California School of Dentistry. He joined Anthem in the fall of 2017 and currently serves as our chief clinical officer directing our Dental Clinical Utilization Review team and Special Investigations Unit. He previously held the position of National Dental Director, Utilization Management, for 14 years with Aetna.

Dr. Balikov is an Accredited Health Care Fraud Investigator (AHFI®) through the National Health Care Anti-Fraud Association (NHCAA), a Certified Dental Consultant through the American Association of Dental Consultants (AADC), and a Certified Quality Assurance Consultant through the California Association of Dental Plans (CADP).

Additionally, he is a member of the American Dental Association, California Dental Association, San Fernando Valley Dental Society, Alpha Omega Dental Society, and former AADC President. He continues to maintain a limited practice in the Los Angeles area and holds active licenses in California, Colorado, and Arizona.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Lorie Ellis

Job Title: Manager II, Dental UM

Relationship to Project: Lorie's team is responsible for utilization review including predeterminations, claims review, grievances, and appeals.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
St. Cloud State U St. Cloud, MN	N/A	N/A	

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2017 - Present	Elevance Health	Manager II, Dental UM

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Lorie has 30 of experience in insurance, including health, PBM, and dental, in the areas of customer service, enrollment, contracts, corporate training, regulatory documentation, and claims. Fifteen of those years have been in leadership roles, ensuring efficiency, compliance, and customer focus while promoting and supporting all process improvement initiatives and embracing change.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Neil Goldberg

Job Title: Director Network Management

Relationship to Project: Neil oversees the Network Development and Management team and national recruitment call center. Additional functions include contractual modifications to maintain and support state or federal law requirements and product introductions, network data integrity for provider directories, and accuracy of claim processing, servicing, and provider education to the provider network.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
San Diego State Univ San Diego, CA	Bachelor of Arts	1991	Social Work
California State Univ Hayward Hayward, CA	Masters	1998	Public Admin & Health Care

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PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2007 - Present	Anthem Blue Cross and Blue Shield	Director Network Management
2005 - 2007	United Healthcare	Assistant Director, Professional Network Relations
2000 - 2005	United Healthcare	Regional Plan Manager
1999 - 2000	United Healthcare	Client and Provider Analyst

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Neil has 24 years of dental network experience working with broad range of clients (Government, Commercial, Labor, Union etc.). His management of the dental network at Anthem has resulted in significant growth leading us to be the largest PPO Dental Network, offering our current and future members the greatest access to high-quality care.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Jennifer McMorrow

Job Title: Dental Provider Network Manager Sr.

Relationship to Project: Jennifer collaborates with internal partners to determine and execute continued expansion and retention strategies — ensuring our networks meet and exceed access standards for current and future membership.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
St. Marys University Minneapolis, MN	Bachelor of Science	2013	Business

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2002 - Present	Elevance Health	Provider Network Mgr Sr.

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

During Jennifer's tenure with the organization, she has recruited and led recruitment teams assisting in the significant of our national network.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Tiffannie Saueressig

Job Title: Manager of Data Analytics & Reporting

Relationship to Project: Tiffannie oversees the dental research and analytics area. She has accountability for provider, network, and client reporting, along with managing provider reimbursement and developing rating and renewal tools for pricing.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Winona State University Winona, MN		2006	Mathematics & Statistics

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2008 - Present	Anthem Blue Cross and Blue Shield	Manager of Data Analytics & Reporting
2006 - 2008	Pearson Education	Business Analyst

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

After graduation, Tiffannie worked as a business analyst, writing code to analyze large sets of data. In her current role she excels at studying and analyzing claim data and provider network data.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Lynn Cascino

Job Title: Dental Provider Network Manager

Relationship to Project: Lynn serves as the lead project network recruiter in New York.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Dental Training Center at the Nassau County Dental Society Uniondale, NY	Certification	2002	Certified Dental Assistant
Farmingdale State College Farmingdale, NY	License	2007	Dental Hygienist

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2018 - Present	Elevance Health	Dental Provider Network Manager
2016 - 2018	Northwell Health	Analyst CPP, FPP
2013 - 2015	EmblemHealth	Dental Network Specialist
2012 - 2013	Dr. Wayne Prigoff	Office Manager
2011 - 2012	HealthPlex	Utilization Auditor

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Lynn has worked in the dental world for many years, from sitting chairside to utilization auditor, office management, and recruitment. She has also led multiple client-specific network recruitments for some of Empire's largest clients.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Suzanne Woodring

Job Title: Staff Vice President, Dental Operations

Relationship to Project: Suzanne will be responsible for the leadership and oversight of the operations staff handling the administration of the Dental Plan program. Her oversight includes group case installation and benefit coding, membership and enrollment, claims, grievance and appeals, member services, and provider customer service.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Dayton Dayton, OH	B.S.	1995	Psychology
Bellevue University Bellevue, NE	M.A.	2010	Organizational Leadership

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2022 - Present	Anthem Blue Cross and Blue Shield	Staff VP, Dental Operations
2017 - 2022	Anthem Blue Cross and Blue Shield	Director II, Customer Care
2014 - 2017	Anthem Blue Cross and Blue Shield	Director II, Medicare Operations

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Suzanne has nearly 10 years of experience in leadership positions in health insurance operations including medical, dental, and Medicare plans. Her experience includes overseeing all aspects of operations including claims, appeals, membership, and customer service in a highly regulated environment. She will apply her Intense focus on achieving exceptional results for the Department while operating in a compliant environment. Her degree in Organizational Leadership and expertise focused on operations, finance, change management, and other relevant topics have enabled her to enhance results in the business setting.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Margaret Pates

Job Title: _Director Service Operations

Relationship to Project: Margaret oversees the Claims Administration team. She creates, prioritizes, and drives claims strategy and initiatives to improve quality and timeliness that surpass service expectations.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
N/A			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2001 - Present	Elevance Health	Director Service Operations
1981 - 2001	Cigna Healthcare	Division Manager

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Prior to joining Elevance Health, Margaret spent 19 years at Cigna as a Division Manager, Financial Analyst, Regional Trainer, Auditor, Manager of Medical, Dental, and in the Subrogation Claims Department,

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Kimberly Neuttila

Job Title: Manager II Claims Operations Anthem Dental Onshore Research and Entry

Relationship to Project:. Kimberly will be responsible for creating, prioritizing, and driving claims strategy and initiatives to improve quality and timeliness.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
N/A			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2000 - Present	Elevance Health	Manager II Operations

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Kimberly has 23 years of industry experience managing a team of dental Claims Representatives and Operations experts.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Jane Tessmann

Job Title: Director, Customer Care

Relationship to Project: Jane oversees all call center activity for members and providers, and the center's overall quality, performance, and success.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Winona State University Winona, MN	Bachelor of Science	1991	Business Administration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2022 - Present	Anthem Blue Cross and Blue Shield	Director Customer Care
2020 - 2022	Humana	Customer Experience Lead
2015 - 2020	Optum	Director Population Health
2006 - 2012	Medica	Director, Service Performance

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Jane's qualifications and experience include:

- Scrum Alliance: Certified Scrum Product Owner
- University of St. Thomas: Certified Professional Project Manager
- Six Sigma Yellow Belt
- Franklin Covey Institute: Certified Manager 4 Disciplines of Execution
- Disney Institute: Professional Development Certificate, Managing for Creativity, and Innovation

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Dan Larsen

Job Title: Manager II Customer Care

Relationship to Project: As the site lead, Dan guides our Member Service teams to ensure a consistently high level of service is provided to members and providers.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
St. John's University Queens, NY	B.A.	1996	Psychology

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2000 - Present	Anthem Blue Cross and Blue Shield	Manager

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Prior to joining Anthem in 2000, Dan held management roles at Ecolab and Enterprise Rent-A-Car.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Rochelle Wright

Job Title: Director Customer Experience

Relationship to Project: Rochelle oversees grievance and appeals, employer services, and training and case implementation. These areas provide support to our customers in researching grievances, appeal determinations, employer support of claims and benefit escalations, training, and implementation/maintenance of plan benefits.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Colorado	Bachelors	2014	Communications
Colorado Technical University Colorado Springs, CO	MBA	2016	Business Administration

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PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2020 - Present	Anthem Blue Cross and Blue Shield	Director
2008 - 2020	Anthem Blue Cross and Blue Shield	Operations Manager Multi
2006 - 2008	Anthem Blue Cross and Blue Shield	Trainer
2000 - 2006	Anthem Blue Cross and Blue Shield	Customer Service Rep I, II, III

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Rochelle's experience includes:

- Director of Grievance & Appeals, Case Install, Employer Services and Training
- Vendor Manager of multiple BPOs internationally

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Sheng Xiong

Job Title: Manager of Grievance and Appeals

Relationship to Project: As manager of Manager of Grievance and Appeals, Sheng handles all dental/vision grievances and appeals from our members and providers, including escalated grievance and appeals issues, and works with other applicable areas to enhance process improvements.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Saint Catherine University St. Paul, MN	B.S.	2018	Communication Studies/Bus Mgmt

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2021 - Present	Elevance Health	Mgr. G&A
2018 - 2021	Elevance Health	Quality Configuration Auditor
2017 - 2018	Elevance Health	Provider Network Management II
2015 - 2017	Elevance Health	Refund Investigator
2012 - 2015	Elevance Health	Claims

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Sheng is a people leader with experience in training, coaching, and team building. She is responsible for driving service quality excellence by leading and influencing. Her experience includes team management, claims processing, and member and provider grievance and appeals engagement. Sheng's skill set also includes analyzing and interpreting data, assessing risks to minimize exposure.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Shana Siebrands

Job Title: Operations Expert

Relationship to Project: Shana provides support to MSRs on escalated customer service and claims processing procedures, guidelines, and application of benefits.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Colorado Colorado Springs, CO	B.A.	2001	Communications

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2007 - Present	Anthem Blue Cross and Blue Shield	Operations Expert
2003 – 2007	Anthem Blue Cross and Blue Shield	Enrollment and Billing Rep I-III

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Shana has 20 years of experience supporting dental plans. She is proficient in dental systems and ADA coding.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Jennifer Hollers

Job Title: Employee Service Representative

Relationship to Project: Jennifer serves as a direct contact and liaison for the Dental Plan and handles any escalated service and claims issues. She assists the Account Management team with claims and enrollment and escalated adjustments, and acts as the seamless link between the Account Management and Operations teams.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Clearfield Job Corp	GED	1998	

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2021-Present	Elevance Health	ESR
2018-2023	Elevance Health	Operations Expert
2014-2018	Elevance Health	CSR I-III

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Jennifer has extensive knowledge of dental claims, benefits, and eligibility. She has a proven track record of speedy resolutions to escalated issues.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Thomas Manor

Job Title: Director Quality Assurance

Relationship to Project: Thomas oversees specialty quality oversight and controls, including performance quality audit.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Wisconsin Eau Claire – Eau Claire, WI	Bachelor of Business Administration	1996	Management, Marketing & Professional Sales
University of St. Thomas St. Paul, MN	MBA	2003	Manufacturing Engineering Systems

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PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2017 - Present	Anthem Blue Cross and Blue Shield	Director of Quality Assurance
2016 - 2018	Accu Consulting Group	President
2007 - 2016	American Red Cross	Vice President Compliance, Chief Compliance Officer Biomedical Services; Senior Director of Quality
2003 - 2007	Donatelle	Corporate Governance of Regulatory and Quality Systems, Quality Manager

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Thomas' experience includes:

- 20 years of Quality and Compliance experience in regulated industries
- ASQ Certified Manager of Quality/Organizational Excellence (CMQ/OE)
- ASQ Certified Quality Engineer (CQE),
- Lean Six Sigma Greenbelt

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Lisa Kubasch

Job Title: Manager II, Dental Contract Administration

Relationship to Project: Lisa oversees dental contract administration, including dental group contracts and dental evidence of coverage issuance.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Moorhead State University Moorhead, MN	Bachelor of Science	1993	Legal Assistant

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2009 - Present	Elevance Health	Manager II Dental Contract Administration
1999 - 2009	DeCare Dental/Delta Dental of MN	Director Dental Contract Administration

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Prior to joining DeCare Dental/Delta Dental of MN, Lisa worked in the Law Offices of Daniel J. Young and the Law Offices of Bologna & Young.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Derek Lindberg

Job Title: Staff Vice President, Technology

Relationship to Project: Derek is the executive accountable for Specialty IT solutions.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Texas A&M College Station, TX	Bachelors	2009	Computer Science

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2022 - Present	Elevance Health	Staff Vice President
2021 – 2022	Anthem, Inc.	Senior Director
2019 – 2021	Anthem, Inc.	Director
2018 – 2019	Anthem, Inc.	Senior Solutions Engineering Advisor

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Prior to joining Anthem in 2019, Derek worked for Deloitte as a Business Technology Analyst, Senior Consultant, and Systems Integration Manager.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Kathryn Ansley

Job Title: Developer Advisor

Relationship to Project: Kathryn serves as the technical advisor and dental claims system expert.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Durban IT College, South Africa	Computer Science	1989	IT/Accountancy

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2011 - Present	Elevance Health	Developer Advisor
2004 - 2010	Decare Dental	Senior Developer
1997 - 2003	Delta Dental of MN	Senior Developer
1990 - 1997	Metal Industries(South Africa)	Developer

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Kathryn has more than 25 years of dental IT experience. She has been instrumental in building a custom dental system that continues to be enhanced and customized to supporting a changing marketplace.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Lucas Bitzan

Job Title: Staff Vice President Dental Product Strategy & Management

Relationship to Project: Lucas is the executive accountable for Dental Product Management. He monitors industry and competitive trends alongside regulatory and public affairs, to develop market-leading and competitive product solutions.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
St. Norbert College De Pere, WI	BBA	2005	Business Administration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2015 - Present	Elevance Health	Staff Vice President
2005 - 2015	Humana Insurance Co.	Strategic Consultant

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Lucas has more than 15 years of industry experience and has been with the organization since 2015. Previously, he held a variety of roles in business development as well as medical and specialty product strategy, development, and management as a Strategic Consultant for Humana. With a strong background and awareness of the market and experience with organizational functions including clinical, network, operations, proposals, and sales, he is passionate about building winning product strategies with strong go-to-market value propositions. He received his Bachelor of Business Administration degree from St. Norbert College with a concentration in Business Administration and Political Science.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Regina Hopkins

Job Title: Director, Dental Product Strategy and Development

Relationship to Project: Regina assists in dental group benefit design consultation within New York.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Roberts Wesleyan College Rochester, NY	Bachelor of Applied Science	Pre-1990	Business Administration, Organizational Management

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PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2013 - Present	Empire BlueCross	Director of Dental Product Strategy & Development
2006 - 2013	Empire BlueCross	Director of Medical Product Management, New York Commercial Group
2005 - 2006	Blue Shield of California	Manager Commercial Product Management (Medical)
2003 - 2005	Excellus Blue Cross and Blue Shield	Upstate NY Regional Manager, Commercial Group Product Mgmnt
2001 - 2003	Preferred Care (MVP)	Sr. Product Manager, Upstate NY Commercial Group, Medicare and Medicaid

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Regina has over 30 years of product strategy and development, project management, and consulting experience working with and for Fortune 500 companies. Earlier in her career, she served as the Director of Corporate Marketing for a global digital imaging company in NYC with direct reports in US and UK, and as a Senior Project Manager.

She has extensive experience with medical and dental product development, management and launch, client relationship management, regulatory, project management and operational and technical liaison. Regina has delivered product training, educational seminars and workshops for dental providers, brokers, and clients. She has also worked with various health plan areas including actuarial, legal, contracts, customer service, operations, technical, clinical, network, brokers, benefit consultants, and sales partners.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: David Lawrence

Job Title: Vice President, CSBD Execution

Relationship to Project: David will have leadership oversight across the medical benefit configuration and case installation teams preforming installation activities.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Indiana Institute of Technology Fort Wayne, IN	Bachelors	2008	Business Administration
Indiana Institute of Technology Fort Wayne, IN	Masters	2010	Business Administration

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PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2023 - Present	Anthem Blue Cross and Blue Shield	Vice President, CSBD Execution
2016 - 2023	Anthem Blue Cross and Blue Shield	Staff Vice President, Enterprise Benefit Administration
2013-2016	Kentucky Employee Health Plan (KEHP)	Sr Director
2013-2014	Blue Cross Blue Shield of Minnesota	Sr Director, Member Service
2012-2013	Blue Cross Blue Shield of Minnesota	Sr Director, Claims
2008-2009	Anthem Blue Cross and Blue Shield	Sr Manager, Grievance and Appeals
2011-2012	Anthem Blue Cross and Blue Shield	Enterprise Vendor Manager
2007-2008	Anthem Blue Cross and Blue Shield	Sr Manager, Specialty Pharmacy

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

David began his career at Anthem in 2007 in the Specialty Pharmacy division. Since then, he has spent 16 years in the Health Insurance industry, leading functions that range from Member Service and Grievance and Appeals, to Claims and Benefit Administration. In March of 2023, David moved into the Vice President role over the CSBD Execution team responsible for installation-related tasks including benefit configuration and enrollment.

David has extensive experience across operational management, program management, and strategic planning. He is a value-centric leader who thrives within fast-paced environments delivering forward-thinking and professionalism.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Danielle Casanova-Cruz

Job Title: Director Market Experience

Relationship to Project:

Danielle has oversight of the Case Install and Membership organization. Her dedicated team for New York clients will partner with both Account Management and Strategic Implementations, to ensure that your structure and eligibility processes are successfully established.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
N/A			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2020 - Present	Empire BlueCross	Director Market Experience
2018 - 2020	Empire BlueCross	Director Enrollment & Billing
2014 - 2018	Empire BlueCross	Mgr of Bus Projects/ Support & Imp.
2009 - 2014	Empire BlueCross	Program Manager
2005 - 2009	Empire BlueCross	Manager of Enrollment & Billing
2000 - 2005	Empire BlueCross	Corporate Trainer
1999 - 2000	Empire BlueCross	Medicare Provider Call Center
1997 - 1999	Empire BlueCross	Medicare Beneficiary Call Center

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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Danielle began her career in Government Business (Medicare) in 1997, supporting both our members and provider communities. Danielle spent many years within the training team, expanding tools, best practices, improvement opportunities to ensure high satisfaction for our members and providers experience.

As her career continued to grow, she expanded her knowledge and moved into the New York commercial market, overseeing both small and large group teams. Over the years, Danielle held many management roles within the operational teams (Case Install, Enrollment, Reporting/Metrics, Project and Support teams, Account Implementation, and Benefit Configuration). Her background within service operations projects on both a local and national level have afforded Danielle the opportunities to identify best practices, build efficiencies, and alter the experiences of our service in a positive way.

Although Danielle has supported many markets within our parent organization, most of her career has focused on the New York market; providing the unique understanding of the needs and expectations of the clients we serve.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: John Lacognata

Job Title: Manager II, Installation & Eligibility

Relationship to Project: John oversees all New York membership activities and installations, including the dedicated New York City eligibility team and the dedicated New York State eligibility team.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
NY Institute of Technology (NY)	Bachelors	1988	Communications

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2004 - Present	Empire BlueCross	Operations Manager
2002 - 2004	Gentiva Health Services	Legal Contract Analyst
1989 - 2002	Metlife/United Healthcare	Underwriting & Finance

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form
RFP entitled:
"Dental Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

John has managed the set up and eligibility maintenance of groups in the New York market for the past 19 years.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form
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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Michelle Diebold

Job Title: Manager III, ASO Billing

Relationship to Project: Michelle manages the billing functions.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Cincinnati Cincinnati, Ohio	BBA	2009	Finance

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2014 - Present	Anthem Blue Cross and Blue Shield	Billing Manager
2009 - 2014	Cintas	Accounting

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Biographical Sketch Form
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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Michelle has 10 years of experience working with and managing billing for large National and New York local accounts.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Rahul Kaushal

Job Title: Director II, Digital Operations

Relationship to Project: Rahul is responsible for Electronic Enrollment Transaction (EET) functions and monitoring to ensure that files are successfully received and loaded.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
PEC, India	Bachelors	2003	Engineering
Xavier Institute, India	MBA	2005	Marketing and Finance

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2019 - Present	Elevance Health	Director II, Digital Ops
2018 - 2019	Infosys Ltd	Director, Client Services & Delivery
2014 - 2018	Highmark Health	Assoc Principal, Clinical & Govt Programs
2007 - 2014	Cognizant Technology Solutions	Associate Director
2005 - 2006	ICICI Lombard General Insurance	Area Sales Manager

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Biographical Sketch Form** **RFP entitled:** **"Dental Plan Services"**

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Rahul's primary responsibility is to support all digital enrollments across Operations and IT for our New York customers.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Janna Liberty

Job Title: Audit and Reporting Liaison

Relationship to Project: As the audit and reporting liaison, Janna tracks and monitors all aspects of audits in process and ensures the Department or the Office of the State Comptroller receives the required reporting in a timely manner. She provides the agencies with all supporting documentation and coordinates all meetings and site visits, including coordinating responses for audits.

She frequently works with the Office of the State Comptroller and the Department of Civil Service Audit and Resource Management Team. In addition, she assists the Department of Civil Service Office of Financial Administration as it relates to client reporting and updates to outbound claim activity files to all three agencies. Janna has supported the account team for the past six years, meeting all deliverables to exceed the Department's expectations. She has the experience and knowledge of the State account, along with a proven record of accomplishment, to ensure we continue to provide excellent service to the Department.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University at Albany Albany, NY	B.A.	2002	Communications

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form
RFP entitled:
"Dental Plan Services"

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2017 - Present	Empire BlueCross	Business Analyst III
2017 - 2017	Beacon Health Options	Customer Service Rep III
2017 - 2017	Conduent (contractor)	QA Specialist
2013 - 2017	MAXIMUS, Inc.	Privacy/Compliance Analyst
2011 - 2013	Empire BlueCross	Sr. Grievance and Appeals Analyst
2007 - 2011	Empire BlueCross	Utilization Management Rep III
2005 - 2007	Empire BlueCross	Operations Expert
2003 - 2005	Empire BlueCross	Provider Service Rep

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Janna has more than 20 years of health insurance experience, with 16 years at Empire. She has been on the NYS Account team acting as a client reporting analyst and audit liaison for over three years. She has developed a strong rapport with auditors at the NYS Office of the State Comptroller and NYS Department of Civil Service Audit and Resource Management Team by coordinating all aspects of their audits including, but not limited to, providing timely and thorough responses, providing requested materials, and facilitating audit site visits and conference calls with relevant internal stakeholders.

She has supported the technical and operational functions of the NYS account for three years including updating client reporting, managing all inbound and outbound files to NYS and our business partners, and coordinating all IT support and ticketing associated with this maintenance.

Janna has five years of experience in quality assurance and conducting system, site, operational, and documentation audits. She also successfully completed the ISO 9001:2008 Certified Lead Auditor Training.

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Biographical Sketch Form
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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Allison Austin

Job Title: Staff VP, Marketing Strategy & Insights

Relationship to Project: Allison will provide strategic marketing leadership to her team who will support the account management team with the Dental Plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Castleton University Castleton, VT	B.S in Business Administration	1993	Marketing

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2022 - Present	Anthem Blue Cross and Blue Shield	Staff VP Marketing, Strategy & Insights
2020 - 2022	Anthem Blue Cross and Blue Shield	Staff VP Marketing, Local & Broker
2017 - 2020	Anthem Blue Cross and Blue Shield	Staff VP Marketing, Small Group
2013-2017	Anthem Blue Cross and Blue Shield	Staff VP Marketing, East Region
2008-2013	Anthem Blue Cross and Blue Shield	Regional Director, Commercial Marketing
1997-2008	Anthem Blue Cross and Blue Shield	Local Georgia Marketing Roles

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Biographical Sketch Form
RFP entitled:
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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Passionate about the role she plays in creating a better health care experience, Allison spent the first few years of her career focused on public relations and marketing for her community's local hospital. She has dedicated her career to promoting authentic change in the B2B health care space. Today, Allison serves as the Staff Vice President Marketing Strategy and Insights at Elevance Health, with a focus on the local health plans, Individual, Small Business and Broker/Consultant Marketing for her company's Anthem Blue Cross Blue Shield 14 state footprint.

Allison's authentic, invested, and trustworthy leadership style is evidenced by her 2022 Associate engagement survey results: an overall score of 91%; manager score of 97%; diversity/equity/inclusion score of 90%; and a value score of 93%. She was also one of 64 Associates selected and certified to be a Culture Workshop Facilitator.

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Biographical Sketch Form
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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Jill Atwood

Job Title: Marketing Strategy Director

Relationship to Project: Jill will be responsible for member marketing and communication support.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Maine Orono, ME	Bachelors of Art	2003	Journalism

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2020 - Present	Elevance Health	Marketing Strategy Director
2017 - 2020	Fuseideas	Account Director
2015 - 2017	CIEE	Director of Marketing
2011 - 2015	VIA Agency	Sr. Project Manager

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Biographical Sketch Form
RFP entitled:
"Dental Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Jill and her team of local marketing managers currently manage communications for two of our parent organization's largest state accounts, along with multiple smaller accounts with custom communication needs within New York, Georgia, and Virginia. Prior to joining Empire, Jill managed marketing programs for organizations such as Sam's Club, Timberland, the Connecticut Lottery, and Georgetown University.

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Biographical Sketch Form
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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Amanda Wauthier

Job Title: Marketing Manager

Relationship to Project: Amanda is accountable for an integrated marketing strategy and analytics.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Hofstra University Hempstead, NY	B.S.	2008	Video, TV & Film
Southern Connecticut State University New Haven, CT	MBA, Marketing	2011	Marketing

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2021 - Present	Elevance Health	Marketing Manager
2014 - 2021	UnitedHealth Group	Regional Marketing Manager
2013 - 2014	OGH	Marketing Manager
2011 - 2013	Onward Healthcare	Campus Relations Manager

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Biographical Sketch Form** **RFP entitled:** **"Dental Plan Services"**

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Amanda currently manages communications for the State of New York accounts along with custom communication needs within New York.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Josh Kahn

Job Title: Staff VP, Digital Product

Relationship to Project: Josh is the executive responsible for digital client and member communication support leadership.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
UNC-Chapel Hill Chapel Hill, NC	Bachelor of Science	2009	Business Administration
Duke Fuqua School of Business Durham, NC	Master of Business Administration	2015	Health Sector Mgmt

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2020 - Present	Elevance Health	Staff VP
2019 - 2020	Castlight Health	Director
2009 - 2013, 2015 - 2019	Deloitte Consulting	Manager

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Biographical Sketch Form** **RFP entitled:** **"Dental Plan Services"**

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Josh has significant experience in digital product related to incentivizing and driving healthier behaviors. He is studied in behavioral psychology and "nudge" theory.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Kate Otto

Job Title: Director, Digital Product

Relationship to Project: Kate will be part of the account management team with responsibility for overseeing development of a microsite.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Washington University in St. Louis St. Louis, MO	Bachelors	1997	Arts & Sciences
Washington University in St. Louis St. Louis, MO	MBA	2016	Business

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2016 - Present	Elevance Health	Director, Digital

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Biographical Sketch Form
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PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Kate began her career with Empire BlueCross in April 2016 as a Director in the Digital organization. In her time here, she has had accountability for a variety of functions including content strategy, enterprise content management platforms, content operations, product development, and product strategy.

Prior to joining Empire, she worked for a variety of organizations from agencies to non-profit healthcare associations in Content and Product management roles.

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Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Individual's Name: Christine Leko

Job Title: Manager, Product Development

Relationship to Project: Christine will be part of the account management team with responsibility for overseeing development of a microsite.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Southwest Minnesota State University Marshall, MN	Bachelors	2001	Business Administration
Hamline University Saint Paul, MN	MBA	2012	Business

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2021 - Present	Elevance Health	Manager, Product Development

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Biographical Sketch Form** **RFP entitled:** **"Dental Plan Services"**

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Christine began her career with Elevance Health in October 2021 as a manager in the Digital organization. In her time at Elevance Health, she has had accountability for Product development and Content Operations.

Prior to joining Anthem, she worked for a variety of organizations in digital/web development space.

Dental - Preliminary Implementation Timeline			
Effective Date	**9/1/2024**		
Group Name	**New York State Dental Plan**		
Implementation Meeting and Paperwork	**Start Date**	**Due Date**	**Responsible Parties**
Conduct Implementation Kickoff Meeting	[redacted]	[redacted]	The Department/Abbey Thornton
Obtain signed Master Application and BAA	[redacted]	[redacted]	The Department/Abbey Thornton
Obtain dental benefit summary/plan sign-off	[redacted]	[redacted]	The Department/Abbey Thornton
Determine enrollment process	[redacted]	[redacted]	The Department/Abbey Thornton
Determine marketing and member communication needs	[redacted]	[redacted]	The Department/Sandy Bogen
Request utilization data to determine member letter mailing list for extended in-network benefits	[redacted]	[redacted]	The Department/Prior Carrier/Sandy Bogen
Determine needs and dates of Health Benefit Fairs, select conferences, and benefit design information sessions	[redacted]	[redacted]	The Department/Sandy Bogen
Account Structure	**Start Date**	**Due Date**	**Owner**
Determine account structure needs for billing, eligibility, claims	[redacted]	[redacted]	The Department/Abbey Thornton
Receive approval of account structure	[redacted]	[redacted]	The Department/Abbey Thornton
Dental Benefits Coding and Claims Processing	**Start Date**	**Due Date**	**Owner**
Completion of benefit plan designs in dental system	[redacted]	[redacted]	Lisa Kubasch
Completion of claims testing	[redacted]	[redacted]	Kim Neuttila
First draft of Certificate Booklet ready for review	[redacted]	[redacted]	Lisa Kubasch
Revise Certificate Booklet as applicable	[redacted]	[redacted]	Lisa Kubasch
Obtain approval of Certificate	[redacted]	[redacted]	The Department
Accumulator File Load	**Start Date**	**Due Date**	**Owner**
Determine needs for prior carrier accumulator report - Transition of benefits	[redacted]	[redacted]	The Department/ Abbey Thornton
Establish secure connection for accumulator file transfers	[redacted]	[redacted]	Prior Carrier/Kathryn Ansley
Completion of accumulator file load	[redacted]	[redacted]	Kathryn Ansley
Eligibility	**Start Date**	**Due Date**	**Owner**
Confirm open enrollment dates	[redacted]	[redacted]	The Department/ Abbey Thornton
Request a test 834 File	[redacted]	[redacted]	The Department/Rahul Kaushal
Testing of eligibility files	[redacted]	[redacted]	The Department/Rahul Kaushal
Request a production 834 File	[redacted]	[redacted]	The Department/Rahul Kaushal
Establish process for dependent student eligibility verification	[redacted]	[redacted]	John Lacognata
Billing	**Start Date**	**Due Date**	**Owner**
Confirm how ASO claim fees will be paid [ACH wire or EFT Demand Debit]	[redacted]	[redacted]	The Department/Michelle Diebold
Confirm billing/reporting requirements with ASO billing representative	[redacted]	[redacted]	The Department/Michelle Diebold
Provider Networks	**Start Date**	**Due Date**	**Owner**
Recruitment plan execution	[redacted]	[redacted]	The Department/Jennifer McMorrow
Provider communication & plan education	[redacted]	[redacted]	Jennifer McMorrow
Find Care customization	[redacted]	[redacted]	Jennifer McMorrow
Network configuration & customization (claim adjudication)	[redacted]	[redacted]	Jennifer McMorrow
Website & Mobile App	**Start Date**	**Due Date**	**Owner**
Completion of customized microsite/website	[redacted]	[redacted]	Kate Otto
Testing of microsite/website	[redacted]	[redacted]	Kate Otto
Completion of Sydney mobile app	[redacted]	[redacted]	Kate Otto
Testing of Sydney mobile app	[redacted]	[redacted]	Kate Otto
Member Services	**Start Date**	**Due Date**	**Owner**
Establish dedicated phone number	[redacted]	[redacted]	Jane Tessmann
Communicate new plan to Member Services	[redacted]	[redacted]	Jill Atwood
Complete training for Call Center staff	[redacted]	[redacted]	Jane Tessmann
Open dedicated Call Center - including recruitment/hiring of dedicated staff	[redacted]	[redacted]	Jane Tessmann
Training grievance and appeal staff	[redacted]	[redacted]	Rochelle Wright

Dental - Preliminary Implementation Timeline			
Effective Date	**9/1/2024**		
Group Name	**New York State Dental Plan**		
Implementation Effective	**Start Date**	**Due Date**	**Owner**
Effective date of the Plan - Welcome to Anthem	[redacted]	[redacted]	Abbey Thornton
Account Manager schedules meeting to review reporting tools	[redacted]	[redacted]	Sandy Bogen

*** Please note the timeline dates are subject to change based upon different factors including but not limited to; complete paperwork received and open enrollment dates. The Implementation Coordinator reviews key milestone dates once additional information is confirmed.**

Dental
Preliminary Implementation Diagram

[redacted]
Implementation kick-off call and introduction to Anthem, obtain signed paperwork, benefit plan sign off, determine enrollment process

[redacted]
Determine account structure needs for billing, eligibility, and claims

[redacted]
Determine necessary member communications, including member letter for extended in-network benefits

[redacted]
Establish and open dedicated call center - Communicate/train member services and call center staff - Grievance and appeal staff training

[redacted]
Provider recruitment - Provider communication and plan education - Find Care customization - Network configuration, customization, and completion

[redacted]
Complete testing of eligibility files - Request production file
Establish process for dependent student verifications

[redacted]
Testing and completion of customized Microsite - Completion and testing of Sydney mobile app

[redacted]
Dental benefit plan load - Completion of claims testing - Draft and revise certificate booklets

[redacted]
Confirm how ASO fees will be paid and confirm billing / reporting requirements with ASO representative

[redacted]
Finalize dedicated phone number and call center - Complete training for call center staff

[redacted]
Establish secure connection for accumulator file transfers and completion of accumulator file load

[redacted]
Completion of accumulator file load and transition of benefits

September 2024: Welcome to Anthem
Plan is effective 9/1/24, Account Management team reviews reporting tools

Please note the timeline dates are subject to change based upon different factors including but not limited to; complete paperwork received and open enrollment dates. The Implementation Coordinator reviews key milestone dates once additional information is confirmed.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Performance Guarantees RFP entitled: "Dental Plan Services"**

Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

Implementation Guarantee: The Offeror proposes to forfeit $[redacted] for each Calendar Day or part thereof, that all Implementation requirements are not met in the time frame stated in Section 3.2. The forfeited amount (Standard Credit Amount) is $1,500.00 a day for each Calendar Day the guarantee is not met. However, an Offeror may propose higher amounts. This guarantee is not subject to the limitation of liability provisions of the Contract.

[redacted]

Enrollment Management Guarantee: The Offeror proposes to forfeit $[redacted] for each twenty-four-hour period or part thereof in which enrollment records that meet the quality standards for loading are not loaded in the Offeror's enrollment system after such enrollment records have been released by the Department. The forfeited amount (Standard Credit Amount) is $1,000.00 for each twenty-four-hour period or part thereof in which this guarantee is not met. However, an Offeror may propose higher amounts.

Call Center Response Time Guarantee: The Offeror proposes to forfeit $[redacted] for each quarter in which the number of phone calls answered within thirty seconds falls below 90% of all incoming calls. The forfeited amount (Standard Credit Amount) is $15,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

Availability Guarantee: The Offeror proposes to forfeit $[redacted] for each quarter in which the Offeror's telephone line is not operational and available to Members and Providers 99.5% percent of the time. The forfeited amount (Standard Credit Amount) is $15,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

[redacted]

Telephone Abandonment Rate Guarantee: The Offeror proposes to forfeit **$**[redacted] for each quarter in which more than 3% of callers disconnect a call prior to the call being answered by a CSR. The forfeited amount (Standard Credit Amount) is $15,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

[redacted]

Telephone Blockage Rate Guarantee: The Offeror proposes to forfeit **$**[redacted] for each quarter in which more than 0% of incoming calls to the Offeror's telephone line are blocked by a busy signal. The forfeited amount (Standard Credit Amount) is $15,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

Reporting Services Guarantee: The Offeror proposes to forfeit $[redacted] for each Calendar Day the Department has not received the Dental Plan management reports and claims file by their respective due dates as outlined in *Program Reporting* (Attachment 17). The forfeited amount (Standard Credit Amount) for each management report or claim file that is not received by its respective due date is $100 per Calendar Day per report. However, an Offeror may propose a higher amount.

Claims Payment Accuracy Guarantee: The Offeror proposes to forfeit $[redacted] for each year in which 98% of claims payment accuracy is not achieved as determined based on an annual audit conducted by the Department. The forfeited amount (Standard Credit Amount) is $60,000.00 for each year this guarantee is not met. However, an Offeror may propose higher amounts.

[redacted]

Claims Processing Guarantee – Twenty-Four (24) Calendar Days Turnaround Time: The Offeror proposes to forfeit **$**[redacted] for each quarter in which less than 99.5% of claims that require no additional information in order to be correctly processed, are not processed within twenty-four Calendar Days from either the date the claim is received electronically or in the Offeror's designated post office box to the date the payment is transmitted to the Provider or mailed to the Member as calculated on a quarterly basis. The forfeited amount (Standard Credit Amount) is $15,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

Network Access Urban Areas Guarantee: The Offeror proposes to forfeit $[redacted] for each quarter in which urban Enrollees do not have Dental Provider access that meets the network Access-Urban Areas requirements as outlined in Section 3.3. The amount quoted by the Offeror shall be applied only once per quarter for General Dentistry and for each of the individual Specialist types if the Offeror fails to maintain required access in Urban Areas. The quoted access standard is not an overall aggregate of Dental Provider access in Urban Areas (i.e., there is one standard for General Dentists and a standard for each of the individual Specialty types as outlined in Section 3.3). The forfeited amount (Standard Credit Amount) is $15,000.00 for any Dental Provider type, calculated quarterly. An Offeror may propose a higher amount.

[redacted]

Provider Type and Minimum Requirement	*Minimum Access Requirement*	*Anthem Proposed Access*
General Dentist – 2 within 5 Miles	*98%*	[redacted]
Pedodontist – 1 within 5 Miles	*91%*	[redacted]
Orthodontist – 1 within 5 Miles	*91%*	[redacted]
Periodontist – 1 within 5 Miles	*91%*	[redacted]
Oral Surgeon – 1 within 5 Miles	*91%*	[redacted]
Endodontist – 1 within 5 Miles	*91%*	[redacted]

Network Access Suburban Areas Guarantee: The Offeror proposes to forfeit $[redacted] for each quarter in which suburban Enrollees do not have Dental Provider access that meets the network Access-Suburban Areas requirements as outlined in Section 3.3. The amount quoted by the Offeror shall be applied only once per quarter for General Dentistry and for each of the individual Specialist types if the Offeror fails to maintain required access in Suburban Areas. The quoted access standard is not an overall aggregate of Dental Provider access in Suburban Areas (i.e., there is one standard for General Dentists and a standard for each of the individual Specialty types as outlined in Section 3.3). The forfeited amount (Standard Credit Amount) is $15,000.00 for any Dental Provider type, calculated quarterly. An Offeror may propose a higher amount.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Performance Guarantees
RFP entitled:
"Dental Plan Services"

[redacted]

Provider Type and Minimum Requirement	*Minimum Access Requirement*	*Anthem Proposed Access*
General Dentist – 2 within 10 Miles	*98%*	[redacted]
Pedodontist – 1 within 15 Miles	*95%*	[redacted]
Orthodontist – 1 within 15 Miles	*95%*	[redacted]
Periodontist – 1 within 15 Miles	*95%*	[redacted]
Oral Surgeon – 1 within 15 Miles	*95%*	[redacted]
Endodontist – 1 within 15 Miles	*95%*	[redacted]

Network Access Rural Areas Guarantee: The Offeror proposes to forfeit $[redacted] for each quarter in which rural Enrollees do not have Dental Provider access that meets the network Access-Rural Areas requirements as outlined in Section 3.3. The amount quoted by the Offeror shall be applied only once per quarter for General Dentistry and for each of the individual Specialist types if the Offeror fails to maintain required access in Rural Areas. The quoted access standard is not an overall aggregate of Dental Provider access in Rural Areas (i.e., there is one standard for General Dentists and a standard for each of the individual Specialty types as outlined in Section 3.3). The forfeited amount (Standard Credit Amount) is $15,000.00 for any Dental Provider type, calculated quarterly. An Offeror may propose a higher amount.

[redacted]

Provider Type and Minimum Requirement	*Minimum Access Requirement*	*Anthem Proposed Access*
General Dentist – 2 within 20 Miles	*95%*	[redacted]
Pedodontist – 1 within 25 Miles	*70%*	[redacted]
Orthodontist – 1 within 25 Miles	*65%*	[redacted]
Periodontist – 1 within 25 Miles	*50%*	[redacted]
Oral Surgeon – 1 within 25 Miles	*90%*	[redacted]
Endodontist – 1 within 25 Miles	*80%*	[redacted]

[redacted]

Transition and Termination Guarantee: The Offeror proposes to forfeit $[redacted] for each day or part thereof that the Transition Plan requirements are not met. The forfeited amount (Standard Credit Amount) is $1,000.00 for each day this guarantee is not met. However, an Offeror may propose higher amounts.

ATTACHMENT 12

New York State
Subcontractors and Suppliers
RFP entitled:
"Dental Plan Services"

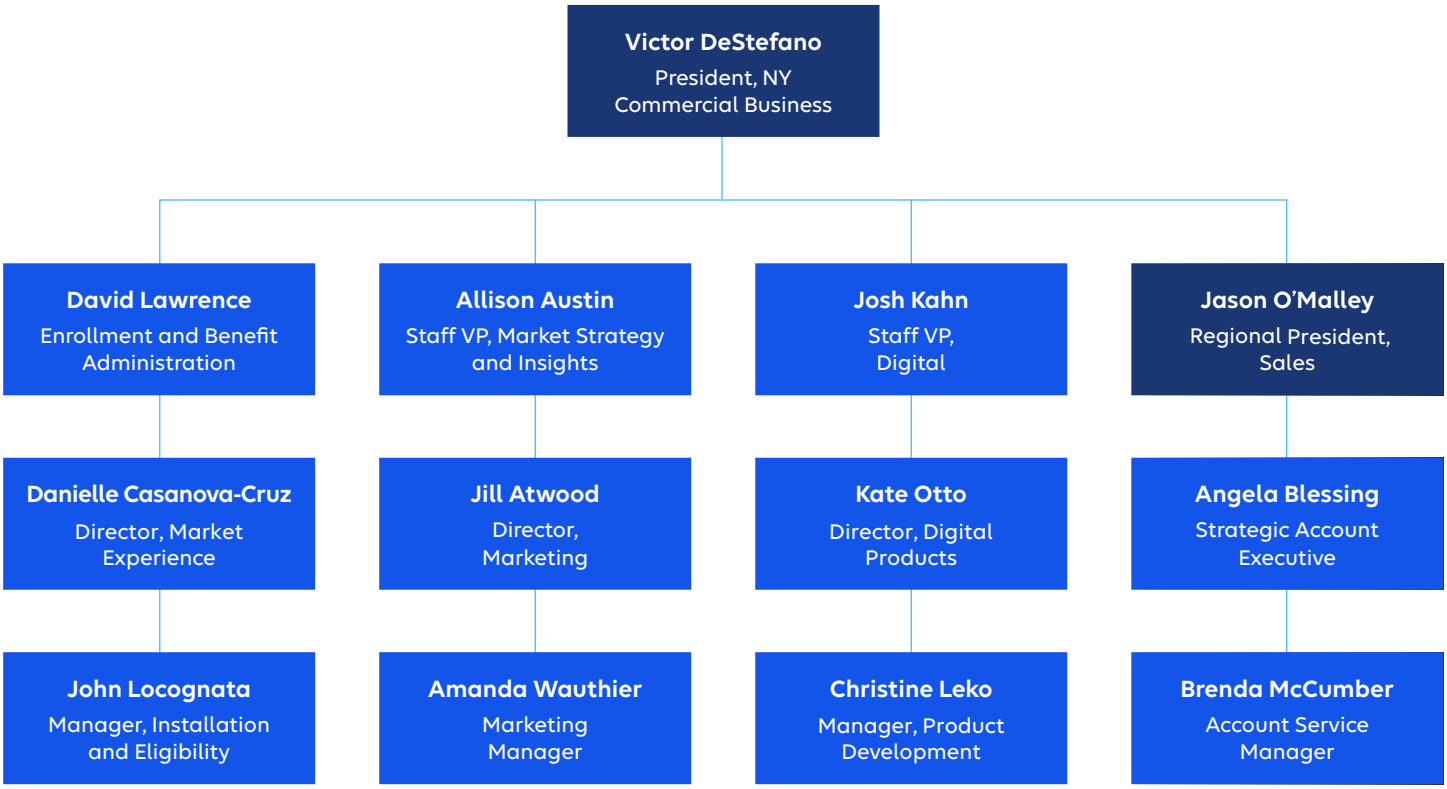
Offeror Name: Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross

As stated in Section 2 of this RFP, an Offeror is encouraged to use New York State businesses in the performance of Project Services. Please complete the following exhibit to reflect the Offeror's proposed utilization of New York State businesses.

Name(s) of New York Subcontractors and/or Suppliers	Address, City, State, and Zip Code	Description of Services or Supplies Provided	Estimated Value Over 1-Year Contract Period	Identify if Subcontractor and/or Supplier
Anthem HealthChoice Assurance, Inc. dba Anthem Blue Cross fully supports having a substantial presence in New York State. We proudly have been serving New York families and businesses since 1934. Anthem is a local partner in the communities of New York, with 5,007 locally based employees living and working in several locations across the state. While we are not identifying specific New York State businesses at this time in the fulfillment of the Department's dental contract, we will strongly consider our needs and use local resources as appropriate to further contribute to the economies of the state and the nation.				

New York State Dental Plan

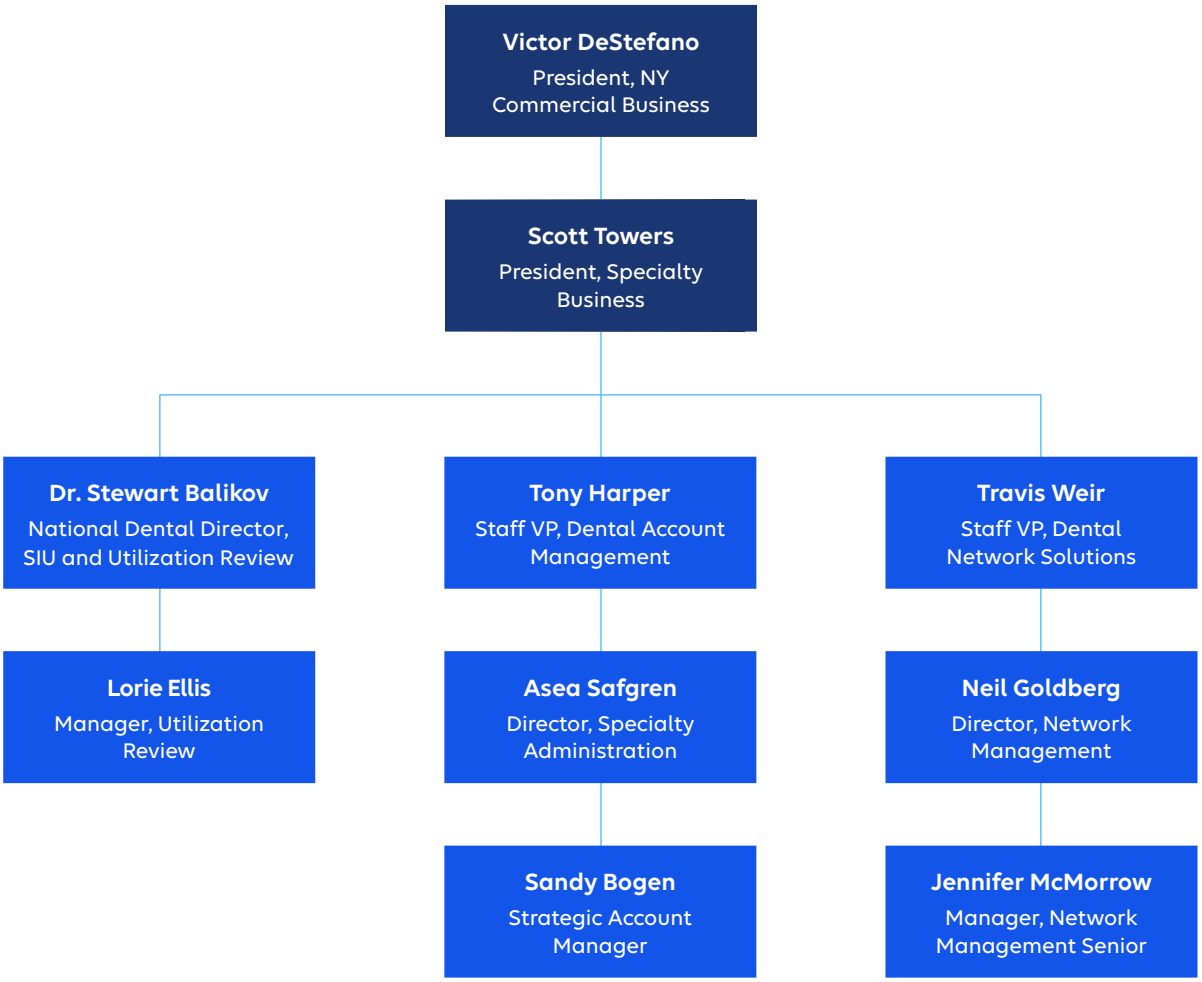
Proposed Dental Service Team



Anthem

New York State Dental Plan

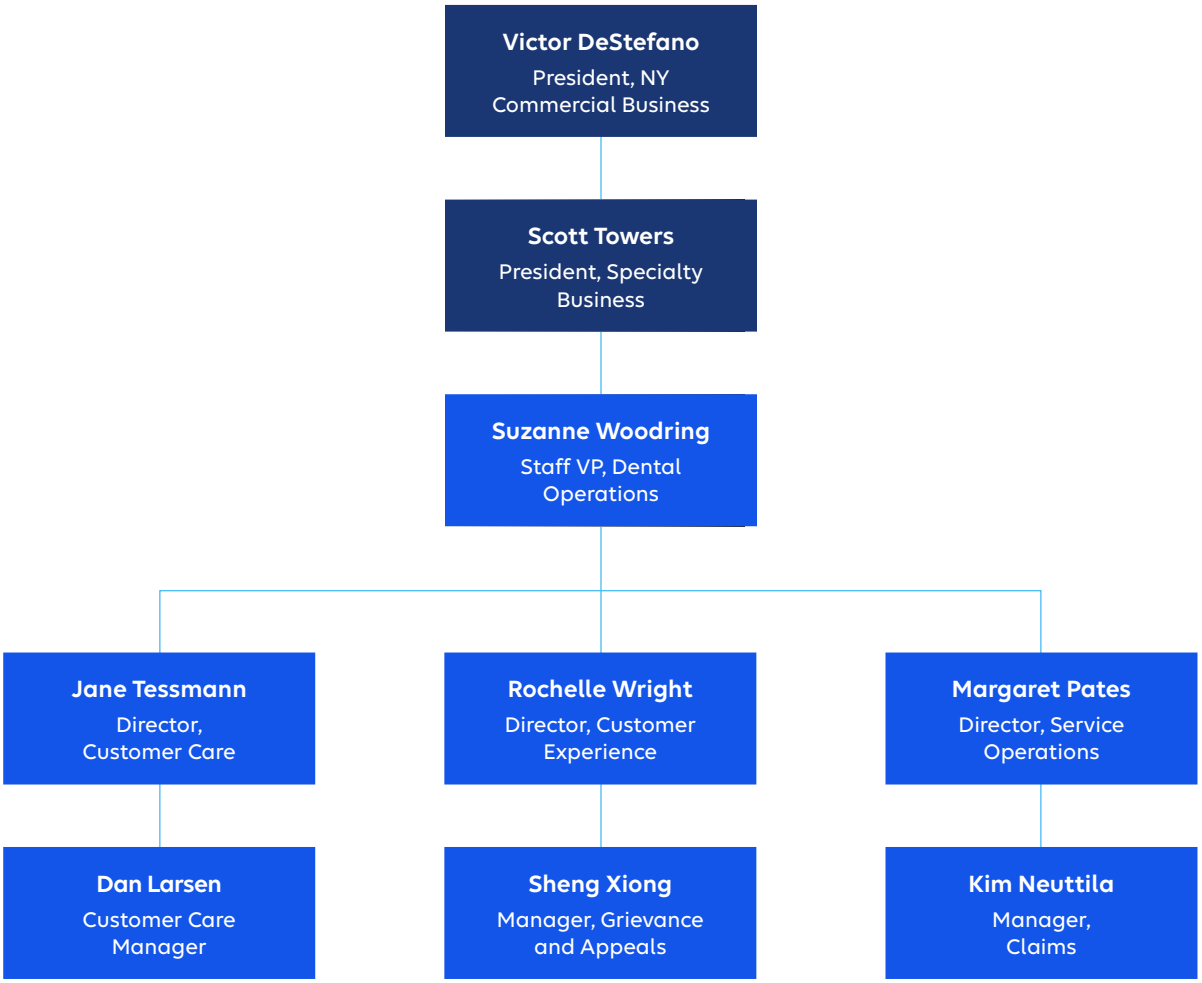
Proposed Dental Service Team



Anthem

New York State Dental Plan

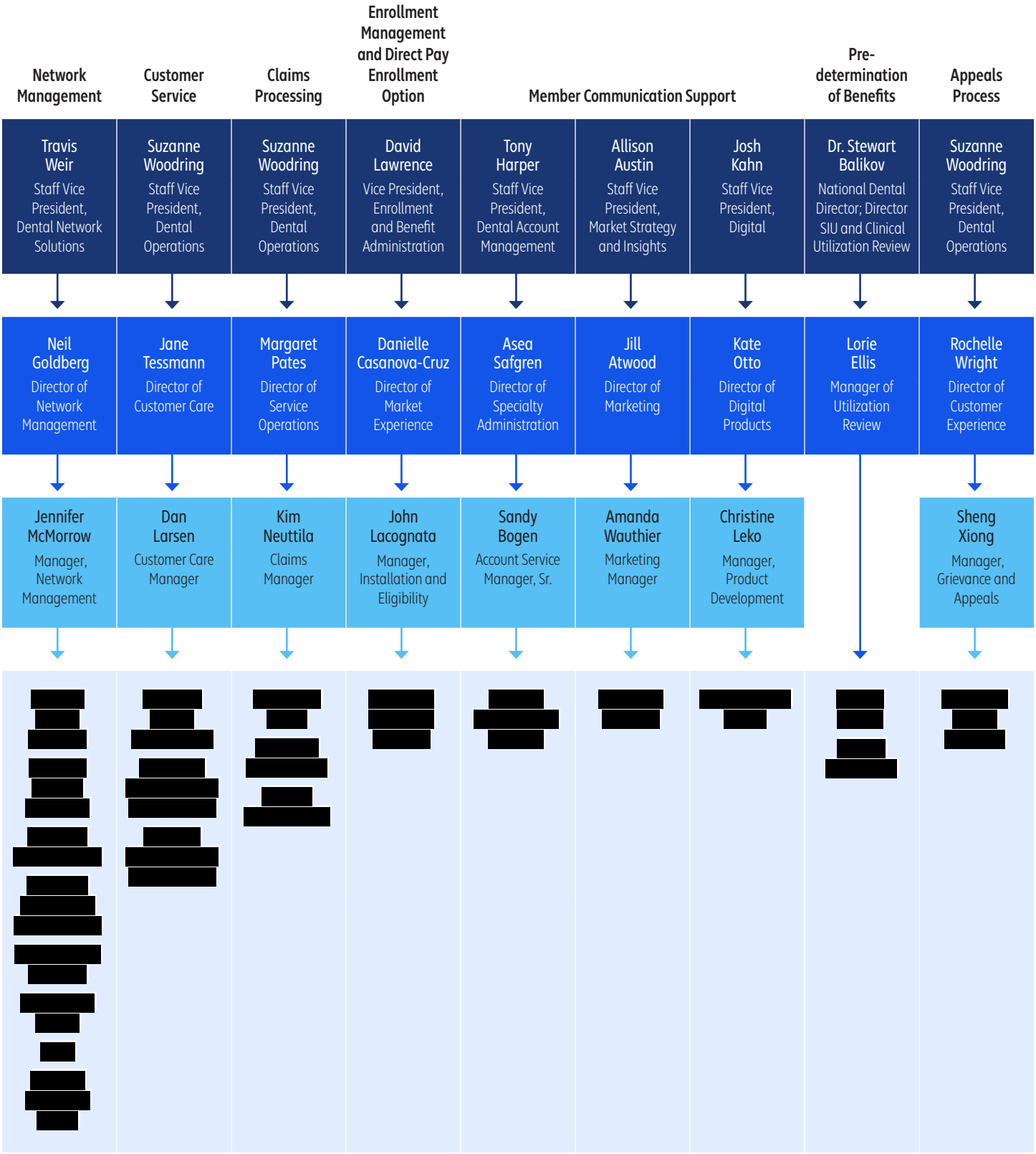
Proposed Dental Service Team



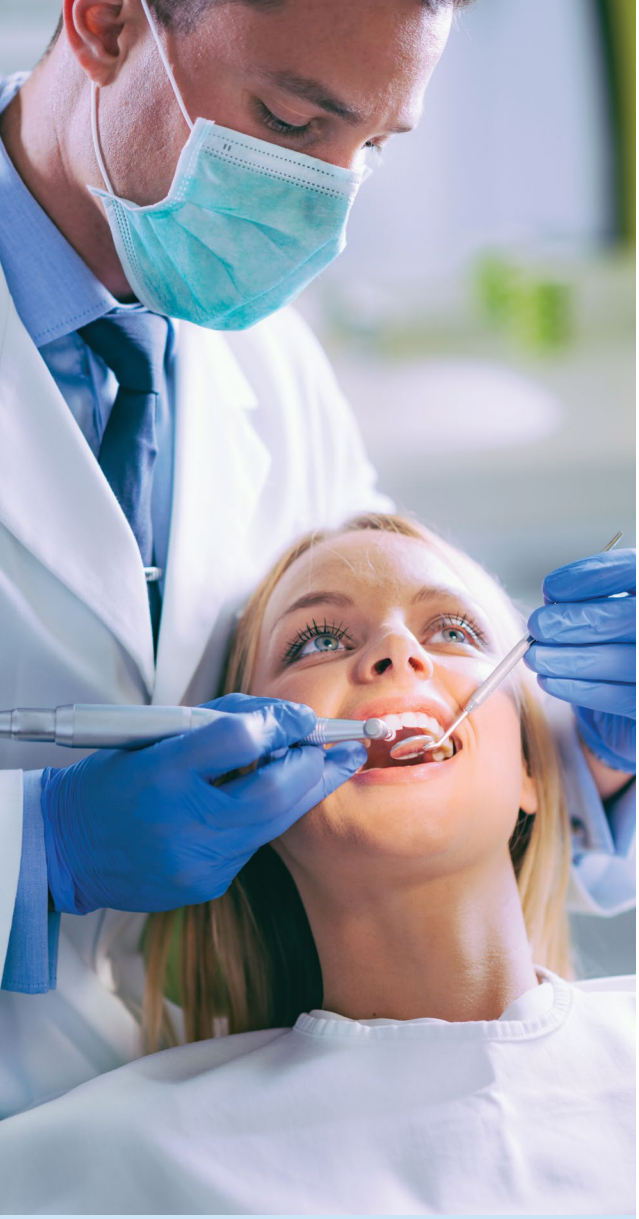
Anthem

New York State Dental Plan

Proposed Dental Staffing Plan



Anthem



Anthem

Regular dental visits can help

keep your whole body healthy

Your [redacted] dental plan from Anthem has important new benefits

Did you know that many chronic illnesses, such as diabetes, cancer, and heart disease, can first show symptoms in the mouth, head, or neck?[1,2] Not only that — certain conditions such as infections, cavities, severe gum disease, and tooth loss can have a big impact on your overall health and quality of life. If you can catch these problems early, they may be easier to treat and less costly.

Your dental plan now has even more ways to help keep you healthy

- **You receive two routine dental cleanings a year**
  Your dental visit includes a dental exam, two teeth cleanings a year, a bitewing X-ray, and a full-mouth (or panoramic) X-ray once every three years. These are covered at 100% when you visit a dentist in your plan's network.
- **Your annual benefit maximum has increased to $2,000 per year**
  This is the amount Anthem will pay for dental benefits in a calendar year. Plus, your diagnostic and preventive services will no longer apply toward your annual maximum. That means your new benefit maximum can cover even more dental care.
- **A brush biopsy is now included in your dental benefit**
  This is the most precise way to help detect and treat oral cancer.

We are here to help

If you have questions about your Anthem dental coverage, call Member Services at 877-814-9709. You can also visit **anthem.com** or download the Sydney℠ Health app for more information.

Nearly
1 in 2
Americans
over age 30 have gum disease, which is linked to other serious health issues.[3]

6 in 10
adults have a chronic health condition.[4]

64%
of adults
diagnosed with oral cancer survive five years after diagnosis.[5]

1 Mayo Clinic: *Oral health: A window to your overall health* (accessed October 2022): mayoclinic.org.
2 American Dental Association: *Cancer (Head and Neck)* (accessed October 2022): ada.org.
3 Centers for Disease Control and Prevention: *Periodontal Disease* (accessed October 2022): cdc.gov.
4 Centers for Disease Control and Prevention: *About Chronic Diseases* (accessed October 2022): cdc.gov.
5 Centers for Disease Control and Prevention: *United States Cancer Statistics: Data Visualizations: 5-year Relative Survival (Percent) Oral Cavity and Pharynx, Invasive Cancers Only, United States* (accessed October 2022): cdc.gov.

1045037INMENABS BV 10/22

Protect your smile and your health with extra dental care

Your [redacted] dental plan includes more care for people with certain medical conditions

Good dental health is part of good overall health. It's especially important for people with certain medical conditions, who face a higher risk for dental problems.

That's why your dental plan offers more protection if you have a qualifying medical condition. You can get extra dental care — such as more cleanings and routine exams — to help keep your oral health on track.* These extra services are 100% covered when you see a dentist in your plan's network. They also won't count against your plan's yearly coverage maximum.

How extra dental care works

If you have any of these conditions:

- Diabetes
- Pregnancy
- Stroke
- Organ or bone marrow transplant
- Cancer treated with chemotherapy
- Head or neck cancer treated with chemotherapy and/or radiation
- HIV or AIDS
- End-stage kidney disease

You can get these services more often:*

- Cleanings
- Gum maintenance
- Fluoride
- Sealants
- Gum scaling and root planing (also known as deep cleaning)
- Routine or problem-focused exams

Take the next step

To **sign up for extra dental care**, call Member Services at 877-814-9709.

Once you're signed up, **talk to your dentist**. They can create a care plan that is right for you.

About **1 in 4** adults in the United States have untreated tooth decay.[1]

Nearly **50%** of U.S. adults show signs of gum disease, which can lead to tooth loss.[2]

* [redacted] dental members must first exhaust their regular plan benefits before extra dental care can be used (such as more cleanings or additional routine exams).

Sources:

1 Centers for Disease Control and Prevention: *Facts About Adult Oral Health* (accessed February 2023): cdc.gov.

2 Centers for Disease Control and Prevention: *Gum Disease* (accessed February 2023): cdc.gov.

1048375INMENABS 01/23

Anthem

Anthem

[redacted]

Take advantage of $4,000 in dental benefits

[redacted] Dental Health Network

Your dental health is a critical part of your overall health. That's why dental benefits powered by the [redacted] Dental Health Network give you coverage other plans don't.

Dental health matters

Nearly 1 in 2 Americans

over age 30 have gum disease, which is linked to other serious health issues, including heart disease and diabetes.*

This includes:

- A $4,000 annual dental benefit maximum, which is twice what most dental plans offer.
- A $2,000 lifetime orthodontic benefit maximum.
- No deductibles or copays.
- 100% coverage for most dental services, including accidental dental injury.
- Dental implant and root canal coverage.

112055CAMENABC BV Rev. 07/22

Enjoy the plan benefits

of the [redacted] Dental Health Network

Here's a summary of the plan features and your coverage when you receive care from a dentist in the plan's network.

To find a dentist in the network, go to **anthem.com/ca/[redacted]**.

[redacted] Dental Health Network

Key features	
Office visit copay	$0
Annual deductible	$0
Annual benefit maximum	$4,000
Annual dental implant maximum	$2,000
Lifetime orthodontic maximum	$2,000

Services	Coverage in the network
Diagnostic and preventive Exams, cleanings, X-rays	100% covered
Fillings and other basic services Fillings, simple tooth extractions, sealants	100% covered
Root canals and retreatments (surgical and nonsurgical)	100% covered
Gum maintenance Gum maintenance, scaling, root planing, gum surgery	100% covered
Oral surgery Simple and surgical extraction	100% covered
Major restorative services Crowns, onlays, veneers	100% covered
Dentures, bridges, and dental implants	50% covered
Repairs and adjustments Crown, denture, and bridge repair; denture and bridge adjustments	50% covered
Orthodontics (braces)	100% covered up to $2,000

We are here to help

If you have questions about your dental coverage, call our Member Services team at 844-729-1565.

* American Dental Association: *Oral-Systemic Health* (accessed August 2022): ada.org.

Sydney Health makes dental care easier

Access personalized dental benefit information wherever you are

The Sydney℠ Health mobile app is the one place to keep track of your dental benefits. With a few taps, you can quickly access your plan details, Member Services, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for dentists and other providers in the SISC Dental Health Network and compare costs. You can filter providers by what is most important to you such as gender, languages spoken, or location.

[redacted] Dental Health Network

Live Chat

Find answers quickly with the Live Chat tool in Sydney Health. You can use the interactive chat feature or talk to an Anthem representative when you have questions about your benefits or need information.

Digital ID Card

Share your ID card right from your phone with your dentist. Print a copy anytime. Email or fax the ID card right from your mobile device.

And more

- Compare costs
- Receive personalized care reminders and tips
- Check benefits, deductibles, and copays
- Add dentists to your personalized care team for easier access to contact information
- Locate resources within the local community

Download Sydney Health today

Use your smartphone camera to scan this QR code.

Download on the App Store | GET IT ON Google Play

Anthem [redacted]

1043264CAMENABC BV 07/22

DEPENDENT STUDENT CERTIFICATION FORM

Enrollee Identification Number: [XXXXXXXXX]

Dependent's Name: [First Name Last Name]

Dependent's Date of Birth: [XX/XX/XXXX]

DEFINITION OF DEPENDENT STUDENT: A full-time dependent student is a person who meets all the following conditions: Is at least 19 years of age, unmarried, receives at least half of their support from the enrollee, and is enrolled full-time in an accredited secondary or preparatory school or college.

If a covered dependent student is required because of illness or injury to take a medically necessary leave of absence from school, the dependent is eligible for continued health insurance coverage for the lesser of: One (1) year after the first day of the leave of absence or last date of attendance in school, whichever is later; or the date that coverage would otherwise terminate for the dependent student under the terms of the policy.

The treating physician must certify to Anthem Blue Cross that the dependent student is suffering from a serious illness or injury and that the leave of absence is medically necessary. During the continuation period, the dependent student will be entitled to the same benefits as if the dependent student was enrolled in school and not on the medically necessary leave of absence.

I certify that my dependent student listed below meets all of the following requirements for eligibility as a dependent student.

1.	19 years of age or older	☐ Yes ☐ No
2.	Unmarried	☐ Yes ☐ No
3.	Is this dependent your natural child, stepchild, or adopted child?	☐ Yes ☐ No
4.	If no, do you provide more than 50% support for this dependent?	☐ Yes ☐ No
5.	Is a full-time student in an accredited secondary or preparatory school or college or is eligible for a dependent student extension. *	☐ Yes ☐ No
6.	Expected date of graduation	[XX/XX/XXXX]

TO BE COMPLETED BY ENROLLEE

Employer Name:
Enrollee Name:
Enrollee ID #:
Dependent Student Name:
School Name:
School Address:

DEPENDENT STUDENT CERTIFICATION FORM

School Phone:	
Semester Start Date:	
Semester End Date:	
I confirm that the above-named Dependent Student is registered as:	☐ Full-time Student ☐ Part-time Student
Dependent Student is in an accredited educational institution for the:	☐ Fall ☐ Winter ☐ Spring ☐ Summer semester
If no longer attending; graduation date or date last attended:	

**A limited extension is available for dependent students no longer enrolled full-time to provide coverage during semester breaks. Please contact your Health Benefits Administrator for more details.*

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in a delay, denial, or termination of coverage for the above-named dependent. I understand that Anthem Blue Cross reserves the right to ask for more information as proof of the above-named dependent's full-time student status. I agree to advise Anthem Blue Cross promptly of any changes in my child's dependent student status.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claims for each such violation.

Enrollee's Signature [First Name Last Name]_____ Date [XX/XX/XXXX]

Please mail, email or fax completed form to:

Anthem Blue Cross
P.O. Box 1407 Church Street Station
New York, NY 10008-1404

Email: [TBD]

Fax Number: [TBD]

Customer Report Sample

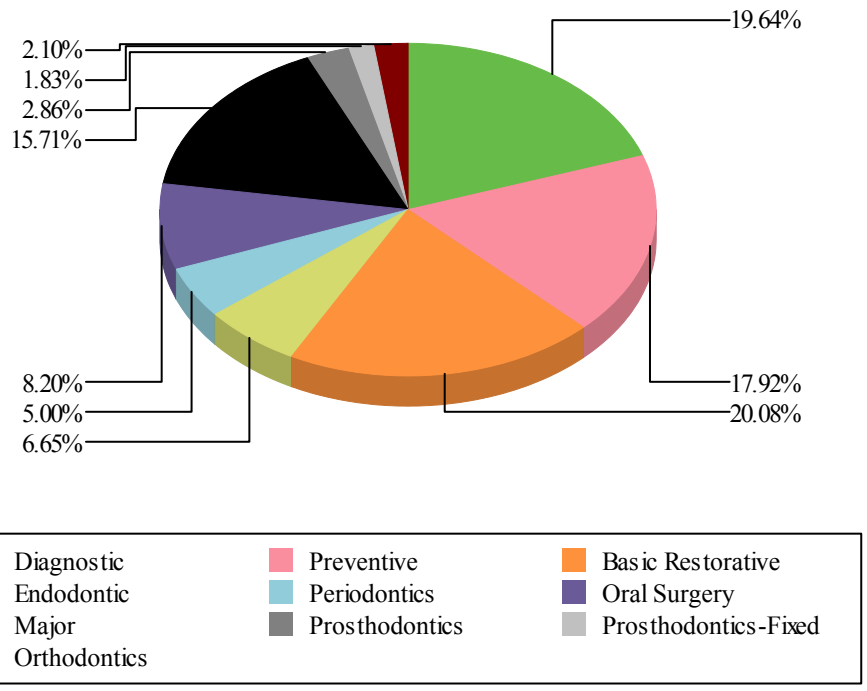
MONTHS	CLAIMS	PAID CLAIMS	% OF PAID CLAIMS	ADMIN/ PREMIUM	EMPLOYEE	EMPLOYEE+ SPOUSE	EMPLOYEE+CHILD	FAMILY	TOTAL EMPLOYEES
JAN	22,394	$3,580,415.12	6.63%	$10,987.90	1,098	449	158	1,158	2,863
FEB	23,941	$3,846,447.02	7.12%	$10,780.00	1,082	440	151	1,154	2,827
MAR	27,265	$4,622,620.21	8.56%	$10,729.95	1,065	437	147	1,141	2,790
APR	31,019	$5,898,679.32	10.92%	$10,572.10	1,042	426	139	1,126	2,733
MAY	27,084	$5,060,348.29	9.37%	$10,522.05	1,033	423	136	1,111	2,703
JUN	28,166	$5,071,058.16	9.39%	$10,210.20	1,015	417	132	1,102	2,666
JUL	26,773	$4,751,198.92	8.80%	$10,160.15	1,009	417	132	1,099	2,657
AUG	25,952	$4,500,321.07	8.33%	$10,152.45	995	415	127	1,095	2,632
SEP	25,748	$4,368,858.28	8.09%	$10,033.10	984	415	125	1,090	2,614
OCT	25,238	$4,043,321.92	7.48%	$9,998.45	980	413	125	1,092	2,610
NOV	25,736	$4,186,119.67	7.75%	$9,948.40	973	413	123	1,082	2,591
DEC	24,306	$4,091,293.95	7.57%	$9,956.10	976	411	125	1,079	2,591
TOTAL	313,622	$54,020,681.93		$124,050.85					
AVG	26,135	$4,501,723.49		$10,337.57	1,021	423	135	1,111	2,690

Customer Report Sample

BENEFIT LEVEL	CURRENT PERIOD (7/1/14-12/31/14)					% CHANGE FROM PRIOR PERIOD (1/1/14-6/30/14)			
	SUBSCRIBER CLAIMS PAID	SPOUSE CLAIMS PAID	CHILD CLAIMS PAID	CLAIMS PAID	% OF TOTAL	% OF TOTAL	SUBSCRIBER CLAIMS PAID	SPOUSE CLAIMS PAID	CHILD CLAIMS PAID
DIAGNOSTIC	$2,809,555	$864,232	$1,421,418	$5,095,205	19.64%	-3.60%	-5.90%	-5.00%	2.40%
PREVENTIVE	$2,158,952	$696,331	$1,793,209	$4,648,492	17.92%	-1.00%	-2.60%	-2.20%	1.60%
BASIC RESTORATIVE	$2,984,079	$873,318	$1,352,044	$5,209,441	20.08%	-7.10%	-8.70%	-9.30%	-1.70%
ENDODONTIC	$1,210,547	$371,737	$142,572	$1,724,856	6.65%	-10.60%	-13.10%	-2.10%	-9.00%
PERIODONTICS	$970,858	$284,661	$42,433	$1,297,951	5.00%	-9.90%	-10.30%	-11.70%	20.60%
ORAL SURGERY	$1,142,912	$278,459	$706,363	$2,127,733	8.20%	-4.80%	-11.30%	-18.80%	17.10%
MAJOR	$2,891,663	$975,278	$209,069	$4,076,010	15.71%	-14.30%	-14.80%	-13.80%	-10.60%
PROSTHODONTICS	$544,394	$185,063	$12,070	$741,527	2.86%	-21.80%	-19.90%	-27.20%	-13.10%
PROSTHODONTICS-FIXED	$341,752	$129,964	$3,207	$474,923	1.83%	-17.80%	-21.90%	-6.70%	169.30%
ORTHODONTICS	$94,286	$21,443	$429,246	$544,976	2.10%	-10.20%	-11.50%	-14.70%	-9.70%
TOTAL	$15,148,998	$4,680,486	$6,111,630	$25,941,114	99.99%				

Customer Report Sample

Group % of Total



Customer Report Sample

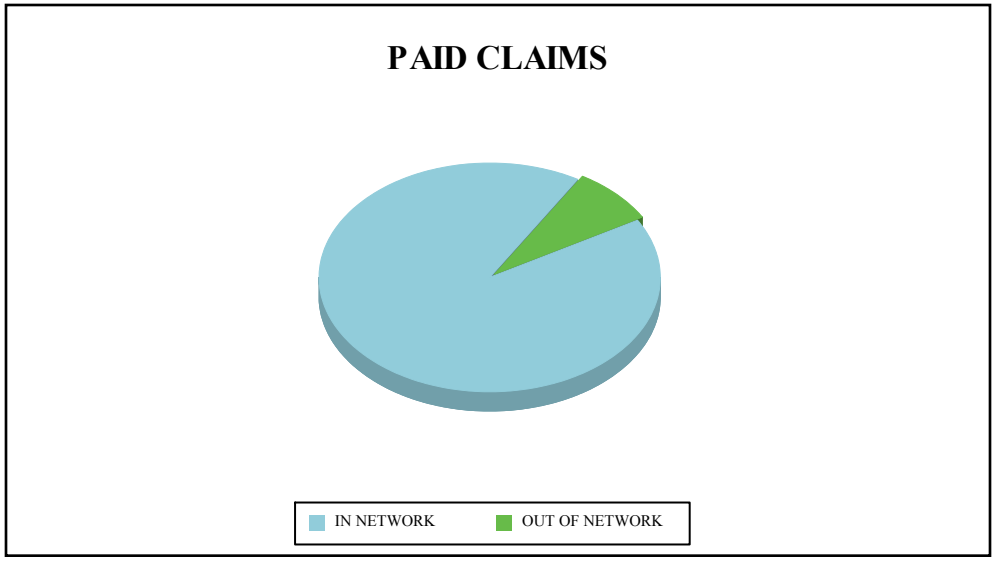
CLAIM SUMMARY	TOTAL DOLLARS	IN NETWORK	OUT OF NETWORK	
TOTAL DOLLARS SUBMITTED	$114,429,673	$102,646,028	$11,783,645	
TOTAL COVERED CHARGES	$73,351,508	$66,439,073	$6,912,435	
DEDUCTIBLE SAVINGS	$3,012,294			
COINSURANCE SAVINGS	$16,318,532			
TOTAL CLAIM DOLLARS PAID	$54,020,682	$49,629,928	$4,390,754	
TOTAL COST CONTAINED	$41,077,290			

COST CONTAINED DETAIL	TOTAL DOLLARS CONTAINED	% OF COVERED		% OF TOTAL CONTAINED
NETWORK SAVINGS				
IN NETWORK DENTIST SAVINGS	$16,390,208	24.67%		
OUT OF NETWORK DENTIST SAVINGS	$590,630	8.54%		
SUBTOTAL	$16,980,837	23.15%		41.34%
PLAN DESIGN SAVINGS				
FREQUENCY LIMITATIONS	$3,181,923	4.34%		
EXCEEDED MAXIMUM	$7,042,248	9.60%		
OTHER CONTRACT/HISTORY SAVINGS	$5,876,596	8.01%		
SUBTOTAL	$16,100,767	21.95%		39.20%
PLAN ADMINISTRATION				
ELIGIBILITY	$2,040,321	2.78%		
DUPLICATE CLAIMS	$4,500,098	6.13%		
COORDINATION OF BENEFITS	$1,455,266	1.98%		
SUBTOTAL	$7,995,685	10.90%		19.46%
TOTAL COSTS CONTAINED	**$41,077,290**	**56.00%**		**100.00%**

Customer #: 9999999999

Customer Report Sample

NETWORK	UNIQUE PATIENTS	% OF UNIQUE PATIENTS	UNIQUE PROVIDERS	% OF UNIQUE PROVIDERS	CLAIMS	% OF CLAIMS	PAID CLAIMS	% OF PAID CLAIMS
IN NETWORK	118,210	90.11%	29,528	83.90%	281,937	91.52%	$49,629,927.53	91.87%
OUT OF NETWORK	12,968	9.89%	5,666	16.10%	26,137	8.48%	$4,390,754.40	8.13%
TOTAL	131,178	100.00%	35,194	100.00%	308,074	100.00%	$54,020,681.93	100.00%



Carryover Utilization Report

Sample Report

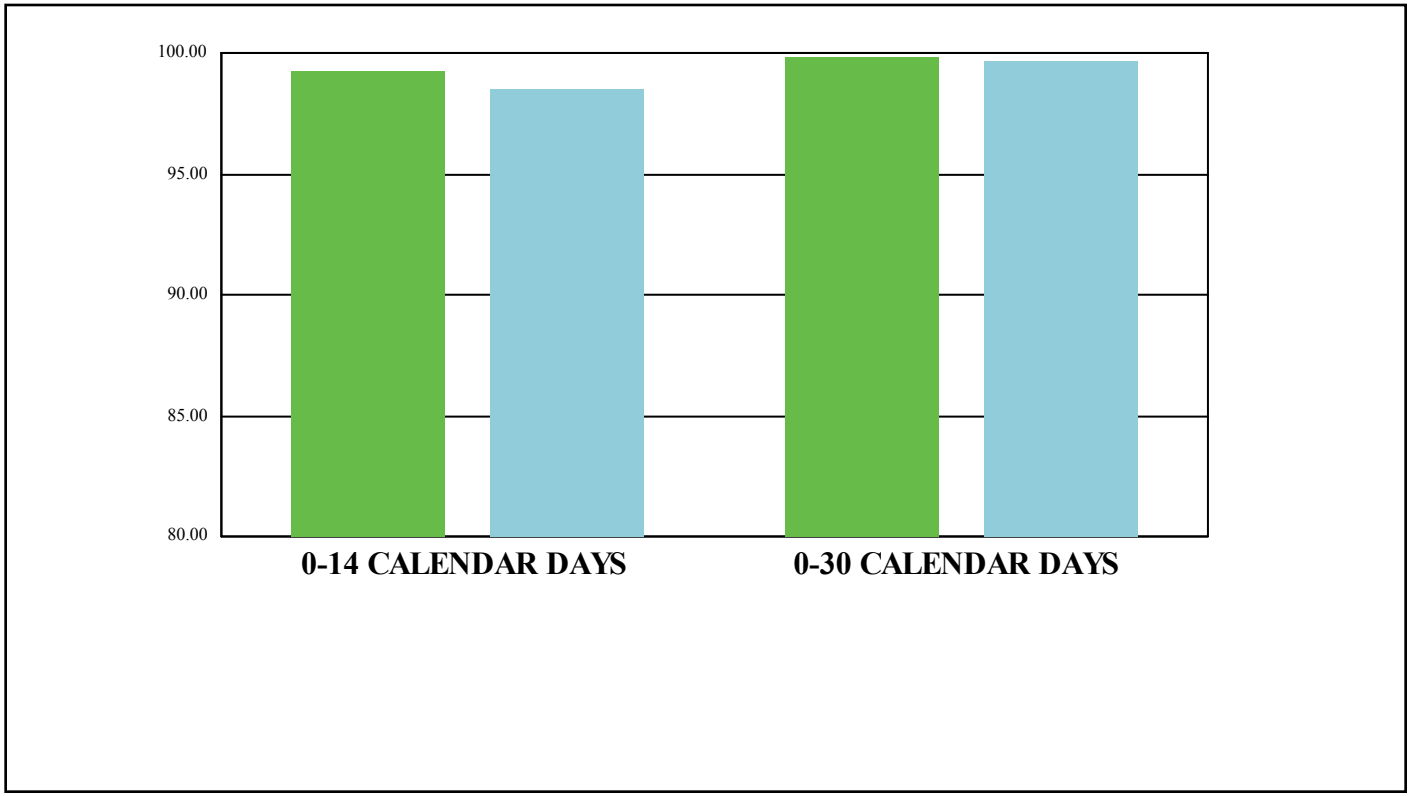
Carryover Account Size	Number of Active Members	% of Active Members	Carryover Account Total
$0	286	57.09%	$0.00
$1-$250	88	17.56%	$21,758.60
$251-$500	61	12.18%	$30,338.60
$501-$750	36	7.19%	$26,913.20
$751-$1,000	30	5.99%	$30,000.00
GRAND TOTALS	**501**	**100.00%**	**$109,010.40**

Number of Members Who Used Carryover Dollars	Carryover Dollars Used	Number of Members Who Earned Carryover Dollars	Carryover Dollars Earned
4	$605.00	147	$36,750.00

Customer Number	0123456789
Group Number	123456
Sub-Group List Name	
Date Range Of Report	01/01/20XX-07/31/20XX
Date Report Produced	09/18/20XX

Customer Report Sample

	January 2014 - December 2014	January 2013 - December 2013
TIME PERIOD	**% OF CLAIMS PROCESSED**	**% OF CLAIMS PROCESSED**
0-14 CALENDAR DAYS	99.26%	98.50%
0-30 CALENDAR DAYS	99.90%	99.73%



Customer Report Sample

DENTAL OFFICE / DENTIST	DENTIST CITY	DENTIST STATE	DENTIST SPECIALTY	PAID CLAIM AMOUNTS	PAID CLAIMS	IN NETWORK	OUT OF NETWORK
Clinc A-Dentist A	City A	CA	General Practitioner	131,306.50	372	X	
Clinc B-Dentist B	City B	MN	General Practitioner	103,774.34	513	X	
Clinc C-Dentist C	City C	CA	General Practitioner	76,274.20	358	X	
Clinc A-Dentist A	City A	CA	General Practitioner	63,158.20	150	X	
Clinc E-Dentist E	City E	MN	General Practitioner	51,041.58	367	X	
Clinc E-Dentist F	City F	MN	General Practitioner	46,733.78	342	X	
Clinc G-Dentist G	City G	MN	General Practitioner	36,573.63	231	X	
Clinc H-Dentist H	City H	CA	General Practitioner	36,505.10	104	X	
Clinc I-Dentist I	City I	MN	General Practitioner	35,541.51	196	X	
Clinc J-Dentist J	City J	MN	General Practitioner	34,884.04	218	X	
Clinc K-Dentist K	City K	CA	General Practitioner	34,202.00	92	X	
Clinc J-Dentist L	City L	MN	General Practitioner	33,235.22	250	X	
Clinc M-Dentist M	City M	MN	General Practitioner	31,123.19	244	X	
Clinc N-Dentist N	City N	MN	General Practitioner	30,861.37	158	X	
Clinc O-Dentist O	City O	MN	General Practitioner	30,823.43	170	X	
Clinc P-Dentist P	City P	MN	General Practitioner	29,185.02	186	X	
Clinc Q-Dentist Q	City Q	MN	General Practitioner	27,599.70	247	X	
Clinc R-Dentist R	City R	MN	General Practitioner	26,689.54	179	X	
Clinc S-Dentist S	City S	CA	General Practitioner	26,660.00	45	X	
Clinc T-Dentist T	City T	MN	General Practitioner	25,075.68	163	X	
Clinc U-Dentist U	City U	GA	General Practitioner	25,064.80	202	X	
Clinc V-Dentist V	City V	GA	General Practitioner	24,881.00	173	X	
Clinc W-Dentist W	City W	MN	General Practitioner	24,064.36	117	X	
Clinc X-Dentist X	City X	CO	General Practitioner	23,591.50	168	X	
Clinc Y-Dentist Y	City Y	MN	General Practitioner	23,201.23	138	X	
TOTAL				**$1,032,050.92**		**$1,032,050.92**	**$0.00**
# OF CLAIMS					**5,383**	**5,383**	**0**
PERCENT OF PAID CLAIMS				**100.00%**		**100.00%**	**0.00%**

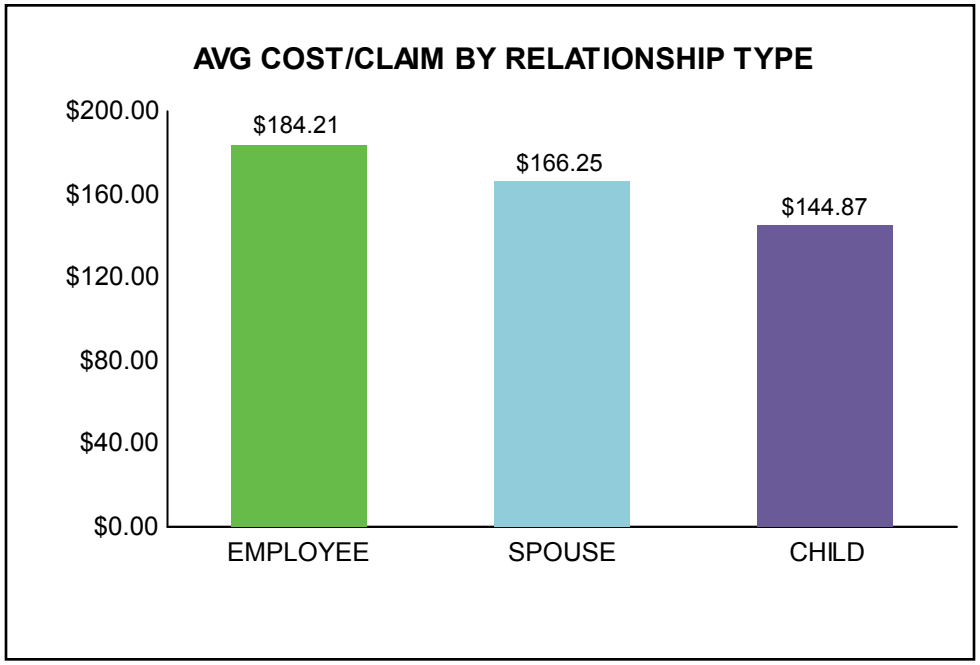
Customer Report Sample

ANNUAL MAXIMUM AMOUNT REACHED	# OF MEMBERS	% OF MEMBERS
$1-$499	87,283	68.8%
$500-$999	18,300	14.4%
$1,000	49	0.0%
$1,001-$1,499	8,793	6.9%
$1,500	6,958	5.5%
TOTAL	126,909	100.0%
TOTAL ENROLLED	126,948	

ANNUAL MAXIMUM AMOUNT REACHED BY RELATIONSHIP TYPE	MEMBERS
EMPLOYEE	4,782
SPOUSE	1,373
CHILD	803
TOTAL	6,958

Customer Report Sample

RELATIONSHIP TYPE	MEMBERS	AVG COST/CLAIM	TOTAL # OF CLAIMS	TOTAL # OF PROCEDURES
EMPLOYEE	66,498	$184.21	173,725	458,924
SPOUSE	22,653	$166.25	59,301	159,328
CHILD	37,758	$144.87	83,924	290,206
TOTAL	126,909	$170.43	316,950	908,458



Customer Report Sample

MONTHLY PAID CLAIMS	INCURRED CLAIMS											
	DEC-2014	NOV-2014	OCT-2014	SEP-2014	AUG-2014	JUL-2014	JUN-2014	MAY-2014	APR-2014	MAR-2014	FEB-2014	JAN-2014
JAN-2014	0	0	0	0	0	0	0	0	0	0	0	2,444,631
FEB-2014	0	0	0	0	0	0	0	0	0	0	2,752,954	850,731
MAR-2014	0	0	0	0	0	0	0	0	0	3,322,159	1,038,540	110,913
APR-2014	0	0	0	0	0	0	0	0	4,250,248	1,377,240	125,829	54,509
MAY-2014	0	0	0	0	0	0	0	3,325,566	1,465,602	129,446	45,514	32,482
JUN-2014	0	0	0	0	0	0	3,551,109	1,145,630	203,571	76,412	28,843	10,007
JUL-2014	0	0	0	0	0	3,387,204	1,043,841	137,769	90,988	33,636	18,631	7,858
AUG-2014	0	0	0	0	3,132,596	1,097,600	99,873	57,858	38,735	28,929	10,441	9,641
SEP-2014	0	0	0	2,923,180	1,142,078	139,886	52,122	30,540	25,504	21,346	8,262	5,265
OCT-2014	0	0	2,778,754	1,005,964	110,911	48,054	32,703	18,177	12,613	10,114	7,825	3,474
NOV-2014	0	2,714,888	1,247,224	87,742	44,004	26,801	14,134	13,062	12,396	9,248	5,073	1,905
DEC-2014	2,923,695	919,157	109,161	42,134	29,436	15,570	12,059	10,185	11,280	4,267	4,724	2,865
TOTAL	2,923,695	3,634,045	4,135,140	4,059,020	4,459,025	4,715,116	4,805,841	4,738,785	6,110,935	5,012,797	4,046,635	3,534,281

Customer Report Sample

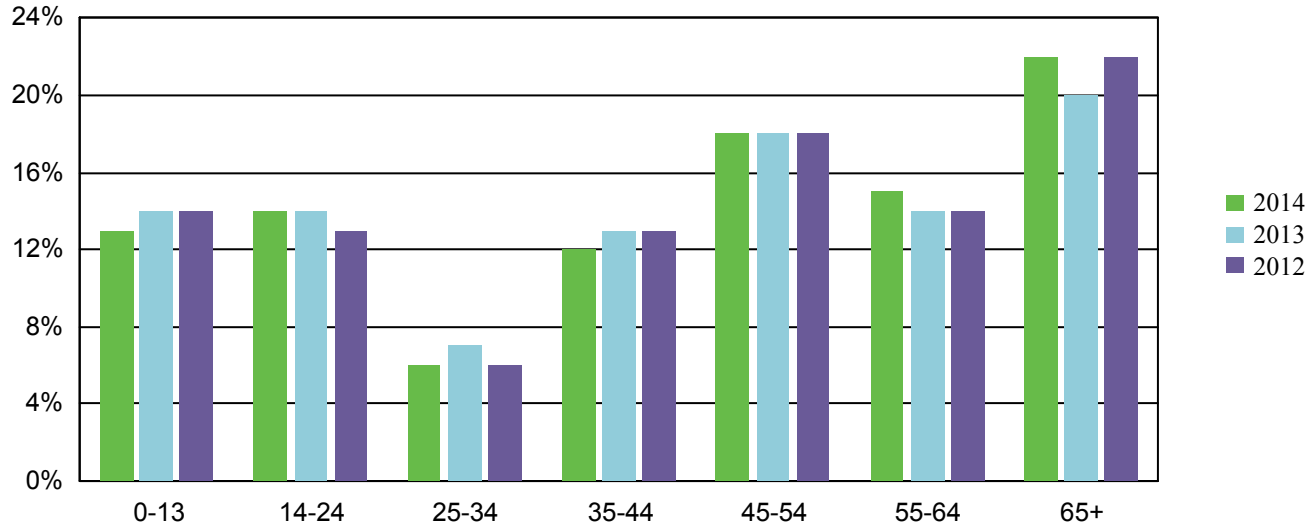
COVERAGE TYPE	AVG # OF EMPLOYEES	% OF TOTAL	AVG # OF MEMBERS	% OF TOTAL
EMPLOYEE	1,021	37.96%	1,021	18.08%
EMPLOYEE+SPOUSE	423	15.72%	848	15.02%
EMPLOYEE+CHILDREN	135	5.02%	367	6.50%
FAMILY	1,111	41.30%	3,411	60.40%

RELATIONSHIP TYPE	AVG # OF MALES	% OF TOTAL	AVG # OF FEMALES	% OF TOTAL
EMPLOYEE	1,782	31.56%	908	16.08%
SPOUSE	284	5.03%	1,242	21.99%
CHILD	708	12.54%	723	12.80%

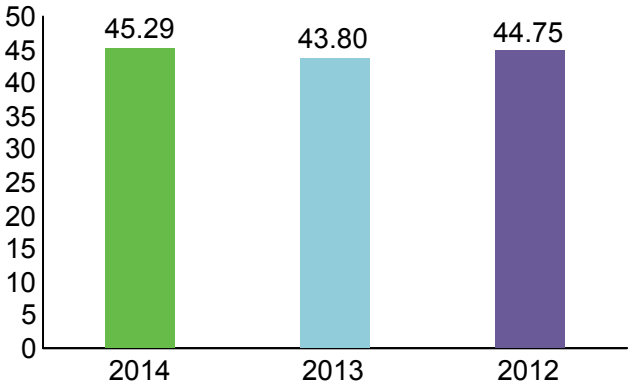
AGE BANDS	AVG # OF MALES	% OF TOTAL	PAID CLAIMS PMPM	AVG # OF FEMALES	% OF TOTAL	PAID CLAIMS PMPM	TOTAL AVG MEMBERS	TOTAL %	TOTAL PAID CLAIMS
0-13	366	6.48%	$807.17	354	6.27%	$850.95	719	12.73%	$7,154,072.90
14-24	386	6.84%	$865.85	400	7.08%	$1,079.18	786	13.92%	$9,190,698.71
25-34	181	3.21%	$2,314.96	170	3.01%	$3,426.88	351	6.22%	$12,018,926.34
35-44	324	5.74%	$1,030.75	327	5.79%	$1,436.96	651	11.53%	$9,650,288.19
45-54	524	9.28%	$539.48	490	8.68%	$923.46	1,014	17.96%	$8,821,885.34
55-64	401	7.10%	$471.82	467	8.27%	$631.31	867	15.35%	$5,803,670.38
65+	593	10.50%	$91.52	665	11.78%	$91.41	1,258	22.28%	$1,381,105.27

Customer Report Sample

PERCENTAGE OF MEMBERS BY AGE



AVG MEMBER AGE



Customer Report Sample

PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	PAID CLAIMS
	DIAGNOSTIC	
0120	EXAM-PERIODIC	$3,115,412.29
0210	X-RAY-FULL SERIES	$1,575,272.32
0274	X-RAY-BITEWINGS FOUR	$1,548,681.47
	PREVENTIVE	
1110	PROPHYLAXIS-ADULT	$6,643,141.71
1120	PROPHYLAXIS-CHILD	$1,475,039.39
1203	TOP FLUORIDE-CHILD	$623,962.57
	BASIC RESTORATIVE	
2392	RESIN POSTERIOR 2 SF	$2,536,302.75
2391	RESIN POSTERIOR 1 SF	$2,061,881.49
2393	RESIN POSTERIOR 3 SF	$1,016,733.33
	ENDODONTIC	
3330	MOLAR ROOT CANAL	$2,039,913.89
3320	BICUSPID ROOT CANAL	$840,252.49
3310	ANTERIOR ROOT CANAL	$410,634.71
	PERIODONTICS	
4341	SC/ROOT PLANE-QUAD	$1,665,008.11
4910	PERIO MAINTENANCE	$170,722.57
4341	SC/ROOT PLANE 4+	$151,566.75

Customer Report Sample

PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	PAID CLAIMS
	ORAL SURGERY	
7210	SURGICAL REM. TOOTH	$1,258,112.56
7140	EXTRACT-ERUPTED/EXPO	$1,081,937.62
7240	IMPACT-COMPLETE BONY	$843,541.57
	MAJOR	
2750	CROWN-PORC/HN METAL	$3,766,343.94
2740	CROWN-PORC/CERAMIC	$1,161,991.08
2752	CROWN-PROC/NOB METAL	$969,466.02
	PROSTHODONTICS	
6010	PLACE IMPLANT BODY	$327,849.70
5214	LOWER PART-CAST BASE	$234,550.63
5213	UPPER PART-CAST BASE	$206,667.71
	PROSTHODONTICS-FIXED	
6240	PONTIC-PORC/HN METAL	$277,279.98
6750	RETAINER-PORC/HN MET	$261,481.17
6242	PONTIC-PORC/NOB MET	$114,218.64

Customer Report Sample

STATE	PAID CLAIMS	% OF TOTAL PAYMENT
CA	$11,211,828.76	20.75%
MN	$9,426,449.72	17.44%
TX	$3,073,989.55	5.69%
FL	$2,907,784.40	5.38%
IL	$2,074,543.33	3.84%
NY	$1,672,487.22	3.09%
MI	$1,623,985.39	3.00%
AZ	$1,520,697.26	2.81%
VA	$1,389,124.48	2.57%
GA	$1,292,848.50	2.39%
CO	$1,288,239.29	2.38%
WI	$1,158,852.22	2.14%
WA	$1,127,453.97	2.08%
OH	$1,105,601.64	2.04%
NJ	$1,089,163.92	2.01%
NC	$1,043,344.83	1.93%
IN	$958,169.24	1.77%
PA	$897,423.30	1.66%
OR	$734,439.27	1.35%

Customer Report Sample

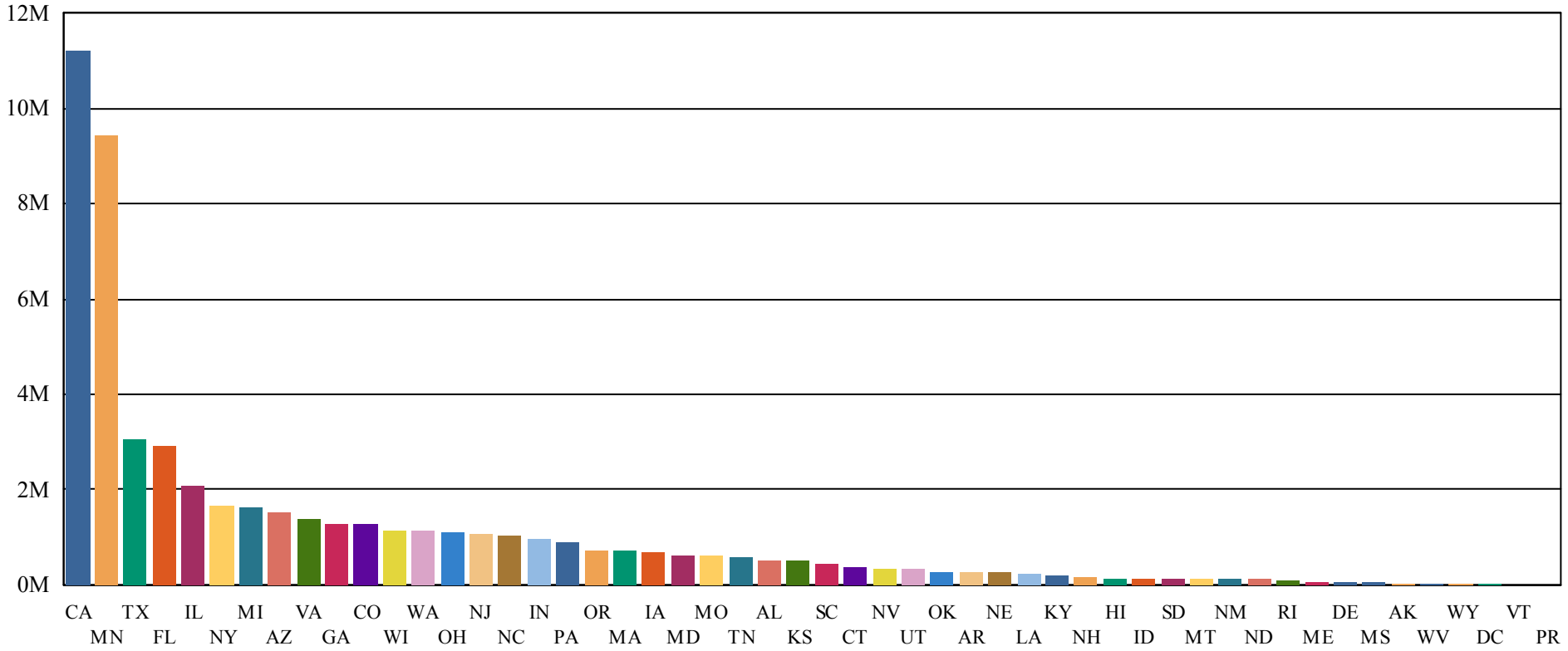
STATE	PAID CLAIMS	% OF TOTAL PAYMENT
MA	$723,905.67	1.34%
IA	$680,780.77	1.26%
MD	$615,911.89	1.14%
MO	$610,988.20	1.13%
TN	$590,423.12	1.09%
AL	$531,375.02	0.98%
KS	$504,279.28	0.93%
SC	$457,946.52	0.84%
CT	$363,076.02	0.67%
NV	$359,002.79	0.66%
UT	$331,279.97	0.61%
OK	$282,767.65	0.52%
AR	$264,508.58	0.48%
NE	$263,880.36	0.48%
LA	$232,071.35	0.42%
KY	$204,250.37	0.37%
NH	$186,077.54	0.34%
HI	$149,708.29	0.27%
ID	$144,151.82	0.26%

Customer Report Sample

STATE	PAID CLAIMS	% OF TOTAL PAYMENT
SD	$141,901.38	0.26%
MT	$137,098.90	0.25%
NM	$131,449.01	0.24%
ND	$119,270.94	0.22%
RI	$86,793.21	0.16%
ME	$71,009.35	0.13%
DE	$52,448.13	0.09%
MS	$51,522.90	0.09%
AK	$45,907.83	0.08%
WV	$38,526.80	0.07%
WY	$27,797.93	0.05%
DC	$20,511.53	0.03%
VT	$2,557.52	0.00%
PR	$1,075.00	0.00%
TOTAL CLAIMS PAID	$54,020,681.93	100.00%

Customer Report Sample

PAID CLAIMS BY STATE



Customer # 9999999999

Specialized Dental Whole Health Reporting

Group ABC

Anthem
Decide to be healthy.℠

Report Year: 2021

Dental enrollment and dental services period:
1/1/2019 - 12/31/2021, claims paid through February 8, 2022.

Peers: Large ASO groups with 2000+ members, 3+ years enrolled and continued enrollment into 2022, and with comparable benefit plans (excl. retiree groups). Total of 63.

Dental Financial and Utilization Report

	Yours				Peers	
	2019	2020	2021	*2021 vs. 2020*	2021	*Yours vs. Peers*
Monthly Employees	28,225	29,165	30,977	*6.2%*	--	
Monthly Members	64,121	66,498	70,458	*6.0%*	--	
Total Paid	$21,323,058	$19,423,851	$23,067,954	*18.8%*	--	
Paid PEPM	$62.96	$55.50	**$62.06**	*11.8%*	**$51.62**	*20.2%*
Paid PMPM	$27.71	$24.34	**$27.28**	*12.1%*	**$24.26**	*12.5%*
Paid PMPM*	$25.79	$22.29	**$24.55**	***10.1%***	**$22.45**	***9.3%***

***excluding orthodontic and unspecified services**

Cost driven factors of Paid PMPM*

Total Utilization	**% of Members Receiving Services** (Patients per Member)	67.2	61.0	**65.1**	*6.7%*	56.9	*14.4%*
	Units per Patient	6.5	6.1	**6.1**	*0.6%*	6.2	*-1.6%*
	Mix of Services (Standardized Cost per Unit)	$146	$149	**$151**	*1.2%*	$149	*1.1%*
	Providers Charged Fee Index (Charged per Standarzed Cost)	97	100	**102**	*2.5%*	100	*2.1%*
	Providers Fee Adjustment (Allowed per Charged, for INN disc, OON UCR, Alt. Benf.)	68.7	67.3	**66.3**	*-1.6%*	70.3	*-5.8%*
	Benefit Adjustment (Paid per Allowed; for Coin, Ded, COB, Maximum, ...)	72.7	72.3	**72.6**	*0.4%*	72.6	*-0.1%*

Key Findings:

Compared to Year 2020, your number of employees and number of members in **2021** increased by 6.2% and 6.0%, respectively. Paid per Employee per Month (**PEPM**) and Paid per Member per Month (**PMPM**) increased by 11.8% and 12.1%, respectively. Excluding orthodontic and unspecified services, Paid PMPM* increased by 10.1%, primarily due to 6.7% more members receiving services, 1.2% more costly services received, and 2.5% higher provider charges, while there was 1.6% more adjustment in provider charges.

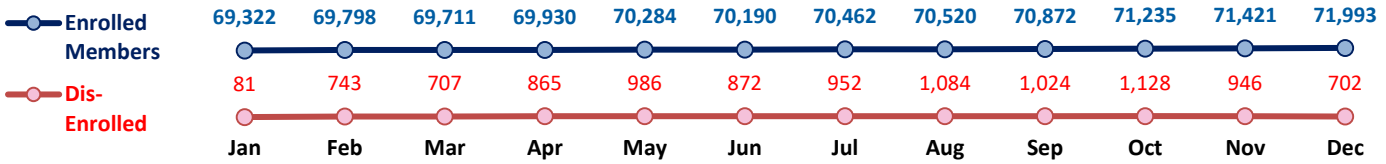
Compared to your peers, your Paid PMPM* in **2021** was 9.3% higher, primarily due to 14.4% more members receiving services, 1.1% more costly services received, and 2.1% higher provider charges, while there were 1.6% fewer services received, and 5.8% more adjustment in provider charges (due to higher provider charges and higher in-network usage).

Your Dental Enrolled Members and Benefit

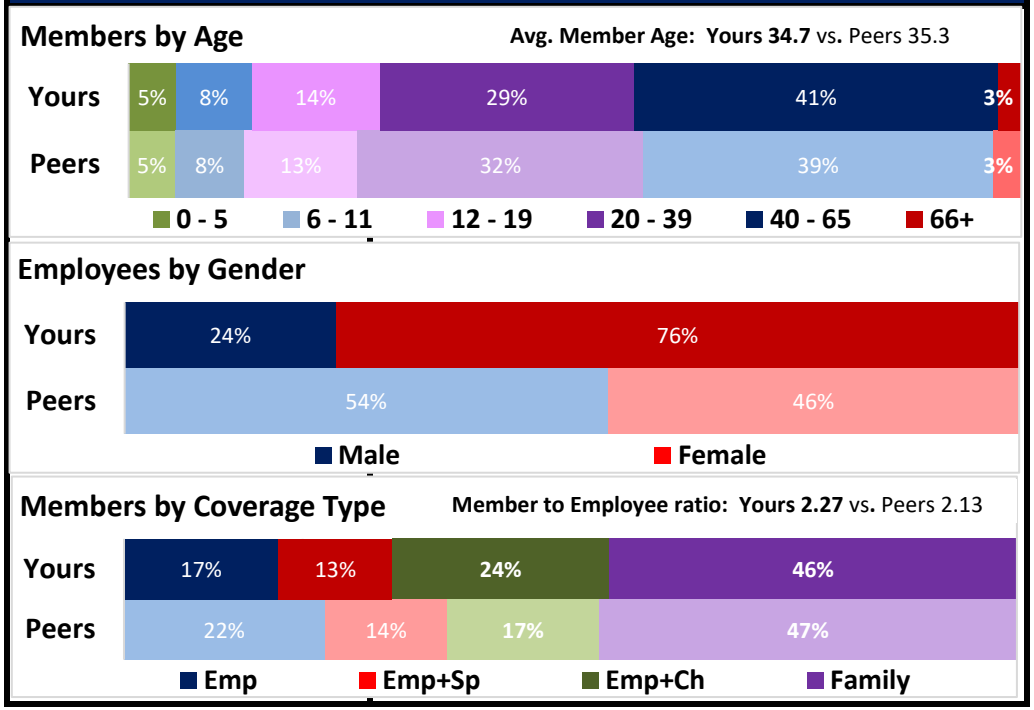
Report Period: 1/1/2021 - 12/31/2021

Annual Turnover Rate:
Yours = 14.3%; Peers = 18.8%

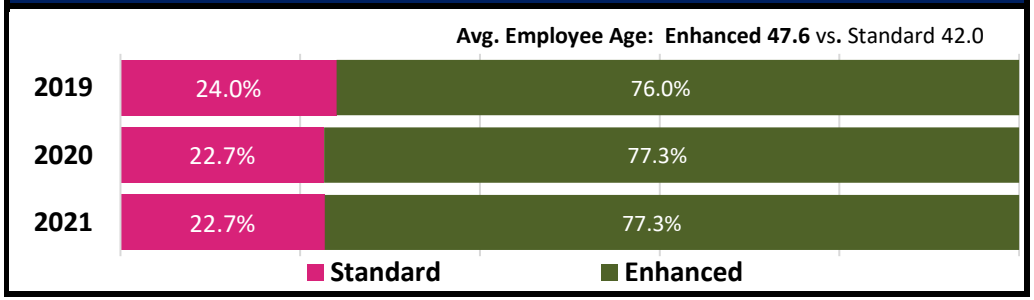
Lower annual turnover rate has a positive effect on the **continuity of dental care**. This is very important for your employees to truly gain from your benefit designs.



Distribution (%) of Your Dental Enrolled Members/Employees



Distribution (%) of Your Employees by Benefit Plan Over Time



	Your Two Plans		Avg. Member Benefit	
	Standard	Enhanced	Yours	Peers
Yearly Maximum	$1,000	$2,000	**$1,788**	$1,787
Deductible INN (OON)				
Individual	$50 ($50)	$0 ($25)	**$11 ($30)**	$59 ($62)
Coinsurance INN (OON)				
Diag & Prev Services	100 (80)	100 (80)	**100 (80)**	99 (97)
Basic Services	80 (60)	80 (60)	**80 (60)**	78 (75)
Major Services		60 (40)	**47 (32)**	59 (57)
Orthodontics				
Lifetime Max		$1,500	**$1,183**	$1,518
Child Coverage	N	Y	**79%**	87%
Adult Coverage	N	Y	**79%**	69%

Compared to your peers:

· **Enrolled Members** - yours were slightly younger with an average age of 34.7 (vs. 35.3). A majority of your employees (76%) were female (vs. 46%). More of your members had coverage types of 'Emp+Ch' (24% vs. 17%) and fewer had 'Emp' only (17% vs. 22%). Your member to employee ratio was 2.27 (vs. 2.13), 6.9% higher.

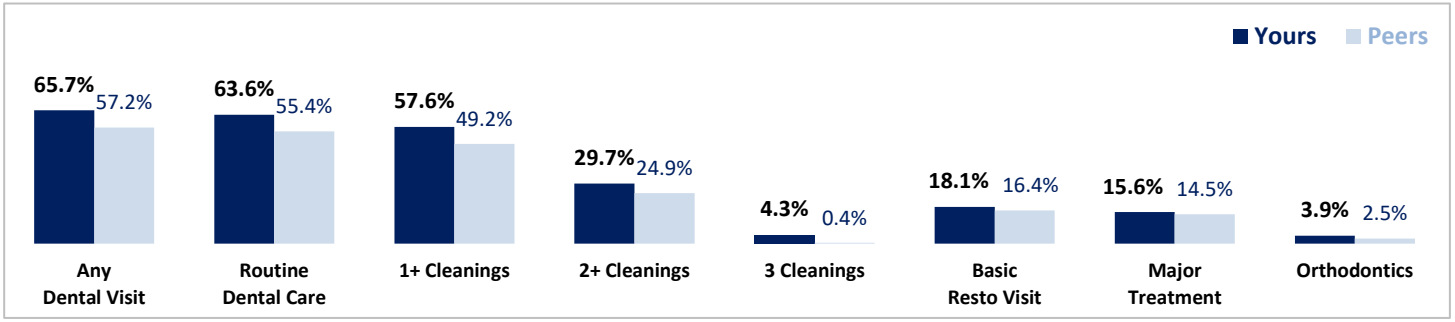
· **Benefit Plan** - on average you had a comparable yearly maximum ($1,788 vs. $1,787) and INN plan coinsurance in Diag & Prev and Basic Services, however, lower plan coinsurance in Major Services (47 vs. 59) and less individual deductibles ($11 vs. $59). You had substantial differences between INN and OON for deductible and coinsurance, while your peers were almost equivalent. Note. Differences in your benefit plans for INN vs OON providers might encourage your members' selection of INN providers.

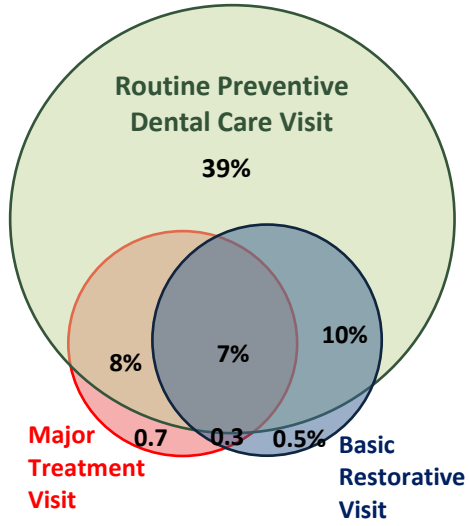
Trend in Benefit Plan Selection: Yours from 2019 to 2021 showed slightly more employees choosing Enhanced plan. Your Enhanced employees were older (47.6 vs. 42.0). Generally speaking, employees choosing a richer plan may consider themselves at higher risk for oral disease which requires major restorative services, and/or may have more dependents anticipating the need for **orthodontic services** or other services.

Your Members Dental Services Utilization

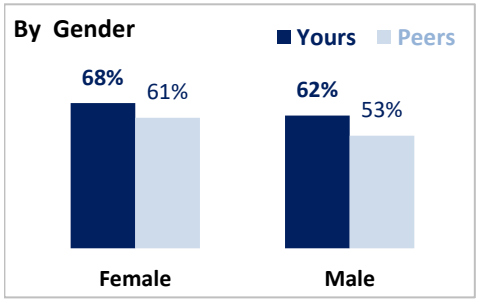
Report Period: 1/1/2021 - 12/31/2021

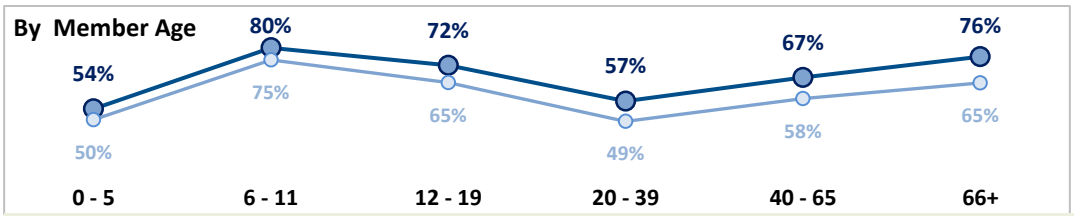
% of Members Receiving Dental Care



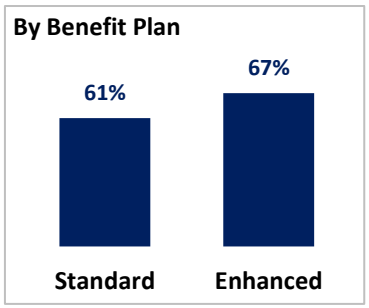


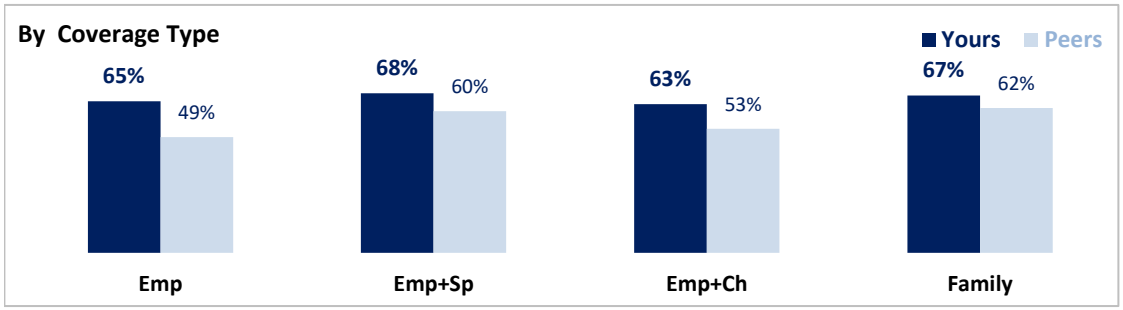
Compared to your peers, your members had more dental visits (65.7% vs. 57.2%), more routine dental care visits (such as oral evaluation/x-ray, cleaning, and perio maintenance) (63.6% vs. 55.4%), and higher utilization of 3rd cleanings (**4.3% vs. 0.4%**). Your members' basic restorative visits (fillings), major treatment visits (crown/bridge/root canal/denture/tooth extraction,...), and orthodontic visits were slightly higher.
About 39% of your members received 'routine preventive dental care only' (vs. 32%). **Routine preventive dental care has a long term positive effect in reducing your overall cost.**

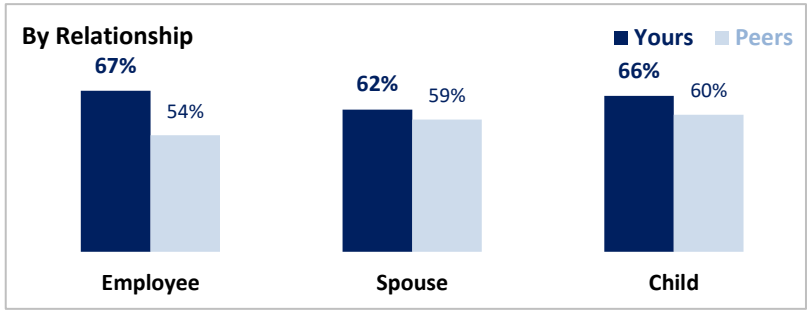




Children ages 0-5 are often less likely to be seen for dental care. Tooth decay can develop any time after the first tooth erupts. The American Academy of Pediatric Dentistry recommends that a child be seen by a dentist when the first tooth erupts or no later than the child's first birthday.





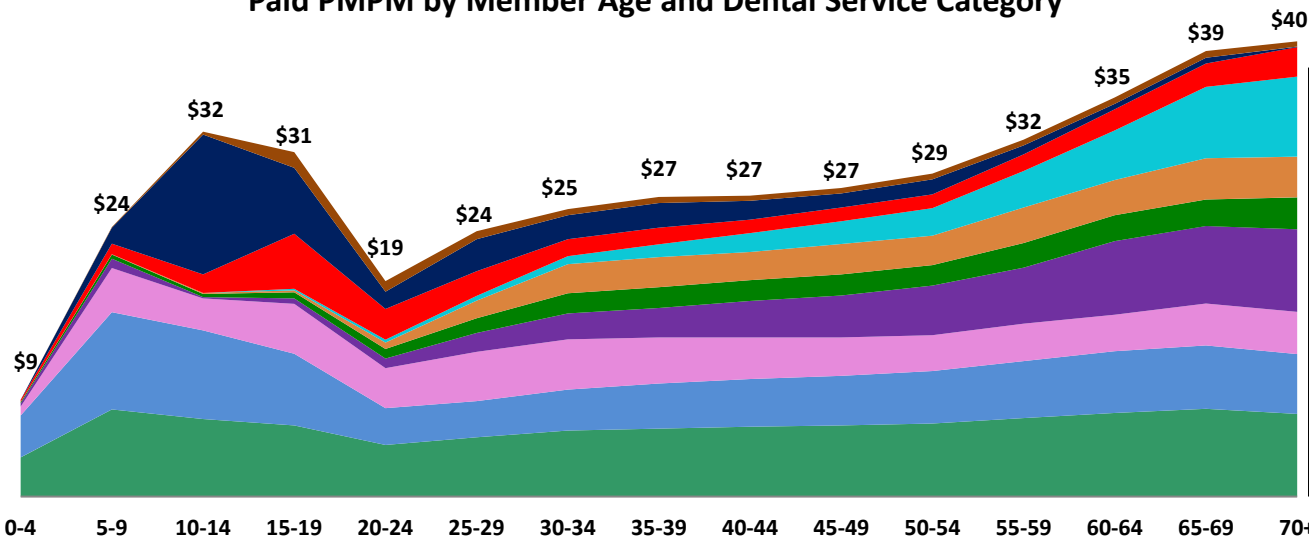


Compared to your peers, your members were more likely to have dental visits when different age, gender, coverage type, and relationship to employee were considered separately. The greatest differences between you and your peers were for Coverage Type as 'Emp' (65% vs. 49%) and Relationship as 'Employee' (67% vs. 54%), due to more female employees and females having higher dental visits. The least difference between you and your peers was for Relationship as 'Spouse' (62% vs. 59%),
Your members in the Enhanced plan were more likely to visit a dental office than members in the Standard plan (67% vs. 61%).

Your Members Dental Services Utilization

Report Period: 1/1/2021 - 12/31/2021

Paid PMPM by Member Age and Dental Service Category

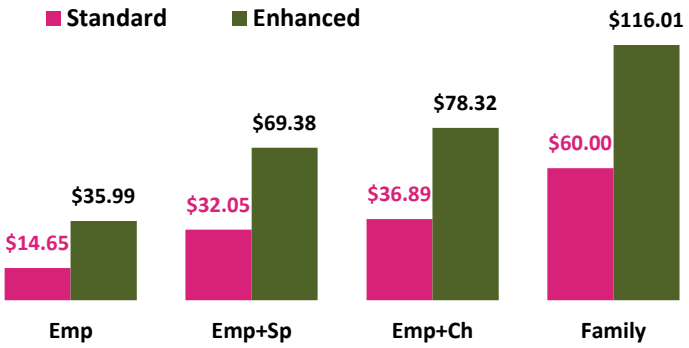


Paid PMPM (%)	
Yours	Peers
$0.57 (2.1%)	$0.45 (1.9%)
$2.73 (10.0%)	$1.80 (7.4%)
$1.84 (6.8%)	$1.61 (6.7%)
$1.47 (5.4%)	$1.18 (4.9%)
$1.78 (6.5%)	$1.34 (5.5%)
$1.39 (5.1%)	$1.24 (5.1%)
$2.64 (9.7%)	$2.78 (11.5%)
$3.57 (13.1%)	$3.35 (13.8%)
$5.03 (18.4%)	$4.49 (18.5%)
$6.25 (22.9%)	$6.00 (24.7%)
$27.28 (100%)	**$24.26 (100%)**

Dental care is age related. Different stages of life may necessitate different types of dental care.
· Children and teens tend to have more preventive care services (fluoride, sealants), orthodontic care, tooth extractions in preparation for orthodontia and wisdom tooth extractions.
· Seniors tend to have more major restorative and prosthodontic services.
This subsequently results in cost differences. The total dental cost rises with age among the adult population.

Compared to your peers, you had a higher % paid for periodontic (6.5% vs. 5.5%) and orthodontic services (10.0% vs. 7.4%); however, a lower % paid in diagnostic (22.9% vs. 24.7%) and major restorative (9.7% vs. 11.5%) services. About 40% of your orthodontic payment was paid to adults (vs.35%).

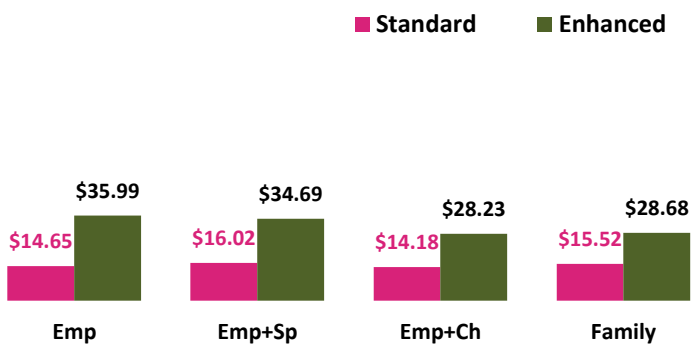
Paid PEPM by Coverage Type and Benefit Plan



Paid PEPM as well as Paid PMPM varies by coverage type and by benefit plan.

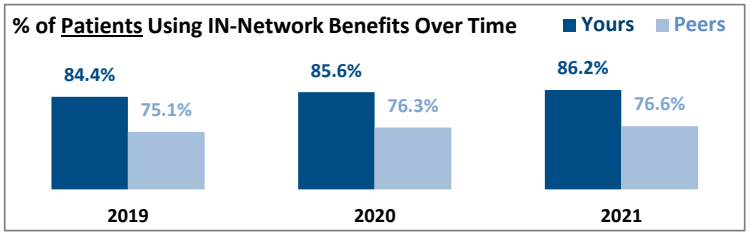
Yours in the Enhanced plan, compared to the Standard plan, had higher Paid PEPM as well as higher Paid PMPM across all the four coverage types.

Paid PMPM by Coverage Type and Benefit Plan



Cost Containment Summary

Report Period: 1/1/2019 - 12/31/2021



	2019		2020		2021		Peers in 2021
Claim Summary	**Total Dollars**	**% of Submit.**	**Total Dollars**	**% of Submit.**	**Total Dollars**	**% of Submit.**	**% of Submit.**
Total Dollars Submitted	**$48,083,515**		**$45,063,980**		**$54,032,156**		
Total Dollars Covered	**$28,847,426**		**$26,332,201**		**$30,996,608**		
Costs Contained	**$19,236,088**	**40.0%**	**$18,731,780**	**41.6%**	**$23,035,548**	**42.6%**	**42.0%**
Total Dollars Paid	**$21,323,058**		**$19,423,851**		**$23,067,954**		
Benefit Plan Savings	**$7,524,369**	**15.6%**	**$6,908,350**	**15.3%**	**$7,928,654**	**14.7%**	**15.1%**

Distribution of Costs Contained

Provider Network Savings (INN)	**$11,679,241**	**24.3%**	**$11,307,212**	**25.1%**	**$13,534,932**	**25.0%**	**20.9%**
Claim Administrative Savings	**$7,556,847**	**15.7%**	**$7,424,567**	**16.5%**	**$9,500,617**	**17.6%**	**21.0%**
Alternative Benefits or Services	$178,993	0.4%	$158,856	0.4%	$608,800	1.1%	0.5%
COB - Awaiting Primary	$295,882	0.6%	$291,944	0.6%	$379,976	0.7%	0.8%
Duplicate Bills	$1,891,345	3.9%	$1,779,729	3.9%	$1,887,797	3.5%	4.6%
Eligibility	$457,338	1.0%	$454,221	1.0%	$539,325	1.0%	1.3%
Frequency Limitation	$1,009,642	2.1%	$940,434	2.1%	$1,959,390	3.6%	2.8%
Invalid or Missing Information	$440,618	0.9%	$503,638	1.1%	$482,455	0.9%	0.8%
Contract or History	$2,678,067	5.6%	$2,709,340	6.0%	$3,216,536	6.0%	5.5%
Reasonable and Customary (OON)	$604,787	1.3%	$586,281	1.3%	$423,020	0.8%	1.6%
Clinical Review	$175	0.0%	$125	0.0%	$3,318	0.0%	3.1%

Distribution of Benefit Plan Savings

Benefit Plan Savings	**$7,524,369**	**15.6%**	**$6,908,350**	**15.3%**	**$7,928,654**	**14.7%**	**15.1%**
Deductible	$191,873	0.4%	$179,943	0.4%	$213,702	0.4%	2.2%
Coinsurance	$5,962,661	12.4%	$5,670,798	12.6%	$6,508,982	12.0%	9.8%
COB Applied	$428,281	0.9%	$373,117	0.8%	$387,181	0.7%	0.5%
Plan Maximum	$941,554	2.0%	$684,492	1.5%	$818,789	1.5%	2.6%

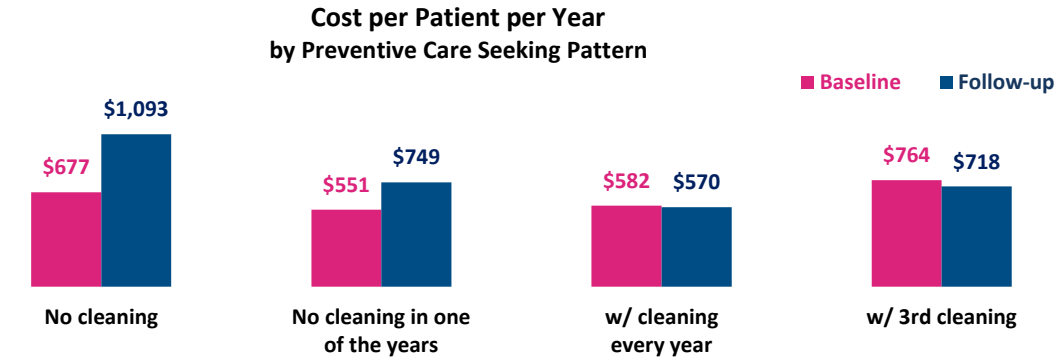
Compared to Year 2020, in 2021 your Cost Containment was slightly more (42.6% vs. 41.6%) while your Benefit Plan Savings was slightly lower (14.7% vs. 15.3%). Specifically, you had more savings in Alternative Benefits or Services[1] (1.1% vs. 0.4%) and Frequency Limitation[2] (3.6% vs. 2.1%), while lower savings in Reasonable and Customary (0.8% vs. 1.3%).

Compared to your peers, in 2021 you had similar Cost Containment (42.6% vs. 42.0%) and similar Benefit Plan Savings (14.7% vs. 15.1%). Specifically, you had more savings from the use of IN-Network Providers (25.0% vs. 20.9%), Alternative Benefits or Services (1.1% vs. 0.5%), Frequency Limitation (3.6% vs. 2.8%), and Coinsurance (12.0% vs. 9.8%). However, there were lower savings in Duplicate Bills (3.5% vs. 4.6%), Clinical Review (0.0% vs.3.1%), and Deductible (0.4% vs. 2.2%).

Example of changes from 2020 to 2021: [1]Crowns/Bridges: Porcelain/Ceramic alternated to base metal. [2]Periapical X-rays: unlimited to 4 times/12M; Fluoride Applications: twice/yr to once/yr; …

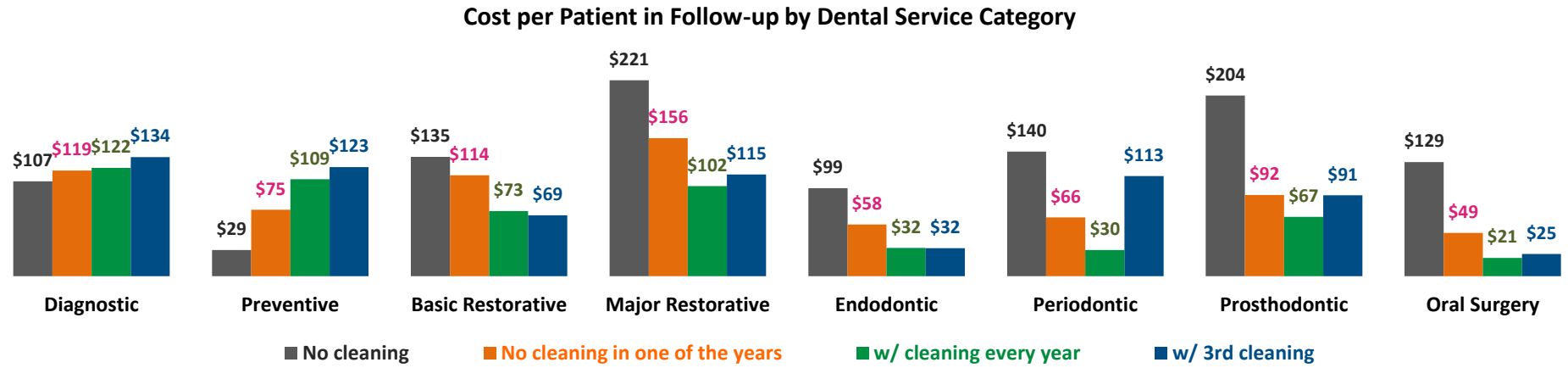
How does preventive dental care visits affect follow-up costs and utilization of dental services?

For your members (ages 21 through 64) with 3 years (2019-2021) of continuous dental coverage
Baseline (2019-2020): members categorized by preventive care visit pattern, i.e., the # of cleanings **(prophylaxes and perio maintenance)** received in baseline
Follow-up (2021): compare cost (total reimbursement = insurance paid + member paid, excluding ortho.) and utilization of dental services by preventive care visit pattern in baseline



The difference between follow-up and baseline costs varies by the preventive care visit pattern. The difference is
· a 62% increase when no cleaning is received.
· a 36% increase when no cleaning in one of the years;
· a **2% decrease** when having **at least one cleaning every year**; and
· a **6% decrease** when having **the 3rd cleaning** in a year.
Note. Members having the 3rd cleaning were on average aged 49, about 4 years older.

Members with less frequent preventive care experienced significantly more follow-up cost in clinically invasive, complex, and therefore costly services, such as, major restorative, endodontics, periodontics, prosthodontics, and oral surgery. As a result, the higher treatment costs for members with less frequent preventive care offset their lower preventive care costs.



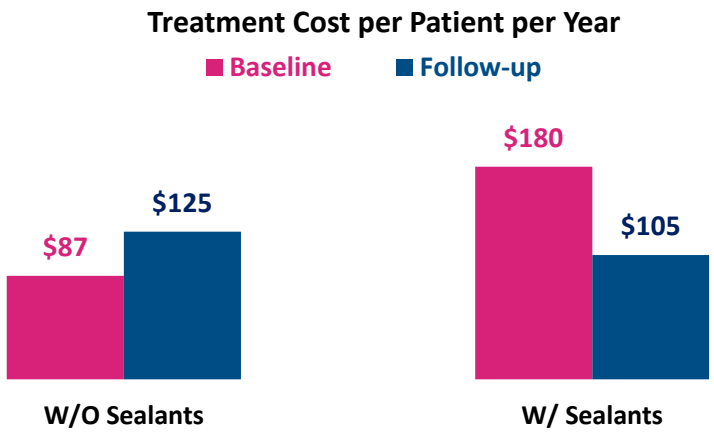
These findings imply that:
· Lack of preventive care may cause an increase in oral diseases. An Increased incidence of oral disease will eventually lead to a need for more extensive dental care that increases costs.
· Members who experience more invasive treatment services have fewer teeth free from problems and fewer natural teeth retained.
· **Continuity of preventive dental care leads to better oral health outcomes at fewer increased costs.**

How does sealant or fluoride visits affect follow-up treatment costs?

For your members children (ages 6 through 16) with 2 years (2020-2021) of continuous dental coverage

Baseline (2020): members categorized by having sealant or fluoride visits

Follow-up (2021): compare cost (total reimbursement = insurance paid + member paid, excluding ortho.) by having sealant or fluoride visits in baseline



Children who had sealants in baseline displayed a higher treatment cost in baseline. However, they showed a drastic decrease in follow-up cost. The cost difference between follow-up and baseline is:

· a $75 **decrease** when children received sealants;

· a $37 increase when children did not receive sealants.

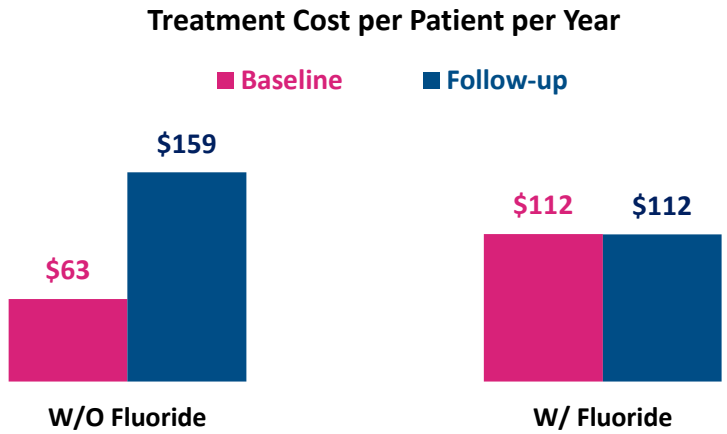
As a result, children who received sealants showed a $20 lower treatment cost in follow-up when compared to children who did not receive sealants.

The removal of plaque and food debris to reduce the risk of gum disease and tooth decay is accomplished by:

· Brushing - smooth and pitted surfaces of teeth;

· Flossing - between the teeth.

Additionaly, sealants can protect the chewing surfaces of the tooth by covering pits and grooves to block out plaque and food and shield them from decay.



Children who had a fluoride visit in baseline showed a stable follow-up cost, while children who did not have a fluoride visit in baseline had a $96 increase in follow-up cost.

As a result, children who received fluoride showed a $47 lower treatment cost in follow-up when compared to children who did not receive fluoride.

Fluoride helps prevent tooth decay by making the tooth more resistant to acid attacks from plaque, bacteria and sugars in the mouth. It may also reverses early decay. Fluoride is found in foods and in water. It can also be directly applied to the teeth through fluoridated toothpastes and mouth rinses. A professionally applied fluoride can be applied to the teeth as a gel, foam, or varnish. These professional treatments contain a much higher level of fluoride than the amount found in toothpastes and mouth rinses.

Phase 1
Transition and Termination of Contract Diagram

Termination Notification to Anthem - Phase 1 Begins
- Six months prior to the Contract End Date or immediately if the Contract is terminated pursuant to Appendix B section 31 (Termination)

Transition Plan
- Anthem Account Management mobilizes Transition and Termination team
- Anthem to propose Transition Plan within 30 calendar days of notice including: tasks, milestones, deliverables and responsible parties
- Sign off on Transition Plan from the Department (within 15 days)
- Schedule weekly calls with the Department and third party or the successor entity if needed

Business as Usual
- Anthem continues to perform all contractual obligations set forth in the Contract, including audit and reporting obligations
- Workforce Management team ensures appropriate staffing levels
- Anthem key personnel and dedicated Account team remain available for the Department

Safeguard in Service
- Active dedicated phone line
- Continue processing all enrollment updates
- Retain NYBEAS access
- Active custom website, mobile app and EmployerAccess site
- Maintain or exceed performance guarantee service metrics
- Continue processing of claims incurred on or before the Contract End Date and reimbursing late-filed claims if warranted
- Continue to provide updates on applicable pending litigation and settlements

Knowledge Plan Transfer
- Written plan to identify relevant processes, procedures, methods, tools, and techniques of its personnel with special skills or responsibilities performed during the Contract.

Benefits
- Determine timeframe for which an extension of benefits may apply
- Mail approved letters to members seeing providers who do not participate in successor entity's network and educate them about their rights to continue to receive a network level of benefits as per New York State Guidelines

Data Transfer Schedule / Test Data
- Determine data files, format and timing - including all data elements of claims activity files for successor
- Include minimum of one year of historical claim data with the data elements required by the Department and/or successor entity and as approved by the Department
- Test file sent to the Department or successor entity at least 22 weeks in advance of the End Date or as agreed upon
- Address any issues discovered upon transferring test file

Production Files
- Provide one or more pre-production files at least twelve weeks prior to the End Date
- Address any issues discovered upon transferring file
- Provide production file six weeks prior to successor entity's Implementation Date
- Provide a second production file to successor entity by close of business three days prior to the End Date
- Transfer member information necessary to ensure continuity of ongoing treatment or future treatment

Phase 2
Transition and Termination of Contract Diagram

Phase 2 Begins
- Begins first day after the Contract End Date or termination date provided pursuant to Appendix B section 31 and will continue until all claims incurred as of the End Date or termination date provided pursuant to Appendix B section 31 have been settled

Transition Plan
- Continue to follow mutually agreed upon Transition Plan developed during Phase 1
- Schedule calls with the Department and third party or the successor entity if needed

Support
- Anthem key personnel and dedicated Account team remain available for the Department

Safeguard in Service
- Retain NYBEAS access
- Receive and apply enrollment updates
- Active EmployerAccess site to provide the Department access to any online claims processing data and history and online reporting systems
- Continue processing of claims incurred on or before the Contract End Date and reimbursing late-filed claims if warranted
- Dedicated telephone lines available for a minimum of six months with adequate available staffing to provide customer service and clinical management service at the same levels provided prior to the End Date, adjusting phone scripts as necessary
- Provide customer service team with protocols for transferring calls to the successor entity when applicable
- Provide reporting as required under the Contract
- Continue to provide updates on applicable pending litigation and settlements

Audits
- Cooperate with all Department and/or OSC audits consistent with the requirements set forth in the Contract
- Perform timely reviews and responses to audit findings submitted by the Department and OSC's audit unit in accordance with the requirements set forth in the Contract
- Remit reimbursement due to the Plan upon final audit determination consistent with the process specified in the Contract

Termination Ends
- Offeror will receive no Administrative Fees but will be reimbursed for all claims settled (i.e., closed)
- Reimbursement for claims will be made on a monthly basis upon the Department's receipt of an accurate invoice.