



State of New Jersey
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
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www.state.nj.us/treasury/pensions

JON S. CORZINE
Governor

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Location:
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Trenton, New Jersey
BRADLEY I. ABELOW
State Treasurer
FREDERICK J. BEAVER
Director

May 22, 2007

To: All Potential Bidders

Re: Request for Proposal (RFP) for:

- Preferred Provider Organizations (PPO),
- Health Maintenance Organizations (HMO)

The following are key dates for this procurement:

- (1) Mandatory Pre-Bid Conference: June 22, 2007, 10:00 A.M.
Division of Pensions and Benefits
50 West State Street
1st Floor
Trenton, NJ 08625-0295
- (2) Bid Proposal Submission: August 16, 2007, 2:00 P.M.
(Faxed Bid Proposals will not be accepted)
Division of Pensions and Benefits
50 West State Street
8th Floor
Trenton, NJ 08625-0295

This RFP requests bid proposals for both a PPO and HMO, and vendors may submit bid proposals for one or both. If a vendor wishes to submit a proposal for both, two separate bid proposals must be submitted to the Division. Please read the entire document carefully, as there are requirements and questions set forth throughout the document for each of the products. Please mark your submission very clearly regarding which health care plan to which you are bidding. Additionally, please mark each of the checkmarks in the "contract requirements" section of the document, affirming that you are in agreement with the provision and can meet the qualification/request as set forth in each portion of this section.

At the Mandatory Pre-bid Conference, and upon completion of a Confidentiality/Non-Disclosure Agreement, your organization will receive confidential information relating to the bid, including census files and claims and utilization data. It will also include schedules to complete that will outline certain aspects of your financial proposal. This

information and the schedules, when combined with the information currently provided will allow you to complete the financial aspects of this bid.

All questions concerning the RFP contents and the bidding process should be directed, in writing to the undersigned.

Sincerely,

Susanne Culliton
Assistant Director
Fax: (609) 393-4606
E-mail: Susanne.Culliton@treas.state.nj.us

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SECTION A
BIDDER'S RFP CHECKLIST

Critical Things to Keep in Mind

1. **Read** the entire RFP. Note critical items such as: mandatory RFP requirements; required forms; bid submission date; number of bid proposal copies required; and contract requirements (i.e., indemnification, insurance, reporting, etc.).
2. **Take advantage of the opportunity to submit questions you may have regarding the RFP.** Submit questions in writing to Ms. Susanne Culliton **prior** to the Mandatory Pre-Bid Conference. Ms. Susanne Culliton is the only Division employee you are allowed to contact regarding the RFP and all contact with her must be in writing.
3. **Confidentiality/Non-Disclosure Agreement** - a non-disclosure agreement is provided in Section Q of this RFP. Review this document and bring a signed copy to the Mandatory Pre-Bid Conference in order to receive the census and claims data.
4. **Attend the Mandatory Pre-Bid Conference, June 22, 2007, at 10:00 A.M.** The Mandatory Pre-Bid Conference provides an opportunity for you to ask clarifying questions and gain a better understanding of the RFP and receive census and claims data that will be provided on CDs or paper reports.
5. **Follow the format required in the RFP** when preparing your bid proposal. Provide point-by-point responses to all sections in a clear and concise manner.
6. **Provide complete answers/descriptions.** Read and answer all questions and requirements. Don't assume the evaluation committee will know what your company's capabilities are or what services you can provide, even if you have previously contracted with the Commission.
7. **Complete all required forms, i.e.,**
 - Bidder Data Sheet;
 - Ownership Disclosure Form;
 - Disclosure of Investigations and Actions Involving Bidder;
 - MacBride Principles Certification;
 - Affirmative Action Employee Information Report or, in the alternative, a New Jersey Affirmative Action Certificate or evidence that the bidder is operating under a Federally-approved or sanctioned affirmative action program;
 - Source Disclosure Certification Form/E0129;
 - Tax Set-Off Form;
 - Confidentiality/Non-Disclosure Agreement; and
 - Evidence of registration with the Division of Revenue, Department

of the Treasury, State of New Jersey. Registration with the Division of Revenue can be done online at www.state.nj.us/treasury/revenue. Click on "Registering Your Business."

Information on obtaining these forms is provided in Section Q of this RFP.

- 8. Check the Division's Web site for RFP addenda.** Before submitting your bid proposal, check the Division's Web site at www.state.nj.us/treasury/pensions/shbp.htm to see whether any addenda were issued for the RFP.
- 9. Review and read the RFP document again** to make sure that your bid proposal addresses all RFP requirements.
- 10. Submit your bid proposal(s) on or before 2:00 P.M. August 16, 2007.** Bidder must submit one (1) complete ORIGINAL bid proposal clearly marked "ORIGINAL" and ten (10) full, complete and exact copies with eleven (11) CDs for each contract you are bidding on (i.e. one for the PPO and one for the HMO) are required to be submitted to the Division of Pensions and Benefits, 50 West State Street, 8th Floor, Trenton, NJ. Late bid proposals will not be accepted.
NOTE – Separate proposals are required for each product – PPO and HMO. Thus, if your organization is quoting on each product, separate proposals must be submitted.

SECTION B
INFORMATION FOR BIDDERS

Purpose and Intent

This Request for Proposal (RFP) is issued by the State Health Benefits Commission (Commission). The purpose of this RFP is to solicit proposals from qualified Bidders to provide claims administration and other services as specified in this RFP for the component plans of the State Health Benefits Program (SHBP), which include:

- Preferred Provider Organization (PPO)
- Health Maintenance Organizations (HMO).

This RFP is not requesting bids on the Employee Prescription Drug Plan that is currently administered by Horizon/Caremark.

Prescription drug coverage for retirees and for employees of Local Employer groups that do not choose to offer prescription drug coverage will be provided through the SHBP medical plan and included in this RFP.

A RFP for a prescription drug plan for all participants may be issued at a later date. If that occurs, prescription drug coverage may be removed for all participants from this RFP. We will advise prospective bidders of the status of the prescription drug RFP at the Mandatory Pre-Bid Conference.

Effective with the implementation of the PPO plan, the Traditional Plan and the NJ PLUS point of service plan will no longer be offered **to certain groups of employees and retirees.**

Note that all plan designs are under review and subject to change as further planning and collective bargaining will be ongoing through 2008. Additionally all pending and future legislation, as well as any regulatory changes, could impact designs and administration of the program.

The overriding goal of the Commission is to contract with vendors who have the administrative and technical capability to efficiently and effectively administer the plan(s), and manage the current and future costs without sacrificing quality or member satisfaction. The intent of this RFP is to award contract(s) to responsible Bidders whose bid(s), conforming to this RFP, are most advantageous to the Commission, price and other factors considered. The Commission may award multiple contracts as a result of the RFP, pursuant to N.J.S.A. 52:34-12.1.

More specifically, the Commission will award a four year contract with two one year extensions. The SHBP will expect the successful bidder to be:

- **Focused on Service.** The SHBP expects to receive a superior level of service and attention from its vendor during the implementation process, as well as on an ongoing basis.
- **Cost Effective.** The successful bidder will demonstrate its interest in the SHBP by quoting competitive discounts and fees, practice effective care management, and agreeing to be held accountable through performance and financial guarantees.
- **Quality Focused.** A bidder's ability to demonstrate high levels of quality and customer satisfaction is very important to the SHBP.
- **Provide Network Access.** The SHBP is looking for a vendor who is able to provide network access to the vast majority of current employees and retirees.

Background

The SHBP was created by the NJ State Health Benefits Program Act ("Act"), N.J.S.A. 52:17.25 et seq., in 1961 to provide health insurance coverage to State employees. The Commission is the body charged with establishing health benefits programs for State employees and promulgating regulations, as necessary, to administer the Act. The Commission is comprised of the State Treasurer (Chairman), the Commissioners of the Department of Banking and Insurance and the Department of Personnel, a State employees' representative chosen by the Public Employees' Committee of the AFL-CIO and a representative chosen by the New Jersey Education Association. The Commission has the authority to purchase and provide health benefits in accordance with the Act. The Commission's purchase regulations are detailed in N.J.A.C. 17:9-10.1 et seq. The Division of Pensions and Benefits (Division) administers the SHBP on behalf of the Commission.

The SHBP covers State employees, as well as employees of Local Employers who have elected to purchase coverage through the Local Employer group of the SHBP. The Local Employer group is separately rated from the State. Presently, the SHBP covers approximately 800,000 lives (including active, retired and COBRA individuals including their dependents) – Approximately

- 29% are enrolled in the Traditional Plan,
- 48% in NJ PLUS
- 23% in HMOs.

About 59% of subscribers are enrolled in the Local group.

Currently, State employees who are covered under the Traditional Plan pay 25% of the premium; under an HMO they pay 5%; and under NJ PLUS they pay no premium. A tentative new bargaining agreement will now require most State employees enrolled in

the SHBP to pay 1.5% of salary into the SHBP regardless of plan chosen or contract level (i.e., single, family).

Overview: Current Plans & Vendors

The current benefit plans and the administrators in place for 2007 include:

TRADITIONAL PLAN

The Traditional Plan is a self-insured, indemnity plan containing a passive indemnity discounted network. The Traditional Plan is currently administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon).

NJ PLUS

NJ PLUS is a self-insured point-of-service-plan added to the SHBP in 1990. Currently, the Plan is only available to employees and retirees residing in New Jersey, Delaware, Florida and parts of Pennsylvania and New York. NJ PLUS is also administered by Horizon.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

The Commission currently contracts with five HMOs, i.e., Aetna, CIGNA, Health Net, AmeriHealth and Oxford. All are self-insured. All five HMOs' service areas cover the entire State of NJ and portions of other states.

MEDICARE ELIGIBLE RETIREES

For Medicare-eligible retirees, all plans coordinate their medical benefits with Medicare. As for the prescription drug benefits, the State is collecting the Medicare Part D Retiree Drug Subsidy.

PRESCRIPTION DRUG PLANS

The Commission requires that all participating SHBP employees and retirees have access to prescription drug coverage. Such access is achieved for active employees through one of the following: (1) the Employee Prescription Drug Plan, available to active State employees and active employees of participating Local Employers who opt for coverage through that plan, (2) a non-SHBP alternative drug plan offered by a participating Local Employer, or (3) inclusion of prescription drug coverage in all SHBP health plans for employees of participating Local Employers who opt for that coverage. Retirees receive Prescription Drug coverage through their SHBP medical plan.

Proposed Structure

	PPO A	PPO B	PPO C	HMO(s)
State Actives		X		X
State Retirees:				
Current Retirees	X	X		X
Future Retirees		X		X
Local - Other Active*	X	X	X	X
Local - Other Retirees	X	X		X
Local - Educ. Active*	X	X	X	X
Local - Educ. Retirees	X	X	X	X

*Please note that the Local - Other and Local Education will have the ability to implement member cost-sharing by Union, and the flexibility to choose from the menu of plan options.

RFP Process

The selection process will follow the timetable outlined below:

Activity	Date
RFP Distribution	May 22, 2007
Mandatory Pre-bid conference	June 22, 2007
Responses to Questions provided to Vendors	July 23, 2007
Proposals Due from Vendors	August 16, 2007
Recommendation to Commission	October 2007
Selection of Vendor(s)	October 2007
Concurrent Activities	
System Development – SHBP	Oct. 2007- Feb. 2008
System Development -Vendors	Oct. 2007- Mar. 2008
Development of Communications Materials	Oct. 2007 – Dec. 2007
Employee/Retiree Outreach Meetings	Jan. 2008 – Feb 2008
Distribute Enrollment Kits to Local Employers (Approx. 960)	Jan. 2008
Open Enrollment	Feb. 2008
Data Loads	Mar. 2008
Issuance of ID Cards	Mar. 15 – 30, 2008
Contract Effective Date	April 1, 2008

Questions and Inquiries Relating to the RFP

The Division will accept questions and inquiries relating to the RFP from all potential bidders. Only written submissions will be considered. Written questions should be mailed, faxed or e-mailed to the Division to the attention of:

Susanne Culliton
Assistant Director
Division of Pensions and Benefits
P.O. Box 295
Trenton, New Jersey 08625-0295
Fax Number: (609) 393-4606
E-Mail: Susanne.Culliton@treas.state.nj.us

Question/Inquiry Protocol

Questions should be directly tied to each contract included in this RFP, following the order of organization of the RFP. Each question should begin by referencing the page number and Section number to which it relates.

All questions received will be compiled and the answers will be placed on the SHBP Web site.

Cut-off Date for Questions

A Mandatory Pre-Bid Conference has been scheduled for this procurement. The cut-off date for questions is the date of the Mandatory Pre-Bid Conference. The Mandatory Pre-Bid Conference is scheduled for 10:00 a.m. on June 22, 2007, at the Division of Pensions and Benefits, 50 West State Street, 1st Floor Board Room, Trenton, NJ.

The purpose of the Mandatory Pre-Bid Conference is to provide a structured opportunity for the Division to answer questions regarding the RFP. It is requested that questions be submitted in writing in advance of the Mandatory Pre-Bid Conference.

You should advise Ms. Culliton beforehand by E-mail or fax as far in advance of the Mandatory Pre-Bid Conference as possible of how many members of your organization will attend. Limit attendees from your organization to three.

Confidentiality Agreement

At the Pre-Bid conference your organization will be required to provide a signed copy of the Confidentiality/Non-Disclosure Agreement (See Section Q of this RFP for more information). This Confidentiality/Non-Disclosure Agreement will be required in order to receive census and claim data that will be provided at the Pre-Bid conference.

Revisions to the RFP

In the event it is necessary to clarify or revise this RFP, such clarification or revision will be by addendum. RFP addendum will be posted on the Division's Web site at: www.state.nj.us/treasury/pensions/shbp.htm. It is critical that you monitor the Division's Web site to ensure that, in the event RFP addenda are issued, you are fully informed of clarifications and/or revisions.

Addenda are Part of the RFP

Addenda posted on the Division's Web site become part of the RFP and, if relating to Schedules A, B C, D or E and the appendices thereto, become part of the Contract(s) resulting from the RFP.

Bid Proposal Delivery and Identification

In order to be considered, the bid proposal must be received on or before the opening time and date of 2:00 p.m. on August 16, 2007, at the Division of Pensions and Benefits, P.O. Box 295, 50 West State Street, 8th Floor, Trenton, New Jersey 08625-0295. Telephone, fax, e-mail or telegraph bid proposals will not be accepted.

Bidder is cautioned to allow adequate delivery time to ensure timely delivery of the bid proposal. A late bid proposal is ineligible for consideration and will be returned unopened to the bidder.

The exterior of the bid proposal package should be labeled with the RFP's title and the opening date and time.

Number of Bid Proposal Copies

Bidder must submit one (1) complete ORIGINAL bid proposal clearly marked "ORIGINAL" and ten (10) full, complete and exact copies with eleven (11) CDs for each contract you are bidding on (i.e. one for the PPO and one for the HMO).

NOTE – Separate proposals are required for each product, PPO and HMO, if your organization is quoting on each product separate proposals must be submitted.

Contents of Bid Proposal

This is a negotiated procurement. The only information that will be made available at bid opening is a listing of bidders and their addresses. Following the notice of intent to award, each bid proposal and, if applicable, each best and final offer, will be made available for public inspection in accordance with the New Jersey Open Public Records Act, N.J.S.A. 47: 1A-1, et seq. Interested parties may make an appointment to inspect bid proposals by contacting Susanne Culliton.

Within a cover letter submitted with its bid proposal, the Bidder must identify any data or materials it asserts are proprietary or trade secret and protected under the New Jersey Open Public Records Act. The proprietary or trade secret material must also be identified by some distinct method such as highlighting or underlining and must indicate only the specific words, figures or paragraphs that constitute trade secret or proprietary information. The classification of line item prices, total bid proposal prices or the entire bid proposal as proprietary or trade secret is not acceptable and will result in rejection of the bid proposal.

Bid Proposal Evaluation/Contract(s) Award

Overview

Prior to bid opening, the Director, Division of Pensions and Benefits, (Director) shall appoint an evaluation committee to evaluate bid proposals received. The evaluation committee shall establish weights for the evaluation criteria outlined below prior to bid opening. The evaluation committee may choose to avail itself of the expertise of outside advisors and/or consultants. The evaluation committee must submit its award recommendation(s) to the Director. The Director shall review the evaluation committee's award recommendation(s) and, thereafter, submit the evaluation committee's award recommendation(s), and any comments the Director may have relating thereto, to the Commission for consideration.

Evaluation Process

(a) The evaluation committee shall establish weights for the evaluation criteria set forth in this RFP. Weights shall not be made public until after the director's issuance of the Notice of Intent to Award.

(b) Bid proposal(s) will initially be reviewed by the evaluation committee to ensure that each meets mandatory requirements of the RFP and Commission regulations set forth at N.J.A.C. 17:9-10.6. A bid proposal not meeting the mandatory requirements of the RFP and N.J.A.C. 17:9-10.6 will be found non-responsive. Proposals deemed non-responsive will be given no further consideration.

(c) In accord with N.J.A.C. 17:9-10.10 and 17:9-10.11, the evaluation committee may either finalize its contract(s) award recommendation or conduct negotiations with those bidders whose bid proposals are determined by the evaluation committee to be responsive and within the competitive range.

(d) If negotiations are conducted, the evaluation committee must notify each responsive bidder in the competitive range of the deficiencies in its bid proposal, providing each bidder with the opportunity to revise its bid proposal and improve its chances for Contract(s) award. Mandatory requirements of the RFP are not negotiable.

(e) The evaluation committee need not identify every aspect of a technically-acceptable bid proposal that received less than a maximum score. Because bid proposals have different shortcomings, it may be necessary to hold more rounds of negotiations with one bidder than with another.

(f) Negotiations must provide for the safeguarding of information and ensure that each bidder is treated fairly. Prohibited negotiations include:

(1) “Technical transfusion.” Technical transfusion is the disclosure of one bidder’s bid proposal to another to help the other improve its bid proposal.

(2) “Technical leveling.” Technical leveling is helping a bidder bring its bid proposal up to the level of other bid proposals through successive rounds of negotiations by pointing out the weaknesses that remain due to the bidder’s lack of diligence, competence or inventiveness.

(3) “Auctioning.” Auctioning is the practice of promoting price bidding between bidders by indicating the price bidders must beat, holding repeated rounds of best and final offers and/or disclosing other bidders’ prices.

(g) Following the completion of negotiations, the evaluation committee must provide written notice to bidders that negotiations are complete. Each bidder must then be afforded the opportunity to revise its bid proposal and submit a best and final offer by a specified date and time. Best and final offers may modify any aspect of the bidder’s proposal, provided the mandatory requirements of the RFP remain satisfied.

(h) It is the intent of this procurement to have one round of best and final offers. While the evaluation committee may seek clarification of a best and final offer, best and final offers stand on their own merits and are not subject to negotiation.

Evaluation Criteria

Responsive bid proposals and, if negotiations are undertaken, best and final offers must be evaluated by the evaluation committee on the basis of price and the following evaluation criteria:

(a) The bidder's approach and plans in meeting the RFP’s requirements.

(b) The bidder’s overall financial stability.

(c) The bidder’s documented experience in successfully administering contracts or programs of similar size and scope.

(d) The qualifications and experience of the bidder’s management, supervisory or other key personnel to be assigned to the contract(s), with emphasis on documented experience with contract(s) or programs of similar size and scope.

(e) The overall ability of the bidder, as judged by the State, to satisfactorily provide all contractual provisions and services.

Contract(s) Award

The evaluation committee shall submit its contract(s) award recommendation to the Director. The Director shall review the evaluation committee's contract(s) award recommendation and any other documentation the Director deems relevant. The Director shall submit the evaluation committee's contract(s) award recommendation, and any comments the Director may have relating thereto, to the Commission for consideration. The Commission must make a decision to award or not to award a contract(s) on the basis of price and other factors.

Right of Final Bid Acceptance

The Commission reserves the right to reject any and all bid proposals, or to award a contract(s) in whole or in part, if deemed to be in the best interest of the SHBP to do so.

Notice of Intent to Award

Following the Commission's decision, a notice of intent to award or not to award a Contract(s) must be issued by the Director. All bidders must receive a copy of the notice of intent to award or not to award a Contract(s). The notice of intent to award must stipulate Contract(s) execution upon the selected bidder's submission of any outstanding items within a time certain.

Right to Protest

A bidder not selected for Contract award has the right to protest the Commission's Contract award decision. Such protest must be filed with the Director within 10 days following the bidder's receipt of the notice of intent to award. The Commission may, in the public interest, shorten the protest period but, in such instance, the Director must provide notice of the shortened protest period within the notice of intent to award.

SECTION C

BID PROPOSAL INSTRUCTIONS

General

While the bidder is given wide latitude concerning the degree of detail it elects to offer in its bid proposal, the bid proposal must fully respond to all of the RFP's requirements. Any qualifying statement made by the bidder in its bid proposal could result in a low technical score or, if relating to an RFP requirement, could result in the bid proposal being non-responsive to an RFP requirement and ineligible for Contract(s) award.

By submitting a bid proposal, the bidder represents that it has satisfied itself, from its own investigation, of all RFP requirements. Neither the Division nor the Commission assumes responsibility or bears liability for any costs incurred by the bidder in the preparation and submittal of a bid proposal in response to this RFP.

In preparing the bid proposal, it is critical that the bidder keep in mind the following definitions:

“May” - denotes that which is permissible, not mandatory.

“Shall” or “Must” - denotes a mandatory requirement. Failure to satisfy a mandatory requirement will result in the automatic rejection of a bid proposal as materially non-responsive.

“Should” - denotes that which is recommended, not mandatory.

Additional definitions of terms used throughout this RFP can be found at Section P.

Bid Proposal Content

NOTE – Separate proposals are required for each product – PPO and HMO, if your organization is quoting on each product separate proposals must be submitted.

The bid proposal must be divided into eight (8) Sections as follows:

SECTION 1: TECHNICAL PROPOSAL

Executive Summary

This section of the proposal should be brief and highlight the following:

- What contracts your firm is bidding on
- Key differentiators that set your firm apart from others
- Key aspects of your proposal

Contract Management

Bidder must present an overview of its plans to manage control and supervise the Contract(s) to ensure satisfactory performance.

Potential Problems

Bidder should set forth a summary of any and all problems that bidder anticipates during the contract. For each problem identified, bidder should provide its proposed solution.

SECTION 2: FORMS/SUBMISSIONS

The following required forms must be completed, signed by an authorized representative of the bidder and included in Section 1 of the bidder's bid proposal:

- 1) Bidder Data Sheet
- 2) Ownership Disclosure Form
- 3) Disclosure of Investigations and Actions Involving Bidder
- 4) MacBride Principles Certification
- 5) Affirmative Action Employee Information Report or, in the alternative, a New Jersey Affirmative Action Certificate or evidence that the bidder is operating under a Federally approved or sanctioned affirmative action program.
- 6) Source Disclosure Certification Form/E0129
- 7) Set-Off for State Tax Notice
- 8) Confidentiality/Non-Disclosure Agreement (to be submitted at the Pre-Bid Conference)
- 9) Evidence of registration with the Division of Revenue, Department of the Treasury, State of New Jersey. Registration with the Division of Revenue can be done on-line at www.state.nj.us/treasury/revenue Click on "Registering Your Business."

See Section Q of this RFP for information on obtaining these required forms.

Joint Venture

If a joint venture, authorized representatives from each party comprising the joint venture must comply with this Forms/Submissions section. In addition, the agreement between the parties relating to the joint venture must be included in Section 2 of the joint venture's bid proposal.

SECTION 3: ORGANIZATIONAL SUPPORT AND EXPERIENCE

Location(s)

Bidder must include the location(s) of bidder's office that will be responsible for managing the Contract(s).

Organization Chart (Contract Specific)

Bidder must include an organization chart, with names showing management, supervisory and other key personnel (including subcontractor's management, supervisory and other key personnel) to be assigned to the Contract(s). Include the title of each such individual.

Organization Chart (Entire Firm)

Bidder should include an organization chart showing the bidder's entire organizational structure. This chart should show the relationship of the individuals proposed for each Plan bid to bidder's overall organizational structure.

Resumes

Bidder should submit detailed resumes for all management, supervisory and key personnel to be assigned to the Contract(s). Resumes should be structured to emphasize relevant qualifications and experience of these individuals in successfully completing contracts of a similar size and scope. Beginning and ending dates should be given for each similar contract.

In the event bidder must hire or otherwise engage management, supervisory and/or key personnel if awarded the Contract, bidder should include a recruitment plan for such personnel. Such recruitment plan should demonstrate that bidder will be able to implement the Contract on its anticipated start date of April 1, 2008.

Resources

The bidder should include a description of the bidder's capabilities, corporate resources, software, national and regional benefit data warehouses, etc. that would indicate the bidder's ability to respond to periodic requests for information relating to: best practices regionally and nationally, trends in benefit designs and plan costs, innovative concepts and designs by other providers or employers, etc.

Experience of Bidder on Contracts of Similar Size and Scope

Bidder must list Contracts of similar size and scope that it holds or has held for the past five years. For each Contract listed, bidder must provide contact information (name, address and phone number) of a knowledgeable person. Bidder must demonstrate

experience with public sector health programs with enrollments of at least 50,000 subscribers.

Financial Capability of the Bidder

Bidder must provide audited financial statements for the last three fiscal years and current bank reference(s).

Subcontractors

Bidder must provide a detailed description of services to be provided by each subcontractor, referencing the applicable task in the Additional Contract Requirements and Schedule B, Scope of Work. Subcontractors do not include individual licensed providers or provider groups.

Bidder should provide detailed resumes for each subcontractor's management, supervisory and other key personnel demonstrating knowledge, ability and experience relevant to the task the subcontractor is to perform.

Bidder should provide documented experience demonstrating that each subcontractor has successfully performed work on contracts of a similar size and scope to the task that the subcontractor is to perform.

Bidder should provide audited financial statements for the last three fiscal years and current bank reference(s) for each subcontractor.

Bidder should provide information on the type of contract, the duration of contract and oversight of quality of services provided to your clients.

SECTION 4 – RESPONSE TO QUESTIONNAIRE

This RFP contains a comprehensive questionnaire in Section D that must be completed.

SECTION 5 – CONFIRMATION OF CONTRACT REQUIREMENTS

This RFP contains a detailed list of contractual requirements. In this section of your proposal confirm your organization's ability to meet these requirements.

SECTION 6 – ASO FEE PROPOSAL

Provide your ASO fee proposals in the charts that are provided in Section G of this RFP.

SECTION 7 – PERFORMANCE AND FINANCIAL GUARANTEES

Confirm your ability to comply with the performance and financial guarantees as presented in Section K of this RFP.

SECTION 8 – ATTACHMENTS

- Attachment 1 – Audited Financial Statement
- Attachment 2 – SAS 70 II Report
- Attachment 3 – Annual Report
- Attachment 4 – Most recent 10 K
- Attachment 5 - Information on Transparency and Quality Initiatives
- Attachment 6 - Number of Providers by Zip Code
- Attachment 7 – Medical Geo Access Reports
- Attachment 8 – Disruption Reports
- Attachment 9– Reimbursement Schedules
- Attachment 10 – Pharmacy Geo Access Reports
- Attachment 11 – Pharmacy Disruption Report
- Attachment 12 – Pharmacy Financial Exhibit
- Attachment 13 – Financial Summary (to be provided at Mandatory Bidder Conference)

SECTION D

BID QUESTIONNAIRE

All questions below should be answered by the Bidder. The format should be:

Question: Restate the question as stated in the RFP.

Answer: Bidder’s response. If bidder is bidding on more than one contract, provide separate responses to the questions for each contract. If the question for which you are responding to does not apply write not applicable (n/a).

I. General Information

1. Confirm that you are in agreement with the terms, conditions and scope of services as outlined in this RFP. Your proposal combined with this RFP will be the contract and by submitting your proposal you agree to the terms and conditions as outlined herein. If there are any issues identify them explicitly.

2. Provide your current financial ratings and date when the rating was received.

	Rating	Date (if rated; if not rated indicate Not Rated)
A.M. Best: Rating Status		
Financial Rating (if rated)		
Standard & Poor's: Rating Status		
Financial Rating (if rated)		
Fitch: Rating Status		
Financial Rating (if rated)		
Moody's: Rating Status		
Financial Rating (if rated)		
Bidder's rating change within the past 12 months (No Change, Not Rated, Improved, Decreased):		
A.M. Best		
Standard & Poor's		
Fitch		
Moody's		

3. Summarize any mergers or acquisitions of other organizations completed in the past 24 months (or in process), and summarize how these actions will:
 - Directly impact the SHBP; and
 - Distinguish you and your services from those of your competitors.
4. Indicate how many PPO members you currently serve.
5. Indicate how many HMO members you currently serve.
6. Number of employees, plans administered, and length of relationship with your organization should also be included in the response. The reference should include the name and address of the employer as well as the name, title, address and phone number of the contact.
7. Provide the attributes of your organization that you believe separates you from your competitors.
8. Describe your firm's involvement in leading edge health care management initiatives such as pay-for-performance, Leapfrog, Bridges to Excellence, etc.
9. At the pre-bid conference you will be provided with an exhibit to complete regarding transparency and initiatives in promoting quality and efficiency of care. Label this exhibit as Attachment 5.

Account Management/Implementation

10. Provide the following information regarding the individual(s) you propose to have overall responsibility for managing the SHBP account:
 - a. A summary of the account team structure including office location (the Division prefers a local presence).
 - b. Name, title and immediate superior of Account Executive and indicate how your company takes this person's performance into account when considering that individual's compensation for the relevant period.
 - c. The individual that has ultimate decision making authority. How often will this individual be made available to the Division?
 - d. How the Account Executive will coordinate with all product areas to provide a seamless account management approach?
 - e. Does the Account Executive have sales/marketing duties in addition to client service responsibilities?

- f. What percentage of his/her total annual work hours are devoted to client account responsibilities? Name other major clients for whom the Account Executive has and will continue to have account responsibilities. What percentage of their time would be dedicated to the State account?
11. Describe your approach to implementing the SHBP account, including in your description the following information:
- a. The structure of the implementation team you suggest to ensure a smooth implementation. Indicate whether the team will be dedicated full-time to the SHBP, and, if not, the nature of their other responsibilities during the SHBP implementation.
 - b. The nature and amount of involvement you will require from the SHBP.
 - c. A preliminary timetable showing tasks that need to be completed, who will perform them, target dates and the major milestones that will be used to monitor progress.
12. What are the most critical steps that you and/or the Division must take to ensure a smooth transition by the effective date?

Customer Service

13. Describe how customer service will be provided to the SHBP employees, retirees and dependents. Include the following:
- a. The SHBP requires the customer service center to be available 8:00 A.M. to 6:00 P.M. Eastern Standard Time Monday through Friday, except State specified holidays; describe how customer service is handled after these operating hours (including calls from members in different time zones);
 - b. Location of call center(s);
 - c. How will the customer service teams be structured;
 - d. Indicate the number of Customer Service Representatives' (CSR)s', qualifications and experience of the CSR team.
 - e. How you segment calls (e.g., routing of inquiries by plan, inquiries about claims, requests to identify network providers, generalized member services questions, etc.). Provide a sample of the specific management reports of telephone inquiry performance.
 - f. The investments your company has made in call center technology over the last two years, addressing specifically your use of caller ID, data warehousing and other technologies that make customer service more

effective; also describe any differences between the technologies used at the call centers that will be servicing the SHBP;

- g. Computer and phone system which supports and tracks customer service calls and staffing.
 - h. The ratio of full time customer service representatives to covered members. Separately identify management staffing ratios – how many managers to covered members.
14. Will the SHBP have a dedicated customer service team(s) for each proposed plan? If not, explain.
 15. What has been the turnover ratio in this unit for 2004, 2005, 2006, and 2007 YTD?
 16. Describe any initiatives that have been implemented in an effort to reduce turnover.
 17. What methodologies (e.g., silent call monitoring) are employed to monitor and control the quality of service provided?
 18. Describe the training procedure for CSRs.
 19. Are CSRs authorized to make claim adjustments? If yes, describe any limitations.
 20. What information screens are available on-line to CSRs?
 21. What types of provider information are available for CSRs to share with members (e.g., medical school, residency training, hospital admitting privileges, etc.)?
 22. What assistance can CSRs provide when a member calls to request help in selecting a physician or other healthcare provider?
 23. Do you tape all customer calls and if not, what percentage are taped? How long are the tapes kept?
 24. What types of Internet capabilities are available to members to facilitate customer service needs?
 25. What types of Internet capabilities are available to members to assist members in making educated healthcare decisions?
 26. Describe your ability to survey employees that have claims issues to determine if the problems were resolved satisfactorily.

Claims Administration

27. Describe how your precertification process operates. What services do you recommend pre-certifying in-network and out-of-network? What diagnostic services do you pre-certify? What mental health services do you pre-certify?
28. Which facility(ies) will handle the claim processing functions and where is it located?
29. Describe the organization(s) that will be established to process claims (i.e., for each plan design) and indicate whether there will be a dedicated unit for the SHBP.
30. Describe the structure of the claim office(s) - number of examiners, qualifications and experience of the claims administration team that will process claims, staffing ratio of examiners to managers, staffing ratio of examiners to covered members, staffing ratio of managers to covered members, etc.
31. At what claim level is there a trigger for manager review?
32. Which other major accounts are processed in the designated claim office(s)?
33. If claims are adjudicated in multiple claim offices, how does the Bidder ensure consistency in claims administration?
34. Describe your claim processing system(s) – its architecture, platforms, features (e.g., automated links between claims system and eligibility system; percentage of auto adjudication for in-network and out-of-network claims; handling of unbundled charges).
35. Are in-network and out-of-network claims processed on the same system? If not, explain how Bidder coordinates the systems.
36. Describe the protocols for the quality assurance surrounding the correct application of network contract rates.
37. What percentage of Bidder's in-network providers submit claims electronically?
38. How does the Bidder guard against duplicate payments?
39. How are overcharges, medically inappropriate or unnecessary care or provider abuse detected?
40. What steps will Bidder take to remedy conditions that are uncovered during utilization review for claims that appear aberrant, excessive or fraudulent?
41. Describe overpayment recovery procedures (including any thresholds).
42. Describe hospital bill audit guidelines and procedures.

43. Are member services, claims processing, medical management and provider relations services centralized in one location? If not, which ones are separately located?
44. Does Bidder foresee any need for manual interventions in the processing of claims? If yes, describe.
45. What has been the annual turnover rate for the claims processing staff for i.e., 2004, 2005, 2006, and 2007 (YTD)?
46. Describe any initiatives that have been implemented in an effort to reduce turnover.
47. Can Bidder's Explanation of Benefits (EOB) provide claim reimbursement details for more than one family member? If yes, how many?
48. Provide a list of standard messages on the EOB and explain Bidder's capability to customize messages on the EOB.
49. Provide a sample of the EOB form(s).
50. Provide a screen shot of how EOBs and claim history are displayed on your Web site.
51. Describe your protocols for the quality assurance surrounding the correct application of network contract rates.
52. Describe the process you propose for transitioning with the predecessor contractor to obtain history of claims towards benefit accumulators and maximums.
53. How does your claim system handle adding claim history to calculate benefit maximums?
54. Are claims for outpatient diagnostic tests pended or denied until a diagnosis code is received?
 - a. If pended, does the system have a look back capability whereby the examiner would be able to review past claims to determine that the member has a chronic condition and thus enabling the processor to process claims that would otherwise be pended or denied due to the absence of a diagnosis?
 - b. If not pended, why not?
55. Provide your definition of experimental and investigational procedures and treatments. What sources do you rely upon to support your decisions on experimental and investigational procedures and treatments?
56. Does the Bidder employ any protocols in its claims adjudication process that limit treatment modalities by providers such as chiropractors, physical therapists, or

occupational therapists whether the treatments modalities occur during a single outpatient visit or over a course of treatment? If yes, what peer-reviewed protocols are employed for which treatments, and if no, explain why not.

57. Describe how and when Bidder would notify members in advance that they are reaching a lifetime medical maximum. Can members be notified in an EOB?.

Systems and Eligibility

58. The SHBP processes all health benefit enrollments, changes and terminations and then sends the processed information to the Contractor daily via Connect-Direct, a product of Sterling Software to update its records with the new information. Contractor must be able to accept, efficiently process and report any errors or omissions back to the Commission daily. Confirm that you can accommodate these procedures using Connect-Direct (version 4.5 compatible).
59. Describe how the Bidder will structure this account, including computer systems, to accommodate the SHBP system whereby the participating employers are divided into the State, Education, Local Employer type (SEL TYPE) field.
60. Describe how the Bidder will make real time changes, as needed to accommodate additions, terminations and reinstatements, as well as changes to: Social Security Number; date of birth; coverage; effective date of coverage; and employer location number, at the member level.
61. Describe how historical information is maintained in the system. For how long?
62. Is the Contractor able to process coverage termination date changes on the Plan Eligibility File without an intervening add of coverage? For example, if SHBP sends a coverage termination effective 7/1/08 and then at a later date sends an 8/1/08 termination date, can Contractor reinstate coverage for the month of July without the SHBP sending an add, then a drop.
63. Specific subscribers (COBRA, over age dependent, part time employees) pay their own monthly premiums. The SHBP requires payment of claims for these 'self-pays' up to the subscriber's premium paid through date. The "paid through date" will be transmitted with the eligibility file. Confirm bidder can pay claims using the "paid through date".
64. Describe what controls are in place to pay claims only for eligible members.
65. What assurances can the Bidder, and all subcontractors, provide that its claims files will be reconciled with SHBP enrollment files? If separate systems are used for enrollment and claim processing, how are changes in enrollment data updated on the system used to pay claims?

66. Describe Bidder's identification card distribution process. Include details such as the card creation locations, distribution methods, use of subcontractors, third party involvement, etc.
67. Describe how on-line access to reports concerning enrollments, eligibility, and distributions of ID cards, will be available to the Division. How will the system be accessed? Confirm Bidder has a secure method of submitting reports electronically to the Division.
68. Describe how dependent information is stored. Is it part of the subscriber record, or a separate record? If separate, how are the two linked so that changes or termination on the subscriber record update the dependent record?
69. If a member has another group health benefits policy with the Contractor, will the Plan's eligibility record be separate or shared? If common data is shared (e.g. SSN, DOB, name), describe how this information can be protected from changes made by other plans or groups.
70. Describe how the Contractor will notify the Commission if it receives information relevant to, but not indicated on, our enrollment records, such as death, divorce, or Medicare entitlement.
71. Set forth your criteria used to establish that a dependent child attaining the age of 23 should continue as a disabled dependent and determination and verification of continued eligibility.
72. If requested by the Commission, does Bidder have the ability to market the SHBP to non-participating Local Employers? If yes, would this service be included in the ASO fee or is there a separate charge for this service? What services would be provided? State the number of staff that will be available.
73. Describe your disaster recovery protocols, procedures and backup systems. Are claim files and microfilm files stored off site? Can you rapidly shift phone service to another center, if needed? Can you rapidly shift claim processing to another center, if needed?
74. Will all of the eligibility information the SHBP provides to support its plans be handled by one system?
75. By what date do you need to receive full eligibility to guarantee delivery of ID cards by 4/1/2008?
76. Describe how your system handles eligibility changes for employees and dependents. What resources are required of the SHBP? Include the following:
 - How do you identify dependents exceeding or nearing a plan's limiting age?

- How do you administer lapses and/or overlaps in coverage?
 - Number of eligibility changes the system can accommodate per employee: i.e. can you process marriage, birth and termination on the same day?
 - Length of time eligibility information is maintained on-line
77. How frequently can eligibility information be updated? How soon is the eligibility system updated on-line after receipt of the new information?
 78. Do the customer service representatives have on-line access to the eligibility system? Can they make changes to the system?
 79. Describe the integration of all the systems that will be used to administer the SHBP plans.
 80. How do your systems integrate with those of your subcontractors being used to administer the plans?
 81. Describe any planned enhancements of Bidder's systems and how they are integrated.
 82. The Contractor must supply a list of technical training and procedure manuals to the Division's SHBP personnel. Are any manuals not available to SHBP personnel?
 83. The Commission requires periodic Enrollment Reconciliation Audits (ERAs). Currently the ERAs are done quarterly but may be done more frequently if necessary to identify and correct processing problems. The Contractor and the Commission agree on certain specifications for each file, such as (1) the "freezing" of enrollment files as of a specific date; (2) the coverage date to be examined; and (3) the criteria used for comparison. The Division will send a file to Contractor. The Contractor must compare the Commission's enrollment data to its enrollment data and identify enrollment records which (1) are on the Contractor's file but not on the State's file; (2) on the State's file but not on the Contractor's file and (3) on both with discrepancies. The Contractor must also identify the number of records in each category as well as the number of records that matched. What discrepancies would the Bidder identify? What would be the Bidder's procedures to identify the causes of discrepancies? What would be the Bidder's procedures to make needed changes in its processing procedures to prevent future errors? What would be the Bidder's procedures to work with the Commission regarding changes in the State's processing procedures to prevent future errors?
 84. If a member requests a new ID card, what is the charge for such a card?

Management Reporting

85. Provide samples of your management reports for each benefit program. Include samples of all required reports outlined in Section L of this RFP. In addition to the required reports, whose cost must be included in the administrative fee, provide samples of standard reports available at no additional cost. Identify any additional costs for ad hoc reports. Outline the contents of these reports.
86. What types of on-line capabilities are available to clients to view and/or create reports?
87. Explain how reporting of the prescription drug and mental health/substance abuse claims and utilization, as well as reporting from any and all subcontractors, will be integrated with reporting on the medical plans.

II. Medical

Network Access

88. Separately for the HMO and PPO networks provide the number of providers within the lesser of 10 miles or 30 minutes average driving time for every zip code in an exhibit that will be provided at the Pre-Bid Conference by the following categories:
 - a. Internal medicine
 - b. Family practice
 - c. Pediatrician
 - d. OB/GYN
 - e. Allergists
 - f. Cardiologists
 - g. Dermatologists
 - h. Endocrinologists
 - i. ENT
 - j. General Surgeon
 - k. Licensed Clinical Social Worker
 - l. Licensed Psychologist
 - m. Neurologist

- n. Oncologist
- o. Ophthalmologist
- p. Orthopedist
- q. Oral surgeon
- r. Psychiatrist
- s. Urologist

Label this as Attachment 6 of your proposal(s).

89. Perform a match of employees/retirees against participating providers in your HMO and PPO networks. Prepare the following GeoAccess reports:
- PPO network
 - HMO

The following access standards should be used:

Practice Specialty	Number of Providers Available	Miles from Employee's/ Retiree's Residence
Urban		
Adult Physicians (Family Practice, General Practice, General Internal Medicine)	2	8
General Pediatricians	2	8
Obstetricians/Gynecologists	2	8
Acute Care Hospitals	1	10
Practice Specialty	Number of Providers Available	Miles from Employee's/ Retiree's Residence
Suburban		
Adult Physicians (Family Practice, General Practice, General Internal Medicine)	2	15
General Pediatricians	2	15
Obstetricians/Gynecologists	2	15
Acute Care Hospitals	1	15
Rural		
Adult Physicians (Family Practice, General Practice, General Internal Medicine)	2	25
General Pediatricians	2	25
Obstetricians/Gynecologists	2	25
Acute Care Hospitals	1	25

The report should show hospital and provider availability by physician specialty for each zip code (or community). Report output is required for those with access and those without access, based upon the stipulated parameters. The report output should show the average distance to each provider group. **In addition to the hard copy report, the data must be supplied in electronic format that has read/write capabilities (i.e. Excel). Do not send the data in a read-only file.** Use only physicians accepting new patients in your Geo-Access provider file. The census data for this analysis will be provided at the bidder's conference. ***Label this as Attachment 7 of your Proposal(s).***

90. What are your book-of-business access standards for HMO or PPO? How would this impact the results of the GeoAccess report that you have prepared using the SHBP's specific access standards?
91. Complete the disruption reports (the data and sample spreadsheets will be provided at the bidders conference) for the SHBP's designated utilized providers:
 - Primary Care Physician list in the worksheet, "**Primary Care Physician.**" The worksheet contains a list of current PCPs for which we are requesting you to identify if the provider is in-network or out-of-network. Identify providers accepting new patients separately from those that are not.
 - Provider list in the worksheet, "**Providers.**" The worksheet contains a list of top providers for which we are requesting you to identify if the provider is in-network or out-of-network.

Label this as Attachment 8 of your proposal(s).

92. Complete the reimbursement schedules (provided at the bidders conference) for the SHBP's designated locations:
 - Physician Reimbursement Schedule in the worksheet, "**Physician Reimbursement.**" The schedule contains a sample list of procedure codes for which we are requesting your provider fee schedule amounts. Be sure to indicate the effective dates for the fees if not 7/1/07. Schedules should be provided for non-Medicare only.
 - Hospital Reimbursement Schedule in the worksheet "**Hospital Savings.**" The schedule contains a sample list of inpatient and outpatient facilities for which we are requesting your total book of business (non-Medicare)eligible charges versus network approved charges. Be sure to indicate if the facility is in-network or out-of-network.

Label this as Attachment 9 of your proposal(s).

93. Provide the numbers of hospital, physicians, and specialists in your network by state. Identify how many providers are accepting new patients and those that are not.

Network Management

94. Describe any specialty network relationships (e.g., chiropractic, therapy, DME, lab) you have where there is SHBP membership. Specify the name of the vendor(s) and the financial arrangements that have been negotiated. How do these contracts benefit the SHBP? How will these costs be passed on to the SHBP?
95. Do you have multi-year contracts with providers? If yes, describe the typical terms of the contract. Describe caps or controls on reimbursement increases from year to year.
96. What services are capitated in your network?
97. What are the anticipated capitation rates for these services for 2007? 2008? If the capitation varies by geographic region, identify the rate differentials.
98. Describe your credentialing process.
99. Describe your recredentialing process.
100. Do you lease any HMO or PPO networks? If yes, describe the nature of the leased arrangements, including contractual obligations, responsibility, management functions, locations, etc. Do you have any arrangements for discounts with other contractors for out-of-network providers.
101. Do you contract with provider groups, clinics or multi-specialty groups? If so, identify. What percentage of your contracting is done with individual providers versus provider groups?
102. For HMOs, do you offer an open access plan? If so, is it a different network? What has been your experience with respect to claims differential in this type of an arrangement? Is the ASO fee different?
103. For areas in which you do not have strong network access, are you willing to create a network? Describe the process and timing. Include in your response if the SHBP would be able to nominate physicians to be included in the network.
104. Describe any special national networks that are utilized, such as National Centers of Excellence; specifically identify:
- a. each Center of Excellence facility with which you contract;
 - b. the nature of illnesses/conditions;
 - c. treatments/services and providers covered by the contract;

- d. if only selected providers are covered by the terms of the contract;
 - e. the selection criteria used in identifying each of these facilities;
 - f. types of payment arrangements, such as discounted fee-for service, per diem or global fee (encompasses facility and provider charges.)
 - g. how are cases selected for Centers of Excellence?
 - h. how do you communicate to members, their families and their providers the member's ability to take advantage of care at a Center of Excellence?
 - i. does Bidder's Center of Excellence program include provision of services, such as discounts at hotels or lodgings, to close relatives who accompany a member to a Center of Excellence?
 - j. do you use an organ transplant network? If so, describe this network.
105. Do you have any type of risk-sharing (withhold, etc.) or pay-for-performance bonus arrangements with Providers? If yes, describe in detail - include sample contract language.
106. What percentage of Network Providers have electronic referral capability throughout the contracting organization?
107. Has Bidder's health plan received accreditation by NCQA (National Committee for Quality Assurance)? If so, for what regions? If no, are you planning to do so? Have you applied and been denied or downgraded? Specify the type of accreditation achieved. Can Bidder's plans produce complete NJ HEDIS reports? Provide the latest complete aggregate HEDIS reports for Bidder's New Jersey HMO and/or PPO plan(s). Has Bidder's accreditation changed in the last five years?
108. Describe your network's activities and requirements with regards to profiling of network physicians. What do you do with the results?
109. Do you offer Medicare Advantage plans? If so, what plan designs do you offer by region.
110. Describe all efforts that bidder takes to negotiate directly or indirectly to obtain discounts with out-of-network providers.
111. How are Outpatient out-of-network facility charges determined? For example, is a schedule used or are reasonable and customary charges used?

Quality Assurance

112. How do you determine physician cost-effectiveness? How is quality of care determined? What measurement units are used for each?
113. Describe Bidder's ongoing quality assurance procedures for hospitals and other health care facilities. With respect to hospitals, do you:
 - a. require that treatment protocols be used?
 - b. investigate whether changes to quality controls are made after adverse outcomes?
 - c. monitor nosocomial infection and anesthesia death rates?
 - d. monitor re-admission rates after inpatient discharge or outpatient treatment (e.g., surgery)?
 - e. validate patient satisfaction with telephone or written surveys?
114. Describe Bidder's ongoing quality assurance procedures for physicians. With respect to physicians, do you:
 - a. share physicians' practice patterns with the respective physicians?
 - b. monitor a surgeon's frequency of surgery by procedure and total surgeries performed during the year?
 - c. monitor emergency room treatment approvals and specialist referral rates?
 - d. monitor the frequency and type of diagnostic and laboratory tests?
 - e. monitor re-admission rates after inpatient discharge or outpatient treatment (e.g., surgery)?
115. In terms of outcomes tracking, have you developed any standards or protocols for network providers to use for the diagnosis and treatment of patients? If yes, describe.
116. What guidelines and protocols are used for determining appropriate lengths of stay? Have the guidelines and protocols been peer reviewed? Who has the authority to deny payment for a confinement or stay? What is the appeal process?
117. What percentage of cases are referred for physician review?
118. Are second level appeals reviewed by a Provider with training in the appropriate specialty for the claim being contested? How does Bidder determine what specialty to use for second level appeals peer review?

119. What is Bidder's criteria for concurrent inpatient on-site review? What percentage of in-network cases are concurrently reviewed? Is concurrent review performed for out-of-network admissions?
120. What guidelines do you use to determine appropriate mental health? Do you use a subcontractor?
121. What guidelines do you use for managing outpatient treatment?
122. What are Bidder's utilization review staff's qualifications and average length of professional experience?
123. What is the ratio of Bidder's utilization review staff to covered population? Provide separately for clinical staff and Medical Directors.
124. What is each of the Medical Directors' role in Bidder's organization?
 - a. Is he or she a full-time or part-time employee?
 - b. What are the minimum credentials for a Medical Director?
 - c. Will there be a Medical Director in each state where SHBP members reside?
 - d. Will Medical Directors be licensed in the state where they perform their oversight and policy setting duties?
125. Are clinical quality assurance surveys used and, if yes, with what frequency?
126. Do you conduct member satisfaction surveys? If yes, how often are they done? Are they performed internally or by an outside organization? Provide a copy of the latest survey results and indicate any corrective actions taken as a result.
127. What plans do you have to improve your Quality Management Program(s)?

Medical Management

128. Describe the methods your Medical Management program(s) uses to target areas where you believe you can make a difference in managing health care utilization and costs. Include the following:
 - a. Do you target cases based on dollar thresholds, diagnoses, volume, provider profile, etc.?
 - b. How often do you conduct on-site reviews for: (i) inpatient hospital facilities; (ii) outpatient facilities; (iii) physician offices; (iv) outpatient labs, x-ray, and testing facilities, and (v) other (specify)?

- c. When and how often do you perform chart review?
129. How do you see your Medical Management programs evolving over the next 3-5 years? As appropriate, provide responses specific to:
- a. Utilization review
 - b. Case Management
 - c. Centers of Excellence
 - d. Disease Management
130. Describe the qualifications of the staff involved in utilization management determinations. Discuss education and experience requirements and the role and responsibilities of the medical directors.
131. Do you have written practice guidelines in place for site determination (inpatient vs. outpatient) and medical necessity? How were the practice guidelines developed? Are the guidelines for medical necessity shared with physicians?
132. What is the location and hours of operation for the Medical Management Department?
133. What is the utilization management process for handling weekend and after-hour emergency calls?
134. Do you offer a 24-hour Nurseline service? If so, describe the program and utilization results.
135. Describe your case management program, including:
- a. Any qualitative and quantitative results.
 - b. What enhancements have been made to your case management program within the last year and what changes are being planned for implementation within the next year?
 - c. What are the qualifications of the case managers? What is the ratio of case managers to covered members?
 - d. How are the cases identified for case management?
136. Are the case management services provided by the Contractor or by a subcontractor? If by a subcontractor, is the subcontractor part of a national organization?

137. How does Bidder identify members who would benefit from early interventions through this program?
138. Identify those conditions and circumstances that would trigger case management.
139. Does Bidder's case management program provide for the patient to be treated at home or in an alternate setting, such as a rehabilitation center or hospice?
140. What kind of savings from case management services would Bidder anticipate achieving for the Plan? Provide a copy of a sample case management savings report.
141. What are your transition of care procedures (e.g. maternity, etc.) for services being rendered by a provider that is not in your network? Discuss how claims will be handled, how the services will be transitioned to a new in network provider, and how medical management will be handled.

Disease Management/Wellness (Indicate any additional fees if applicable)

142. Currently the SHBP has comprehensive Disease Management (DM) programs that cover different conditions.
 - a. Outline your disease management programs.
 - b. What conditions do you target?
 - c. How do you measure outcomes for these disease management programs?
 - d. How does it integrate between the Medical and Prescription Drug programs?
 - e. Do you have the ability to track (or estimate):
 - Reduced hospital days
 - Impact on emergency room visits
 - Level of patient satisfaction
 - Cost savings
143. Are members enrolled on an "opt-in" or "opt-out" basis? Discuss how you engage targeted individuals to participate in the program. We are looking for key program characteristics that contribute to optimal enrollment and participation. Describe methods used to reach individuals with incomplete contact information. Do you employ a designated coach/disease manager for each targeted individual for outreach class/visits and incoming calls?

144. Discuss imminent plans to change your existing disease management services. Address expansion in scope of current programs, new disease management programs planned, links to other care management services, etc.
145. Provide any return on investment (ROI) figures available for your program as a whole and for any specific disease that is targeted. Do you have the ability to provide the SHBP ROI on their specific Disease Management programs for their members?
146. How will current Disease Management participants be transitioned into the new Disease Management programs?
147. Describe any guaranteed improvements in clinical outcomes, utilization, member satisfaction, absenteeism, and administrative performance. Be sure to list the portion of your fees that will be placed at risk for each performance guarantee component.
148. Do the Disease Management programs have the ability to target certain populations such as retirees?
149. Are all Disease Management participants screened for Depression?
150. Describe your Wellness Services that could be available to the SHBP.
151. Provide information about the Health Risk Assessment (HRA) tools you provide to members.
152. How are HRA results integrated into the management of the individual's care? How is this information integrated into the DM programs?
153. What type of techniques are used in engaging members into completing an HRA?
154. How are Health Coaches used? What are their qualifications? Do they make outbound calls as a result of HRA input?
155. Describe your efforts at Dental/Medical integration and discuss specifically how they would be applied to the SHBP, as well as potential cost impact.
156. Describe your capabilities with respect to online-personal health records.

Communications

157. Provide samples of your standard employee communication materials.
158. Outline how your communication materials can be customized and at what cost for various levels of customization.

159. When are your standard employee communication materials delivered to employees?
160. For HMO networks requiring selection of a Primary Care Physician, describe what types of communications are sent to employees who neglect to select a PCP.
161. Identify suggested communications and change management service capabilities that you can provide to the SHBP.
162. Provide a list of recommendations on additional services or tools that your organization can provide to the SHBP that have not been identified in the RFP as being currently provided (e.g. Support tools during open enrollment, online changes and other participant vs. plan sponsor services).

Mental Health/Substance Abuse (MH/SA)

163. Is your MH/SA network owned by your firm, a subsidiary, or do you contract with another MH/SA provider?
164. Is there a separate service center that handles customer service issues relating to MH/SA? If so:
 - a. describe how calls are routed to that center from other call centers
 - b. the hours of operation
 - c. the staffing of the service center
165. How will this coverage be integrated with the medical and prescription drug coverage?
166. How do you propose continuity of care for individuals undergoing Mental Health or Substance Abuse treatment with providers not currently in your network?
167. Are these services capitated? If so, provide the capitation amount (PMPM) for each of the products you are bidding on for 2007 and 2008. If the services are capitated confirm that your organization will provide reports on claims and encounters.
168. The State Employee Advisory Service (EAS) provides assistance to State employees with substance abuse problems, often evaluating and assessing the enrollee to recommend treatment. Please confirm that you can guarantee you can coordinate services upon request by the Division. State employees with Commercial Drivers Licenses (CDL) who have substance abuse problems are of particular concern. Confirm that you can coordinate cases within 24 hours of notification.

169. Describe procedures for assuring consideration of the enrollee’s preferences in treatment or services; language needs; handicapped access needs; and transportation needs.

Audits

170. Describe the key features of your internal audit and quality review procedures for claims administration and customer service. Provide the percentage and frequency of claims and customer service contacts audited.

171. What are the current office processing standards for claims examiners (CE), including variances by level and/or experience, for the following measurements?

- a. Number claims per day –
- b. Financial Accuracy –
- c. Procedural Accuracy –
- d. Turn Around Time (TAT) –

172. What percentage of claims are audited pre-disbursement? Post-disbursement?

173. Describe internal audit procedures including the number of claims audited per CE; how frequently each CE is audited and how results are reported.

174. Are there any special audits (e.g., high dollar claims) or reviews? If yes, describe.

175. How are errors detected in the audit process handled? Explain if the examiner corrects their own errors, or are they handled by a special correction unit, or other procedure.

176. What have been the office audit results for 2004, 2005, 2006 and YTD 2007 in the following categories? (Be sure to include target error rate.)

Performance Category	2004		2005		2006		2007	
	Office Result	Target						
Financial Accuracy								
Procedural Accuracy								
Turn Around Time (TAT)								

177. If the Commission gives the Bidder a negative finding on an audit report, state which individuals within the Contractor's organization will review the audit results from the Commission and determine if interface processing changes are necessary or what activities are necessary to remedy the uncovered problem.
178. Confirm that the Bidder agrees to refund all identified overpayments resulting from an external audit (including overpayments contained in claims outside the audit sample resulting from the same problems/issues identified within the sample).

Coordination of Benefits (COB)

179. Describe Bidder's COB process (e.g., Is there a special COB unit? How is the unit organized and staffed? Are formal COB guidelines in place? How often are other insurance [OI] reviews conducted? What other circumstances typically trigger a COB or OI investigation?).
180. Are all dollar amounts investigated or is there a minimum amount required to trigger a COB investigation?
181. Are actives and early-retirees (pre-65) contacted for other insurance information? If yes, how often?
182. What is COB recovery rate (as a percentage of claims payments) for calendar years 2004, 2005, 2006 and 2007 YTD, separately, for Bidder's Medicare covered population and non-Medicare population?
183. Can Bidder match claim files against Medicare's files (Parts A, B, C and D)?
184. How does Bidder perform COB as the secondary plan when the primary plan capitates the provider?
185. How are potential third party liability (TPL) cases, including Worker's Compensation, identified?
186. Are TPL cases handled in-house or through a vendor? (If through a vendor, describe how vendor is reimbursed.)

III. Prescription Drugs: All contracts awarded under this RFP will include a prescription drug benefit which will provide a prescription drug card plan for all employees of Local Employers that do not provide a separate free-standing prescription drug benefit, and all State and Local Retirees

General

187. Describe your prescription drug infrastructure including whether the program (retail, mail and specialty) is done in-house or subcontracted to another vendor.
188. Provide the percentage of total revenue that the Pharmacy Benefits Manager (PBM) represents to your organization.
189. Briefly explain what it is about your approach in providing prescription drug plan services and benefits that differentiates you from your competitors.
190. Do you require a separate ID card for the Prescription Drug coverage?

Plan Design

191. Describe how your company administers:
 - a. A wide variety of copayment options including Generic and Brand copayments, mail and network copayments, percent copayments, multiple tier copayment option, coinsurance with minimum/maximum copayment amounts.
 - b. A variety of plan deductible options including both prescription drug benefit deductibles and deductibles integrated with the medical plans.
 - c. Maximum out-of-pocket options and maximum benefit requirements.

Mail Order

192. Where would the SHBP designated mail order facility be located? Is it in the same location as the administrative offices and the customer service unit?
193. At what percent of total capacity is the mail order pharmacy currently operating? How much new volume is expected to be added in 2008?
194. Are all mail order claims processed online, real-time, through the PBM administrative system?

195. Does the mail order pharmacy provide its own customer service unit or is this responsibility provided by a separate customer service unit?
196. Do you promote a 90-day supply of medication in every case possible? If not, how is the medication supply tailored around the patient's specific need?
197. What is your current mail order pharmacy generic dispensing rate? What do you expect it to be in 2008? How do you manage the mail order pharmacy to the highest generic dispensing rate possible? What actions are required by the SHBP to allow the mail order pharmacy to maximize their generic dispensing?
198. What is your mail order pharmacy prescription filling error rate? How do you manage the error rate to the lowest possible? Does the mail order pharmacy track internal errors (not leaving the facility) separately from external errors (those that did leave the facility)? How do you handle internal and external dispensing errors when they occur?
199. What is your average turn-around time for orders from your facility? What is your target turn-around time? How do you manage the performance of this facility to these targets?
200. Does the mail order pharmacy offer voice response and/or Web site ordering and order tracking services?
201. How do you handle PBM Drug Utilization Review (DUR) messages when they are presented to the mail order pharmacy staff during the handling of a prescription order? Does your mail order pharmacy staff document their action from these messages?
202. Does your mail order pharmacy perform "drug substitution" on targeted brand and generic medications? How are drugs selected for inclusion in the drug substitution process?
203. Explain how this process works and list the targeted drugs and the preferred drugs currently affected by this process? How is this list reviewed and how often is it updated?
204. Explain your mail order pricing requirements for a). Lower of retail price or formula price, b). Lower of contract price or plan copayment.
205. What price discounting will be offered on non-covered drugs and services? What procedures are established to ensure that the pharmacy is in compliance with this price discounting methodology?
206. Are your CSRs instructed to recommend use of the mail order pharmacy to members with new prescriptions or when discussing with the member claims submitted by network pharmacies?

Retail Network

207. How many pharmacies are in the bidder's network nationally?
208. Describe your network pharmacy credentialing process. Provide a description of your re-credentialing process. How often is re-credentialing performed and how is the provider information verified?
209. Do you provide network pharmacy audits? Are these desk audits or onsite audits? How many per year and type and how often are they performed per provider? How do you audit for network pharmacy contract compliance including their proper handling of DUR messaging? Can audit representatives of the SHBP participate with your audit staff in their audit activities? How many pharmacy providers have been disciplined due to these activities over the last two years?
210. Describe your pharmacy network options i.e. Standard Network vs. Deeper Discounted Network.
211. How is your pharmacy help desk organized? Describe the systems and processes supporting the help desk staff. What are staff hiring and training requirements?
212. What are the pharmacy help desk's phone handling performance statistics? What are your performance targets?
213. What latitude does the service staff have to resolve claim edit questions from providers?
214. Does the PBM vendor network pharmacy service offer voice response and/or Web site ordering to the network pharmacies to the members?
215. How do you grade the performance of network pharmacies, both financial and service performance factors? How do you use this data to enhance network performance?
216. How many pharmacies has your PBM terminated due to poor performance in the last two years? How many for contract non-compliance?
217. How do you deal with pharmacy chain organizations? Do you have direct access to their stores or are you required to work through their chain headquarters? Do you allow them to block PBM system messages to their stores? If so, which messages and how is this justified?
218. How do you inform the network pharmacies of new generic items when they become available? How do you manage the network to the highest performance in this area?

219. Please confirm that copays are the lower of the cost of the drug or the stated copay. What price discounting will be offered on employee pay-all drugs? What procedures are established to ensure that the pharmacy is in compliance with these provisions?
220. Do you have the capability to provide a retail maintenance network where less than 3 copays can be charged for a 90 day supply of a drug at a retail facility?
221. Can you handle a “mail at retail” program? If so, fully describe as well as compare the financial implications, including but not limited to AWP discounts, dispensing fees, and rebates and other pharmaceutical revenue.

Provider Access

222. Are there locations or states in which the SHBP employees reside where your organization is unable to offer coverage? If yes, indicate which states or localities.
223. Using the census data provided, provide network access data on a state-by-state-basis, the percent of participants within 1.5 and 10 road miles of a participating network pharmacy. How would you propose addressing any access concerns within your network? Label as Attachment 10 of your Proposal(s).
224. Complete the disruption report (that will be provided at the bidders conference) for the SHBP’s designated utilized pharmacies:
 - Prescription Drug Pharmacy list in the worksheet, “**Pharmacy.**” The worksheet contains a list of utilized pharmacies for which we are requesting you to identify if the provider is in network or out of network.

Label as Attachment 11 of your Proposal(s).

Pricing

225. What is your source for AWP?
226. Will you guarantee each component of the pricing formula (Discounts, MAC savings, Rebates, and other Pharmaceutical Revenue, Dispensing Fees, Other) presented on a dollar for dollar basis?
227. Describe how 100% of rebates and other pharmaceutical revenue and other incentive payments will be passed on to the SHBP.
228. Describe your MAC pricing program. Do you offer voluntary, mandatory or incentive based MAC programs? Describe how patients are informed about and impacted by such programs.

229. Provide an electronic file of the National Drug Code (NDC) numbers affected by your MAC pricing along with the package quantity, current AWP and your current unit MAC price for that NDC number.

Clinical Programs

230. Describe your clinical and Drug Utilization Review (DUR) programs and the measurements used to gauge their effectiveness. What is your source for your Clinical and DUR databases? Indicate which actions are taken prior to a member receiving covered medications and which are performed after the fact.
231. Describe all available prior authorization programs and how these interventions are handled in a professional and timely fashion.
232. Do you offer a “starter quantity program” that requires a member to receive coverage for an initial smaller quantity of medication prior to receiving a larger quantity of medication?
233. Indicate clinical programs that are considered proper patient management and plan performance that these are included in the SHBP basic administration costs.
234. Describe your methods of encouraging participants and physicians to use formulary/generic drugs, other than those methods in place with pharmacy providers. What level of professional is used for each step in the process? How do you resolve disputes with the attending physician?
235. Do you guarantee that the preferred products in your formulary are less expensive to the plan than other therapeutic alternatives?

Specialty Pharmacy

236. Describe your capabilities pertaining to specialty drugs (e.g. biotech drugs.)
237. Provide your list of Specialty drugs and the associated discount and dispensing fee costs.

Claims Administration/Customer Service

238. Describe your claims system – its architecture, platforms and features.
239. Describe your protocols for the quality assurance surrounding the correct application of network contract rates.
240. Identify the location of the claim and customer service office(s) that would be used to process the SHBP prescription drug claims. Include the following information

for each: Describe the organization(s) that will be established to process the SHBP claims (i.e., for each plan design, indicate whether there will be a separate dedicated unit, one unit for all the SHBP plans, a portion of a claim team that serves multiple customers, etc.).

241. Describe the structure, number of examiners, qualifications and experience of the claims administration team that will process the SHBP claims.
242. Describe the structure, number of CSRs, qualifications and experience of your CSR team.
243. Describe the key features of your internal audit and quality review procedures for claims administration and customer service. Provide the percentage and frequency of claims and customer service contacts audited.

Financials

244. Confirm that zero balance claims are included in all of the financial guarantees including the discount and rebate guarantees.
245. The pricing proposal should be on a transparent basis where the SHBP pays what is actually paid to the pharmacy with a minimum guaranteed discount off of AWP per script. Confirm that your proposal meets this requirement.
246. Complete the exhibits that will be provided at the pre-bid conference to reflect your prescription drug financial proposal. ***Label it Attachment 12 of your Proposal(s).***

SECTION E-1

STANDARD TERMS AND CONDITIONS (SCHEDULE A)

1. Contractor Responsibilities

Unless the Bidder is specifically instructed otherwise in the RFP, the following terms and conditions will apply to all contracts or purchase agreements made with the State of New Jersey. These terms are in addition to the terms and conditions set forth in the RFP and should be read in conjunction with same unless the RFP specifically indicates otherwise. If a Bidder proposes changes or modifications or takes exception to any of the State's terms and conditions, the Bidder must so state specifically in writing in the bid proposal. Any proposed change, modification or exception in the State's terms and conditions by a Bidder will be a factor in the determination of an award of a Contract(s).

All of the State's terms and conditions will become a part of any contract(s) awarded as a result of the RFP, whether stated in part, in summary or by reference. In the event the Bidder's terms and conditions conflict with the State's, the State's terms and conditions will prevail, unless the Bidder is notified in writing of the State's acceptance of the Bidder's terms and conditions.

Contractor is responsible for the professional quality, technical accuracy and timely completion and submission of all services and deliverables for themselves and all subcontractors. Contractor must, without additional compensation, correct or revise any errors, omissions, or other deficiencies in its services and deliverables. Approval by the Director and/or the Commission of services and deliverables must not be construed as a waiver of any rights the Commission may have arising out of Contractor's performance.

The statutes, laws or codes cited are available for review at the New Jersey State Library, 185 West State Street, Trenton, New Jersey 08625.

If awarded a contract or purchase agreement, the Bidder's status must be that of any independent principal and not as an employee of the State.

2. State Law Requiring Mandatory Compliance by All Contractors

- **Services Performed in the US**

Chapter 92, PL 2005 requires that all services performed under this contract or performed under any subcontract under this contract must be performed within the United States.

- **Business Registration**

Effective September 1, 2004, pursuant to an amendment to N.J.S.A. 52:32-44, State and local entities are prohibited from entering into a contract with an entity unless the contractor has provided a copy of its Business Registration Certificate (or interim registration) as part of its bid submission. Failure to submit a copy of the Business Registration Certificate within the bid proposal will be cause for rejection of the bid proposal.

The contractor and any subcontractor providing goods or performing services under the contract, and each of their affiliates, must, during the term of the contract, collect and remit to the Director of the Division of Taxation in the Department of the Treasury the use tax due pursuant to the “Sales and Use Tax Act”, P.L. 1966, c. 30 (N.J.S.A. 54:32B-1 et seq.) on all their sales of tangible personal property delivered into the State. This requirement must apply to all contracts awarded on and after September 1, 2004. Any questions in this regard can be directed to the Division of Revenue at (609) 292-1730. Form NJ-REG can be filed online at <http://www.state.nj.us/treasury/revenue/busregcert.htm>

- **Anti-Discrimination**

All parties to any contract with the State of New Jersey agree not to discriminate in employment and agree to abide by all anti-discrimination laws including those contained within N.J.S.A. 10:2-1 through N.J.S.A. 10:2-4, N.J.S.A.10:5-1 et seq. and N.J.S.A.10:5-31 through 10:5-38, and all rules and regulations issued there under.

- **Prevailing Wage Act**

The New Jersey Prevailing Wage Act, N.J.S.A. 34: 11-56.26 et seq. is hereby made part of every contract entered into on behalf of the State of New Jersey, except those contracts which are not within the contemplation of the Act. The bidder's signature on this proposal is his/her guarantee that neither he/she nor any subcontractors he/she might employ to perform the work covered by this proposal has been suspended or debarred by the Commissioner, Department of Labor for violation of the provisions of the Prevailing Wage Act.

- **Americans with Disabilities Act**

The contractor must comply with all provisions of the Americans With Disabilities Act (ADA), P.L 101-336, in accordance with 42 U.S.C. 12101 et seq.

- **Ownership Disclosure**

Contracts for any work, goods or services cannot be issued to any corporation or partnership unless prior to or at the time of bid submission the bidder has disclosed

the names and addresses of all its owners holding 10% or more of the corporation or partnership's stock or interest. Refer to N.J.S.A. 52:25-24.2.

- **Compliance – Laws**

The contractor must comply with all local, state and federal laws, rules and regulations applicable to this contract and to the goods delivered and/or services performed hereunder.

- **Compliance – State**

It is agreed and understood that any contracts and/or orders placed as a result of this proposal must be governed and construed and the rights and obligations of the parties hereto must be determined in accordance with the laws of the State of New Jersey.

- **Liability-Copyright**

The Contractor must hold and save the Commission, the Division, and the State of New Jersey, their officers, agents, servants and employees, harmless from liability of any nature or kind for or on account of the use of any copyrighted or non-copyrighted composition, secret process, patented or non-patented invention, article or appliance furnished or used in the performance of the Contract.

3. Indemnification

With regard to its responsibilities as claim administrator under this Agreement, Contractor shall defend, indemnify and hold the Commission, the Division, and the State of New Jersey, their officers, agents, servants and employees harmless from and against all costs or expenses of whatever nature, claims, causes of action, damages, proceedings, assessments, penalties, judgments, attorney's fees, expenses and liabilities of any kind or nature, except for the costs of providing the Member's Plan Benefits which shall remain the responsibility of the Commission, which occur as the result of acts or omissions of Contractor which are intentionally wrongful or which, all facts and circumstances taken into account, constitute a failure by Contractor to perform its claims administration services with that degree of skill and judgment possessed by one experienced in furnishing claim administration services.

With regard to its responsibilities as the managed care network manager, Contractor shall defend, indemnify and hold the Commission, the Division, and the State of New Jersey, their officers, agents, servants and employees harmless from and against all costs or expenses of whatever nature, claims, causes of action, damages, proceedings, assessments, penalties, judgments, attorney's fees, expenses and liabilities of any kind or nature, resulting from: (1) the negligent or intentionally wrongful acts or omissions of Contractor's employees who participate in Contractor's provider networks in the event Contractor employs, in an employee-employer relationship, providers to deliver healthcare services to Members; and/or (2) the negligent or intentionally wrongful acts or

omissions of Contractor or its employees with respect to the performance of other responsibilities of Contractor under this Agreement.

The indemnification obligation shall survive termination of this Agreement and any other entered into by Contractor in furtherance of this Agreement

4. Specific: Contractor agrees that -

Approval by the Contract Manager, the Director and/or the Commission of the work performed and/or reports, plans, or specifications provided by Contractor must not operate to limit Contractor's obligations;

The Division, Director, Commission and State of New Jersey assume no obligation to indemnify Contractor, its agents, employees or subcontractors for any claim which may arise from the Contract(s); and

The provisions of this indemnification clause must in no way limit the Contractor's obligations under the Contract(s), nor shall they be construed to relieve the Contractor from any liability, nor preclude the Commission or the State of New Jersey from taking any other actions available under any other provisions of the Contract(s) or otherwise at law or equity.

5. Insurance

The Contractor must secure and maintain in force for the term of the Contract liability insurance as provided herein. Within 10 business days of notification of contract award, the Contractor must provide the State with current certificates of insurance for all coverages and renewals thereof, naming the State, and specifically including the Division and the Commission as an Additional Insured and must contain the provision that the insurance provided in the certificate must not be cancelled for any reason except after thirty days written notice to:

STATE OF NEW JERSEY
Director
Division of Pensions and Benefits
P O Box 295
Trenton, NJ, New Jersey 08625-0295

The insurance to be provided by the Contractor must be as follows:

- *Comprehensive General Liability Insurance or its equivalent:* The minimum limit of liability must be \$1,000,000 per occurrence as a combined single limit for bodily injury and property damage. The above-required Comprehensive General Liability Insurance policy or its equivalent must name the State, its officers, and employees as additional insureds. The coverage to be provided under these policies must be at least as broad as that provided by the standard basic, un-amended, and unendorsed

Comprehensive General Liability Insurance occurrence coverage forms or its equivalent currently in use in the State of New Jersey, which must not be circumscribed by any endorsements limiting the breadth of coverage. The policy must be endorsed to include:

- *Automobile liability insurance* which must be written to cover any automobile used by the insured contractor. Limits of liability for bodily injury and property damage must not be less than \$1 million per occurrence as a combined single limit.
- *Workers Compensation Insurance* applicable to the laws of the State of New Jersey and Employers Liability Insurance with limits not less than:

\$1,000,000 BODILY INJURY, EACH OCCURRENCE
\$1,000,000 DISEASE EACH EMPLOYEE
\$1,000,000 DISEASE AGGREGATE LIMIT

- Contractor must have Umbrella liability insurance providing coverage in excess of all casualty insurance. A standard clause shall be attached advising that, in the event of any self-insured retention or exhaustion of primary limits; the policy shall “drop down” and be considered primary. The minimum umbrella liability limits shall be \$25,000,000 per occurrence and in the aggregate.
- Contractor must obtain professional liability insurance with coverage limits that are appropriate and usual in the industry.
- Contractor must require that each and every licensed Network Provider contracted in connection with this Agreement maintain professional liability (medical malpractice) insurance with limits of at least \$1 million for each occurrence and \$3 million in the aggregate, except where in any identified geographic area, other professional liability coverage limits are appropriate and usual for the Network Provider’s clinical specialty and/or services in that Network Provider’s geographic area. It shall be Contractor’s responsibility to ensure that the insurance is valid at the time of credentialing and recheck credentials routinely thereafter in accordance with the National Committee for Quality Assurance (NCQA) standard.

Terms Governing All Proposals to the Commission

6. Contract Amount

The estimated amount of the contract(s), when stated on the Advertised Request for Proposal form, shall not be construed as either the maximum or minimum amount which the State shall be obliged to order as the result of this Request for Proposal or any contract entered into as a result of this Request for Proposal.

7. Contract Period and Extension Option

The Contract(s) must be for a period of four (4) years. By mutual written consent of the Contractor and the Director, the Contract(s) may be extended for an additional two (2) years, with no one extension being for more than one (1) year. If the Contractor agrees to the extension, all terms and conditions of the existing contract at the time of extension, including price, will be applicable.

8. Bid and Performance Security

a. Bid Security - If bid security is required, such security must be submitted with the bid in the amount listed in the Request for Proposal, see N.J.A.C. 17: 12- 2.4. Acceptable forms of bid security are as follows:

1. A properly executed individual or annual bid bond issued by an insurance or security company authorized to do business in the State of New Jersey, a certified or cashier's check drawn to the order of the Treasurer, State of New Jersey, or an irrevocable letter of credit drawn naming the Treasurer, State of New Jersey as beneficiary issued by a federally insured financial institution.
2. The State will hold all bid security during the evaluation process. As soon as is practicable after the completion of the evaluation, the State will:
 - a. Issue an award notice for those offers accepted by the State;
 - b. Return all bond securities to those who have not been issued an award notice.

All bid security from contractors who have been issued an award notice shall be held until the successful execution of all required contractual documents and bonds (performance bond, insurance, etc. If the contractor fails to execute the required contractual documents and bonds within thirty (30) calendar days after receipt of award notice, the contractor may be found in default and the contract terminated by the State. In case of default, the State reserves all rights inclusive of, but not limited to, the right to purchase material and/or to complete the required work in accordance with the New Jersey Administrative Code and to recover any actual excess costs from the contractor. Collection against the bid security shall be one of the measures available toward the recovery of any excess costs.

b. Performance Security - If performance security is required, the successful bidder shall furnish performance security in such amount on any award of a term contractor line item purchase, see N.J.A.C. 17: 12- 2.5. Acceptable forms of performance security are as follows:

1. The contractor shall be required to furnish an irrevocable security in the amount listed in the Request for Proposal payable to the Treasurer, State

of New Jersey, binding the contractor to provide faithful performance of the contract.

2. The performance security shall be in the form of a properly executed individual or annual performance bond issued by an insurance or security company authorized to do business in the State of New Jersey, a certified or cashier's check drawn to the order of the Treasurer, State of New Jersey, or an irrevocable letter of credit drawn naming the Treasurer, State of New Jersey as beneficiary issued by a federally insured financial institution.

The Performance Security must be submitted to the State within 30 days of the effective date of the contract award and cover the period of the contract and any extensions thereof. Failure to submit performance security may result in cancellation of contract for cause pursuant to provision 3.5b,1, and nonpayment for work performed.

9. Vendor Right to Protest- Intent to Award

Except in cases of emergency, bidders have the right to protest the Director's proposed award of the Contract(s) as announced in the Notice of Intent to Award. Unless otherwise stated, a bidder's protest must be submitted to the Director within 10 days after receipt of written notification that its bid has not been accepted or that an award of Contract(s) has been made. In the public interest, the Director may shorten this protest period, but must provide at least 48 hours for bidders to respond to a proposed award. In cases of emergency, stated in the record, the Director may waive the appeal period.

10. Termination of Contract

For Convenience

Notwithstanding any provision or language in this Contract(s) to the contrary, when the needs of the Commission change, the Commission may terminate this agreement with or without cause at any time, in whole or in part, any Contract(s) entered into as a result of this RFP. Such termination notice must be given to the Contractor in writing upon at least ninety (90) days written notice or on a fixed date based on a formal Request for Proposal process. The Director must issue such notice. The Contractor must furnish the Commission with such close-out reports, as may be reasonably required.

For Cause

Where a Contractor fails to perform or comply with a Contract, and/or fails to comply with the complaints procedure, the Director may terminate the Contract(s) upon 30 days notice to the Contractor with an opportunity to respond. The

Director must issue such notice. The Contractor must furnish the Commission with such close-out reports, as may be reasonably required.

Where a Contractor continues to perform a Contract(s) poorly, as demonstrated by excess volume of formal complaints, poor performance of service, failure to pay claims, etc., so that the Director is repeatedly required to use the complaints procedure, the Director may terminate the Contract(s) upon 10 days notice to the Contractor with an opportunity to respond.

The Commission's right to rescind the Contract(s) for cause also includes: the Contractor's violation of State or Federal law (as demonstrated by the Contractor's admission of same or a final decision of an appropriate decision making body); Contractor's debarment by the Federal or any state government or agency or political subdivision of such; and any reason relating to the ability of the Contractor to fulfill its contractual obligations.

In the event of the termination of a contract, the contractor must continue until such time as set by the Commission, but not less than 12 months, to process all claims for services incurred by a members prior to termination and not yet paid at time of termination (run out), and provide these services in the same manner as before the termination- at no additional cost because the ASO fee is a mature fee.

In cases of emergency the Director may shorten the time periods of notification and may dispense with an opportunity to respond.

In event the Contract(s) is cancelled for cause, Contractor is entitled to receive compensation for services actually and satisfactorily performed less the difference in price incurred by the Commission in securing contract(s) services from an alternative vendor.

11. Complaints

Where a bidder has a history of performance problems as demonstrated by formal complaints and/or contract cancellations for cause, a bidder may be bypassed for this award.

12. Extension of Contract Quasi-State Agencies

It is understood and agreed that in addition to State Agencies, Quasi-State Agencies may also participate in this contract. Quasi-State Agencies are defined in N.J.S.A. 52:27B-56.1 as any agency, commission, board, authority or other such governmental entity which is established and is allocated to a State department or any bi-state governmental entity of which the State of New Jersey is a member.

13. Extension of Contracts to Political Subdivisions, Volunteer Fire Departments and First Aid Squads, and Independent Institutions of Higher Education

N.J.S.A. 52:25-16.1 permits counties, municipalities and school districts to participate in any term contract(s), that may be established as a result of this proposal.

N.J.S.A. 52:25-16.2 permits volunteer fire departments, volunteer first aid squads and rescue squads to participate in any term contract(s) that may be established as a result of this proposal.

N.J.S.A. 52:25-16.5 permits independent institutions of higher education to participate in any term contract(s) that may be established as a result of this proposal, provided that each purchase by the Independent Institution of higher education shall have a minimum cost of \$500.

In order for the State contract to be extended to counties, municipalities, school districts, volunteer fire departments, first aid squads and independent institutions of higher education the bidder must agree to the extension and so state in his bid. proposal. The extension to counties municipalities, school districts, volunteer fire departments, first aid squads and Independent Institutions of higher education must be under the same terms and conditions, including price, applicable to the State.

14. Extensions of Contracts to County Colleges

N.J.S.A. 18A:64A - 25. 9 permits any college to participate in any term contract(s) that may be established as a result of this proposal.

15. Extensions of Contracts to State Colleges

N.J.S.A. 18A:64- 60 permits any State College to participate in any term contract(s) that may be established as a result of this proposal.

16. Changes in Law

Whenever an unforeseen change in applicable law or regulations affects the Contract(s), Contractor must advise the Contract Manager in writing and include in such written transmittal any estimated increase or decrease in the cost of its services. The Director and Contractor must negotiate an equitable adjustment, if any, to the Contract(s) price.

17. Additional Work and/or Special Projects

Contractor must not begin performing any additional work or special projects without first obtaining written approval from the Contract Manager. In the event Contractor proceeds with additional work and/or special projects without the Contract Manager's written approval, it must be at Contractor's sole risk. Neither the Commission nor the State of New Jersey shall have an obligation to pay for additional work and/or special projects performed without the Contract Manager's prior written approval.

In the event of additional work and/or special projects, Contractor must present a written proposal to the Contract Manager. Contractor's written proposal must provide a detailed description of the additional work and/or special project to be performed broken down by task and subtask including details on the level of effort, hours, labor categories, cost etc., necessary to complete the additional work and/or special project.

18. Contracts Amendments

Any changes or modification to the terms of the Contract(s) must only be valid when reduced to writing and signed by the Contractor and the Director.

19. Substitution of Staff

If it becomes necessary for the Contractor to substitute any management, supervisor, or key personnel, the Contract must identify, in writing, to contract manager ten days prior to appointment, the substitute personnel and the work to be performed. Contractor must provide detailed justification documenting the necessity for the substitution.

Resumes must be submitted evidencing that the individuals proposed as substitutions have qualifications and experiences equal to or better than the individual(s) originally proposed or currently assigned. Contractor must forward a request to substitute staff to the Contract Manager for consideration and approval. No substitute personnel are authorized to begin work until Contractor has received written approval to proceed from the Contract Manager.

20. Subcontracting or Addition of a Subcontractor

The Contract may not be subcontracted or assigned by the Contractor, in whole or in part, without the prior written consent of the Contract Manager. Such consent, if granted, shall not relieve the Contractor of any responsibilities under the Contract.

In the event the Bidder proposes to subcontract for the services to be performed under the terms of the Contract(s) award, it must be stated in the bid and attached for approval a list of said subcontractors and an itemization of the products and/or services to be supplied by them.

Contractor's written request to the Contract Manager to add or substitute a subcontractor must include justification documenting the necessity for the substitution or addition. Contractor must provide detailed resumes of the proposed subcontractor's management, supervisory and other key personnel that demonstrate knowledge, ability and experience relative to that part of the work the subcontractor is to undertake. In the event that a subcontractor is proposed as a substitution, the proposed subcontractor must equal or exceed the qualifications and experiences of the subcontractor being replaced. In the event that a subcontractor is proposed as an addition, the proposed subcontractor's qualifications and experiences must equal or exceed that of similar personnel proposed

by the Contractor in its original bid. Contractor must forward a request for substitution to the Contract Manager for consideration and approval. No substitute personnel are authorized to begin work until Contractor has received written approval to proceed from the Contract Manager.

Nothing contained in the specifications must be construed as creating any contractual relationship between any subcontractor and the Commission.

21. Mergers, Acquisitions

If, subsequent to the award of any Contract resulting from this RFP, the Contractor merges with or is acquired by another firm, the following documents must be submitted to the Director:

- Corporate resolutions prepared by the awarded Contractor and new entity ratifying acceptance of the original Contract, terms, conditions and prices.
- State of New Jersey Bidders Application reflecting all updated information including ownership disclosure.
- Vendor Federal Employer Identification Number.

The documents must be submitted within thirty (30) days of completion of the merger or acquisition. Failure to do so may result in termination of Contract.

If subsequent to the award of any Contract resulting from this RFP, the Contractor's partnership or corporation dissolves, the Director must be so notified. All responsible parties of the dissolved partnership or corporation must submit to the Director in writing, the names of the parties proposed to perform the Contract, and the names of the parties to whom payment should be made. No payment should be made until all parties to the dissolved partnership or corporation submit the required documents to the Director.

22. Performance and Financial Guarantee of Bidder

The Bidder hereby certifies that: all services rendered to the Commission must be performed in strict and full accordance with the specifications stated in the Contract including performance guarantees, etc. The Contract must not be considered complete until final approval by the Commission is rendered.

23. Delivery Guarantees

Deliveries must be made at such time and in such quantities as ordered in strict accordance with conditions contained in the RFP.

The Contractor must be responsible for the delivery of material in first class condition to the Commission and in accordance with good commercial practice.

Items delivered must be strictly in accordance with the RFP.

In the event delivery of goods or services is not made within the number of days stipulated or under the schedule defined in the RFP, the Commission may be authorized to obtain the material or service from any available source, the difference in price, if any, to be paid by the Contractor failing to meet Contractual commitments.

24. Director's Right of Final Bid Acceptance

The Director reserves the right to reject any or all bids, or to award in whole or in part if deemed to be in the best interest of the State to do so. The Director shall have authority to award orders or contracts to the vendor or vendors best meeting all specifications and conditions in accordance with N.J.S.A. 52:34-12. Tie bids will be awarded by the Director in accordance with N.J.A.C.17:12-2.1D.

25. Bid Acceptances and Rejections

The provisions of N.J.A.C. 17:12-2.9, relating to the Director's right, to waive minor elements of non-compliance with bid specifications and N.J.A.C. 17: 12- 2.2 which defines causes for automatic bid rejection, apply to all proposals and bids.

26. State's Right to Inspect Bidder's Facilities

The Evaluation Committee and/or Commission reserves the right to inspect the Bidder's establishment before making an award, for the purposes of ascertaining whether the Bidder has the necessary facilities for performing the Contract.

The Evaluation Committee may also consult with clients of the Bidder during the evaluation of bids. Such consultation is intended to assist the Committee in making a Contract award which is most advantageous to the Commission.

27. State's Right to Request Further Information

The Director reserves the right to request all information which may assist in making a Contract award, including factors necessary to evaluate the Bidder's financial capabilities to perform the Contract. Further, the Director reserves the right to request a Bidder to explain, in detail, how the bid price was determined.

28. Maintenance of Records

The Contractor must maintain records for products and/or services delivered against the Contract for a period of three (3) years from the date of final payment. Such records must be made available to the Commission upon request for purposes of conducting an audit or for ascertaining information regarding dollar volume or number of transactions.

29. Assignment of Antitrust Claim(s)

The Contractor recognizes that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the ultimate purchaser. Therefore, and as consideration for executing this Contract, the Contractor, acting herein by and through its duly-authorized agent, hereby conveys, sells, assigns, and transfers to the State of New Jersey, for itself and on behalf of its political subdivisions and public agencies, all right, title and interest to all claims and causes of action it may now or hereafter acquire under the antitrust laws of the United States or the State of New Jersey, relating to the particular goods and services purchased or acquired by the State of New Jersey or any of its political subdivisions or public agencies pursuant to this Contract.

In connection with this assignment, the following are the express obligations of the Contractor;

It will take no action which will in any way diminish the value of the rights conveyed or assigned hereunder.

It will advise the Attorney General of New Jersey in advance of its intention to commence any action on its own behalf regarding any such claim or cause(s) of action; or immediately upon becoming aware of the fact that an action has been commenced on its behalf by some other person(s) and the pendency of such action.

It will notify the defendants in any antitrust suit of the fact at the earliest practicable opportunity after the Contractor has initiated an action on its own behalf or becomes aware that such an action has been filed on its behalf by another person. A copy of such notice will be sent to the Attorney General of New Jersey.

Furthermore, it is understood and agreed that in the event any payment under any such claim or cause of action is made to the Contractor, it must promptly pay over to the State of New Jersey the allotted share thereof, if any, assigned to the State hereunder.

30. Tax Charges

The State of New Jersey is exempt from State sales or use taxes and Federal excise taxes. Therefore, price quotations must not include such taxes. The State's Federal Excise Tax Exemption number is 22-75-0050K.

31. Availability of Funds

The Commission's obligation to pay the Contractor is contingent upon the availability of funds appropriated by the State Legislature. Under N.J.S.A. 52:14-17.33 there is no legal liability on the part of the Commission unless the funds are appropriated in the State's annual budget.

32. Reciprocity

In accordance with N.J.S.A. 52:32-1.4 and N.J.A.C. 17:9-10.12, the Commission may invoke reciprocal action against an out-of-state bidder whose state maintains a preference practice for its bidders. Any bidder is free to submit information related to the preference practices of another state. This information may be submitted in writing as part of the bid proposal, and should be in the form of resolutions passed by an appropriate governing body, regulations, a Notice to Bidders, laws, etc. It is the responsibility of the bidder to provide the documentation with the bid proposal or submit it to the Division of Pensions and Benefits within five (5) business days of the public bid opening. Written evidence of another state's preference practices that is not provided to the Division within five business days of the public bid opening will not be considered in the evaluation of bids received.

33. Standards Prohibiting Conflicts of Interest

The following prohibitions on vendor activities must apply to all contracts or purchase agreements made with the State of New Jersey, pursuant to Executive Order No. 189 (1988).

No vendor shall pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value of any kind to any State officer or employee or special State officer or employee, as defined by N.J.S.A. 52:13D-13b and e., in the Department of the Treasury or any other agency with which such vendor transacts or offers or proposes to transact business, or to any member of the immediate family, as defined by N.J.S.A. 52:13D-13i., of any such officer or employee, or partnership, firm or corporation with which they are employed or associated, or in which such officer or employee has an interest within the meaning of N.J.S.A. 52: 13D-13g.

The solicitation of any fee, commission, compensation, gift, gratuity or other thing of value by any State officer or employee or special State officer or employee from any State vendor must be reported in writing forthwith by the vendor to the Attorney General and the Executive Commission on Ethical Standards.

No vendor may, directly or indirectly, undertake any private business, commercial or entrepreneurial relationship with, whether or not pursuant to employment, contract or other agreement, express or implied, or sell any interest in such vendor to, any State officer or employee or special State officer or employee or special State officer or

employee having any duties or responsibilities in connection with the purchase, acquisition or sale of any property or services by or to any State agency or any instrumentality thereof, or with any person, firm or entity with which he/she is employed or associated or in which he/she has an interest within the meaning of N.J.S.A. 52: 130-13g. Any relationships subject to this provision must be reported in writing forthwith to the Executive Commission on Ethical Standards, which may grant a waiver of this restriction upon application of the State officer or employee or special State officer or employee upon a finding that the present or proposed relationship does not present the potential, actuality or appearance of a conflict of interest.

No vendor shall influence, or attempt to influence or cause to be influenced, any State officer or employee or special State officer or employee in the employee's official capacity in any manner which might tend to impair the objectivity or independence of judgment of said officer or employee.

No vendor shall cause or influence, or attempt to cause or influence, any State officer or employee or special State officer or employee to use, or attempt to use, the employee's official position to secure unwarranted privileges or advantages for the vendor or any other person.

The provisions cited above must not be construed to prohibit a State officer or employee or special State officer or employee from receiving gifts from or contracting with vendors under the same terms and conditions as are offered or made available to members of the general public subject to any guidelines the Executive Commission on Ethical Standards may.

34. Notice to All Bidders Set-Off for State Tax Notice

Pursuant to P.L. 1995, c. 159, effective January 1, 1996, and notwithstanding any provision of the law to the contrary, whenever any taxpayer, partnership or S corporation under contract to provide goods or services or construction projects to the State of New Jersey or its agencies or instrumentalities, including the legislative and judicial branches of State government, is entitled to payment for those goods or services at the same time a taxpayer, partner or shareholder of that entity is indebted for any State tax, the Director of the Division of Taxation shall seek to set off that taxpayer's or shareholder's share of the payment due the taxpayer, partnership, or S corporation. The amount set off must not allow for the deduction of any expenses or other deductions which might be attributable to the taxpayer, partner or shareholder subject to set-off under this act.

The Director of the Division of Taxation must give notice to the set-off to the taxpayer and provide an opportunity for a hearing within 30 days of such notice under the procedures for protests established under R.S. 54:49-18. No requests for conference, protest, or subsequent appeal to the Tax Court from any protest under this section must stay the collection of the indebtedness. Interest that may be payable by the State, pursuant to P.L. 1987, c.184 (c.52:32-32 et seq.), to the taxpayer must be stayed.

35. Ownership of Material

All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the Contract(s), including, but not limited to, all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video and/or audio), pictures, drawings, analyses, graphic representations, computer software programs and accompanying documentation and print-outs, notes and memoranda, written procedures and documents, regardless of the state of completion, which are prepared for or are a result of the services required under the Contract(s) shall be and remain the property of the Commission and must be delivered by Contractor to the Commission upon 30 days notice from the Director. With respect to software computer programs and/or source codes developed for the Commission, the work must be considered “work for hire”, i.e., the Commission, not Contractor or subcontractor, must have full and complete ownership of all software computer programs and/or source codes developed.

36. News Releases

Contractor is not permitted to issue news releases pertaining to any aspect of the services being provided under the Contract(s) without the prior written consent of the Director.

37. Advertising

Contractor must not use the Commission’s, Division’s and/or State’s name, logos, images, or any data or results arising from the Contract(s) as a part of any commercial advertising without first obtaining the prior written consent of the Director.

38. Licenses and Permits

Contractor must, at its own expense, obtain and maintain all required licenses, permits, and authorizations necessary to perform the Contract(s). Upon the Contract Manager’s request, Contractor must supply the Contract Manager with evidence of all such licenses, permits and authorizations.

39. Claims

Any and all claims that may be asserted against the Commission or the State of New Jersey by the Contractor shall be subject to the New Jersey Tort Claims Act, N.J.S.A. 59: 1-1, et seq., and/or the New Jersey Contractual Liability Act, N.J.S.A. 59: 13-1, et seq.

40. Remedies

Nothing in the Contract(s) shall be construed to be a waiver by the Commission or the State of New Jersey of any warranty, expressed or implied, or any remedy at law or equity, except as specifically and expressly stated in a writing executed by the Director. Failure by the Contract Manager, Director, the Division and/or the Commission to insist on compliance with any provision of the Contract(s) at any given time or under any given set of circumstances must not operate to waive or modify such provision or in any manner render it unenforceable.

41. Delivery

Contractor must immediately advise the Contract Manager of any circumstance or event that could result in late completion of any task or subtask called for to be completed on a date certain. In the event delivery is not made in accordance with the agreed upon schedule, the Director may cancel the work with no payment being owed Contractor.

42. Contract(s) Transition

In the event services end by either Contract(s) expiration or termination, it must be incumbent upon Contractor to continue services, if requested by the Contract Manager, until new services can be completely operational. Contractor acknowledges its responsibility to cooperate fully with the replacement contractor, the Division and the Commission to ensure a smooth and timely transition to the replacement contractor.

43. Notices

Notices required to be given by the Contractor to the Commission, Director or Contract Manager must be in writing and must be validly served if addressed and mailed by fax or regular mail to the following address:

As to the Commission and/or Director:

Frederick J. Beaver, Director
Division of Pensions and Benefits
50 West State Street, 8th Floor
P.O. Box 295
Trenton, NJ 08625
Fax (609) 393-4606
With copy to:
Florence J. Sheppard, Deputy Director

As to the Contract Manager:

Florence J. Sheppard, Deputy Director
(See address and fax above).

44. Applicable Law

This contract and any and all litigation arising there from or related thereto must be governed by the applicable laws, regulations and rules of evidence of the State of New Jersey without reference to conflict of laws principles.

SECTION E-2

CONTRACTUAL REQUIREMENTS (SCHEDULE A)

Obligations of the Commission and the Division

1. The Commission shall enter into and execute contracts, and other agreements required, or reasonably necessary for implementation of this Agreement which is consistent with the scope of this Agreement.
2. The Commission and the Division shall maintain and provide to Contractor records as are reasonably necessary for the administration of the Plan.
3. Contractor must be entitled to rely on information furnished to it by the Commission and the Division in the Plan Eligibility file and any written communications by an authorized representative. The Commission agrees that Contractor must be held harmless for any inaccuracy of such information.
4. The Commission and the Division shall have the obligation to furnish any information required in accordance with a mutually agreed upon account structure and Plan Eligibility File as specified therein, to establish and maintain any accounts and records necessary in order for Contractor to carry out its duties as specified under this Agreement.
5. Contractor shall not be responsible for a delay in the performance of this Agreement, or for the non-performance of this Agreement, which is caused by or contributed to in whole or in part by the failure of the Commission or the Division to furnish any required information promptly. In the case of a delay by the Commission or the Division in furnishing the required information, Contractor shall be excused from the responsibility for delays of performance, but only for the length of the delay by the Commission or Division.
6. The Commission shall provide Contractor with the names of individuals, together within the scope of their authority, authorized to act for the Commission in connection with this Agreement.
7. The Commission and the Division shall process all enrollments, terminations and changes on a timely basis and must provide Contractor with the necessary information to establish a complete and accurate Eligibility Record for all Members.
8. The Commission and the Division shall maintain copies of all enrollment applications received from Members. The applications must be maintained for a period of no less than ten (10) years. During that time, Contractor shall have access to these documents.
9. The Commission and the Division shall provide Contractor with a report showing the number of Members in the different experience groups for the State and Participating Employer accounts.

10. If the Commission fails, after timely notice, to provide funds to the bank for the daily payment of checks cleared by the bank or for cleared electronic transfers paid by Contractor to large institutions and other medical facilities, Contractor has the right to cease disbursement of benefit payments until the requested funds have been provided. Notice of such default under this section may be by telephone and in writing via facsimile machine, or in writing by overnight delivery. If the Commission fails to provide such funds within twenty-four (24) hours of written notice of default from Contractor, then the Contractor may terminate this Contract(s) upon written notice to the Commission
11. Administrative Fees shall be paid in accordance with the Schedule C. Administrative Fees must be payable to Contractor by the Commission within thirty-one (31) days after the beginning of the monthly coverage period based on the Commission's membership file. Administrative fees and other charges must be wired to a bank selected by Contractor.
12. If the Commission fails, after timely notice, to pay the administrative fees payable by the Commission to Contractor, Contractor has the right to cease disbursement of benefit payments until the requested funds have been provided. Notice of such default under this section, may be by telephone and in writing via facsimile machine, or in writing by overnight delivery of such default. If the Commission fails to provide such funds within fifteen (15) days of notice of default from Contractor, Contractor may terminate this Contract(s) upon written notice to the Commission.

Obligations of the Contractor

The following obligations of the Contractor are material aspects of the bid. If there are any questions or concerns with these requirements they must be raised at the Bidders Conference. Failure to confirm each of these requirements will make the proposal non-compliant.

Requirement	Confirmation (✓)
1. General	
A. Meeting with the Commission and Division as necessary;	
B. When requested, the Contractor must provide at no cost to the Commission, for attendance at Commission meetings for individuals assigned to the management of the Plan including, but not limited to those responsible for the:	
i. management of the account	
ii. management of claims processing and medical services,	
iii. recruitment and retention of providers,	
iv. development and implementation of medical policy,	
v. appropriate Medical Directors as needed,	
vi. management information systems and member relations.	
C. Must assist in the writing of plan handbook and formal Plan documents, brochures, advisory letters and communication materials.	

Requirement	Confirmation (✓)
2. Enrollment and Eligibility	
a. The Contractor must support the annual Open Enrollment period established by the Commission. The support includes providing of materials, attending health benefits fairs and health benefits presentations. All materials provided must be approved by the Commission prior to distribution.	
b. The Contractor must support any special open enrollment period. The support may include communication to the employers and subscribers. A special open enrollment is triggered when the Commission deems it necessary.	

<p>c. Contractor must produce and distribute member Identification Cards to enrolled members within ten (10) business days of the receipt and processing of a subscriber's eligibility record or a change warranting the production and release of a new member Identification Card. The format of the membership Identification Card must be approved by the Contract Manager. One ID card must be sent to the individual subscriber or two ID cards to a family.</p>	
<p>d. During the term of this contract, the Contractor or any affiliate or subsidiary must not solicit or try to induce a participating Local Employer to enter into an agreement for any type of health insurance coverage provided under this contract. The Contractor must not use any information obtained as a result of this contract, including information on participating employers, employees, dependents, and claim experience, for any other purpose other than processing claims and providing such other services as are required under this contract. In the event the Contractor or any affiliate or subsidiary receives from a participating Local Employer a request for a proposal and/or a request for claim information for coverage of the type being provided under this contract, the Contractor must advise the Division of the request. Claim information will only be released with Commission approval.</p>	
<p>e. The SHBP processes all health benefit enrollments, changes and terminations for Active, Retired, COBRA and Chapter 375 members and then sends the processed information to the Contractor daily via Connect-Direct, a product of Sterling Software to update SHBP's records with the new information. The file that is sent each day is referred to herein as the Plan Eligibility File described in Section O1. Contractor must be able to accept, efficiently process and report any errors or omissions back to the Commission daily.</p>	
<p>f. The Contractor must accept the Plan Eligibility File transmitted from the Commission daily after 12:00 am via Connect-Direct containing eligibility transactions and update its eligibility records daily. The purpose of the daily transmission is to ensure that the Contractor has the most current and accurate eligibility information. After updating its eligibility file, Contractor must send to the Commission a Daily Return File before 8:30 am by the 2nd business day after the transmission. The Daily Return File layout is set forth at Section O4.</p>	

<p>g. In the event of a transmission or other failure, the file may be sent by the State during business hours. On rare occasion, the Contractor must be able to accept multiple Plan Eligibility Files in a single day, on a Saturday and/or Sunday, or on a State holiday.</p>	
<p>h. The Contractor must be able to maintain concurrent employment status and/or employer location eligibility information for a given enrollee, and support termination from one experience group and enrollment in another experience group in the same day.</p>	
<p>i. The contractor must be able to accept Plan Eligibility File effective dates that may be up to six months in the future.</p>	
<p>j. Contractor must securely transmit the necessary and appropriate information to any other organization it has contracted with to perform any services applicable to the provision of benefits under the Plan.</p>	
<p>k. The Commission utilizes a Positive Transaction Reporting format. The Contractor must be able to receive the entire Plan Eligibility File and only process those fields in which the resident information has been added, deleted or changed. In the case where the Contractor is the administrator for more than one plan under the State Health Benefits Program (SHBP), and stores member information on more than one file, the Contractor must be able to execute changes to a member's information for each plan in which that member is enrolled based on one change instruction in the Plan Eligibility File.</p>	
<p>l. After each transmission of the Plan Eligibility File, the Contractor must report back to the Commission on the day following the transmission, an electronic transaction report named the, "Daily Return File". The Daily Return File must list the number of enrollments, terminations, and changes effectuated. The Daily Return File will also list any errors that prevented proper processing of any enrollment, termination or change on the Plan Eligibility File. The Daily Return File must contain detailed records for the unprocessed transactions and the Commission-specified reason codes as set forth in Section O4, Daily Return File Transmission Layout; Error Return Codes.</p>	
<p>m. The Contractor must support the Commission's peak daily transmission activity of up to 7,000 record sets within the Plan Eligibility File.</p>	
<p>n. The Contractor must store history information by member with the social security number as an access key.</p>	

o. The Contractor must support retroactive enrollments and terminations of up to one year for members.	
p. The Contractor must store dependent information as sent by the Commission and only pay claims for those dependents actively covered on the file. Any dependent claim that is denied based on ineligibility must be reported to the Commission.	
q. The Contractor must ensure that only Commission-originated eligibility information and changes will be reflected on the Plan records contained in Contractor's files.	
r. The Contractor must provide edits/security to ensure the integrity of the data on the Contractor files.	
s. The Contractor must accept alternative sequence numbers in lieu of actual SSNs for newborns and foreign nationals.	
t. The Contractor must have a process to replace its current employer file with a new employer file supplied by the Commission on a monthly basis. The layout for the employer file is attached as Section O5.	
u. Contractor will report, to the persons designated by Contract Manager, within one business day of discovery, any events or conditions adversely affecting the processing of enrollment or claims.	
v. Contractor will report the following routine operating data daily: Batch enrollment counts (received, processed, not processed); detail of batch enrollment data successfully processed; detail of batch enrollment data unsuccessfully processed; ID cards produced; rejected ID cards; changes made by Contractor to member's records not on the Plan Eligibility File.	
w. The Contractor will provide on-line access to the Contractor's enrollment system for inquiry and enrollment maintenance.	
x. The Contractor must maintain its records so that it can categorize members in the following three employer types: State, Educational Employer (Educational) or Local Employer (Local). The SHBP uses the "SEL TYPE" designation to demarcate the groups. The "S" refers to all State Active, COBRA, Chapter 375 (overage dependents) and Retired members, including all State biweekly, State autonomous entities, and State universities and colleges. The "E" group refers to all Active, COBRA, Chapter 375, and Retired members of participating Educational Employers. There are some retirees of non-participating educational employers that are members even though their employer is not in the program. Educational employers include Boards of Education, county colleges, commissions and vocational technical schools. The "L" refers to all Active, COBRA, Chapter 375 and Retired	

members of participating Local Employers and Retirees of certain non-participating Local Employers who do not qualify as an Educational Employer. Some examples of these employers are counties, municipalities, sewage authorities, housing authorities, etc.	
y. In addition to being assigned an SEL TYPE, members must also be enrolled by employment status as an Active, Retired, COBRA, or Chapter 375 member (ARCO). The SHBP uses the “ARCO TYPE” designation to demarcate a member’s employment status.	

Requirement	Confirmation (✓)
3. Required Claim Administration Services	
a. Contractor must process claims for services incurred on or after the Effective Date of coverage. Contractor must continue the calculation of accumulations based on claims paid prior to the Effective Date of Coverage;	
b. Maintain current complete and accurate records of all claims and correspondence associated with each claim. Each claim will, upon receipt, be immediately assigned an appropriate tracking number which will remain with the claim until it can be reviewed for completeness before adjudication;	
c. Request in writing from the provider, the Commission, or, if appropriate, the member, whatever additional information is necessary for the appropriate disposition of the claim if it finds during the adjudication process, that information essential to the accurate coding and subsequent determination of benefits has not been provided;	
d. Maintain and utilize Prevailing Healthcare Charges System (PHCS) software for purposes of determining usual, reasonable and customary allowance (this does not apply to HMO contracts);	
e. Maintain and utilize software containing edits to identify and track members by services received, level of care assigned, and conditions treated;	
f. Maintain and utilize software containing edits to identify and track providers by services rendered and claim dollars received;	
g. Maintain appropriate systems edits and critically examine charges for all services that appear aberrant, excessive or fraudulent. Examine such services with the provider, when necessary and appropriate;	

h. Conduct account-specific audits (separate from routine claim office audits) of its own office(s) and those of affiliated organizations and subcontractors for the Commission to ensure accurate processing and must furnish to the Commission quarterly reports showing the level of accuracy achieved;	
i. Investigate claims and medical services necessary, to determine medical necessity, appropriateness of care; over and under-utilization of medical services; existence of other coverage;	
j. Verify member eligibility before paying claims;	
k. Timely and accurately process all claims received in conformity with the Claim Administration Performance Standards that appear in Section K;	
l. Review and process all claims submitted and issue reimbursement as per contract design and an Explanation of Benefits (EOB) as appropriate;	
m. Issue electronic funds transfers, benefits checks to contracted providers and facilities as appropriate and to non-contracted providers and facilities or members in a timely manner;	
n. Accept electronically-transmitted Medicare claims and coordinate those claims with the Plan;	
o. Develop, in conjunction with the Contract Manager, all materials that are used to communicate with members including claim forms, form letters, etc. necessary to administer the Plans;	
p. The Contractor's participating providers must be prohibited from balance billing members for charges for periods of confinement that were not approved by the Contractor;	
q. Contracted hospitals to perform preadmission review, concurrent review, discharge planning and retrospective review. The existence of concurrent review and discharge services will be transparent to the member;	
r. Notify claimants of denied claims and the reason for the denial when required;	
s. Review denied claims that are appealed by a member to the Contractor in accordance with standards established by the Commission or by law. In order to do so, the Commission delegates to Contractor the authority, responsibility and discretion to initially interpret and construe the provisions of the Plan, as necessary to reach factually supported conclusions and to make a full and fair review of each claim and to notify each member in writing of each claim that has been denied. Contractor must inform each member, whose claim is denied after exhausting the Contractor's internal appeals process, that the member has a right to appeal to the Commission, stating the address and procedure for such an appeal. Final authority to	

interpret and construe the provisions of the Plan, on appeal by the member, remains with the Commission and the Contractor must comply with the Commission's decisions;	
t. Consult with the Commission on the resolution of member claim disputes by members who have exhausted the Contractor's internal appeals process and who are now appealing to the Commission;	
u. Provide representatives for all Commission meetings (generally monthly) where claims appeals for the Plan will be heard;	
v. Verify that all requirements of the Federal Department of Health and Human Services, (DHHS) with regard to HIPAA-mandated electronic data interchange (EDI) for claims transactions are met. File and field formats must conform to ANSI ASC X12N Guideline's and critical dates must be met for EDI implementation;	
w. Contractor must make a reasonable effort to recover claim amounts overpaid or paid in error and refund the recoveries to the Commission or credit these recoveries against any amounts payable by the Commission. The Contractor may pursue the overpayment with the provider and/or member.	
x. Contractor must make all reasonable efforts to recover claims paid in error when the member has been involved in a workplace accident. Reasonable efforts include: asserting liens, appearing in workers' compensation court to recover liens and all correspondence with member's attorney.	
y. With regard to recovery of overpayment to members, the Contractor must never pursue legal remedies such as dunning or placing liens for overpayment. After reasonable attempts are made to recover the overpayment, the Contractor may deduct the overpayment from future payments to the member. If the overpayment was the result of an error of the Contractor, the overpayment will be immediately absorbed by Contractor and will not be charged to the Commission, or to the member.	
z. Contractor must disclose and fully account to the Commission any and all funds received by it as a recovery of an overpayment or incorrect payment.	
aa. Monies recovered such as subrogation outside of New Jersey of a claim or lien must be fully disclosed and accounted for and credited to the Commission's claims account.	
bb. Contractor must abide by the provisions of N.J.S.A. 26:2J:11.1 whether or not providing services under an HMO or PPO. N.J.S.A. 26:2J:11.1 provides for the continuation of services for covered members for four months after the termination of a contract with a provider hospital.	
cc. All capitation fees must be billed as claims.	

dd. Contractor must either provide on-line inquiry access to the Division to the Contractor's claim payment system or assign a contact for the Division to call concerning claims paid.	
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Requirement	Confirmation (✓)
4. Fraud activities	
A. Contractor must develop procedures to identify providers and/or members who appear to be committing fraud and work with the Commission and appropriate law enforcement agencies to pursue prosecution; and when notified by the Commission, that a member or provider is being prosecuted, provide all claim information and participate as a fact or an expert witness as necessary.	

Requirement	Confirmation (✓)
5. Subrogation (only outside of New Jersey)	
A. Contractor must inquire of the member whether a third party may be liable for the cost of the care received, and, if yes, request that the identity of the third party, and if known, the name of the third party's insurer, for purposes of instituting subrogation;	
B. Contractor must actively pursue the Commission's right of subrogation to recover claim payments from third parties, including pursuing payments made when there is a work related accident or illness.	

Requirement	Confirmation (✓)
6. Coordination of Benefits	
A. Contractor must inquire as to the existence of other group medical coverage and coordinate payment of claims with other payors. The SHBP uses the birthday rule.	
B. Coordination of Benefits will be administered in accordance with the Pay and Pursue process.	

Requirement	Confirmation (✓)
7. Customer Service	
A. The Contractor must provide at a minimum a designated customer services unit to inform members as to the specifics of the Plan and answer claim processing questions during normal business hours. The Contractor's call center is subject to the Performance Standards set forth in Section K.	
B. Dedicated Customer Service toll free number(s)	
C. Customer Service Hours – Monday through Friday; 8 a.m. to 6 p.m. Eastern Standard Time, excluding agreed upon holidays	

Requirement	Confirmation (✓)
8. Financial	
A. Form of Compensation and Payment	
i. Payment by Contractor of any amount payable under the Plan must be made by checks drawn by Contractor payable through a bank (referred to in this Contract(s) as "the Bank selected by Contractor") or via electronic fund transfers to providers.	
ii. The Contractor must request reimbursement for claim checks that have cleared their bank account and for electronic fund transfers Contractor has paid to providers. The Contractor will be reimbursed for claim checks and electronic fund transfers to providers that have cleared the Contractor's bank account by the Contractor transmitting the total amount cleared via electronic mail or facsimile machine to the Commission by 11:00 a.m., EST daily, to determine the total amount that will be funded by wire transfer to the Contractor's designated bank on the same day. The transmission must include a breakdown between State and Local amounts. If the amount to be funded is not provided by Contractor to the Commission by 11:00 a.m. EST, it must be added to the next wire transfer and no charges must be assessed against the Commission.	
iii. Contractor agrees that if in the normal course of business, it, or any other organization with which Contractor has a working arrangement, chooses to advance any funds that are due, to any provider, subsidiary or subcontractor, the cost of such advance must not be charged back to the Commission except the Commission must reimburse Contractor within the confines of the provisions contained in this Contract(s).	

iv.	Contractor must disclose, fully account for, and remit, to the Commission any and all funds received by it as the result of a recovery of an overpayment or incorrect payment, prescription drug rebates and other pharmaceutical revenues, or subrogation of a claim or lien. Any discounted or negotiated rates or payment arrangements, any price adjustment, or refunds, and any retroactive or supplemental payments or credits negotiated with regard to covered services received by SHBP members must be remitted to the Commission. ASO fees must take into consideration this provision.	
v.	Contractor will never charge the Commission for a claim payment that is greater than the actual amount paid by Contractor.	
vi.	Contractor must submit to the Commission an itemization of the charges and fees (other than claim payments) and credit for services provided in the administration of the Plan.	
vii.	Contractor must provide the Commission with a monthly list of checks that were cleared by its bank and electronic fund transfers. The total should match the sum of the wire transfers made to Contractor's bank account. Monthly cleared checks should be in Social Security/subscriber identification number order and must include the check number, check issue date, amount of the check and the applicable data elements. Monthly electronic fund transfers must include the date funds are transferred, payee name, amount of fund transfer, monthly total and the applicable data elements should also include the check number, check issue date, payee name (last, first, mi.), amount of the check and monthly grand total. The totals must also be broken into State and participating Local Employer's experience groups with subtotals. Monthly electronic fund transfers should include the date funds are transferred, payee name, amount of the fund transfer and monthly total. The totals should match the total amount wired including a full and complete listing of all debit and credits. The totals should also be broken down between the State and participating Local Employers. These reports must be provided to the Commission on a CD disk or available for downloading from a secure Web site in Microsoft ACCESS 2003 format or other formats acceptable to the Commission no later than the 10 th day of the following month.	
viii.	Contractor must provide the Commission with an estimate of incurred unpaid claims, administrative fees and amounts of outstanding checks as of June 30 of each year. The	

	reports and estimate must be broken down between State and participating Local Employers and provided to the Commission by June 20. Bank reconciliation and other related reports are Contractor's responsibility.	
ix.	Contractor must comply with the State of New Jersey Unclaimed Property laws and regulations in regard to escheated unclaimed monies and provide the Commission with an annual report identifying any outstanding checks more than twelve months from the date of issue. The report must be used for escheat purposes and should conform to the reporting formats required by the State of New Jersey Unclaimed Property Unit.	

Requirement	Confirmation (✓)
9. Technical Staffing / Communications	
A. There may be special projects initiated by the Contract Manager requiring IT resources beyond those allocated for general support. For this type of project, the Contractor will provide to the Contract Manager a proposal that provides cost projections for the project.	
B. The Contractor must resolve/accommodate all data processing problems/changes within a reasonable time period mutually agreed upon, and the required changes must be implemented in a timely manner. The Contract Manager will identify how the technical priorities will be set.	
C. Contractor's staff will be required to participate in IT system status meetings on a regular basis. This would include but not be limited to, the Account Executive, IT, Eligibility and Claims Managers. Currently, these meetings are held monthly in Trenton. The meetings will focus on open IT problems/changes and any issues associated with them.	
D. All changes, (Commission or Contractor generated) must be tested between the Commission and the Contractor prior to implementation.	
E. Response time should not exceed 2-3 seconds per transaction for inquiry and update access.	
F. A minimum of two-level security must be provided for inquiry and update capabilities.	

Requirement	Confirmation (✓)
10. Audits	
<p>A. Contractor must cooperate in the administration of routine audits performed by the Commission or its designee, on various aspects of the administration of the Plan, including but not limited to claims processing, medical management and enrollment data. The various audits are designed to ensure (1) contract compliance, (2) that the interface system is working properly, (3) proper payment of claims where the individual should have coverage or (4) proper rejection of claims where the individual's coverage has terminated, and (5) correct allocation of claims according to SHBP experience groups and (6) efficient and effective medical management.</p>	
<p>B. An audit may be conducted if the Commission has a reasonable and good faith belief that a situation exists that will result in harm to the Plan. The Commission reserves the right to review and audit all records associated with the administration of the Plan for cause at any time during the normal business hours of the Contractor after providing written notice. Audits must encompass records held by any subcontractor or related organization and held by any entity that is a member of the contractor group of companies. The Contractor agrees that the results of any review or audit are for the Commission's exclusive use.</p>	
<p>C. All reviews or audits may be performed by the Commission or any designee chosen by the Commission, other than a designee whose action would reasonably be considered by the Contractor to be a conflict of interest. The findings of any designee authorized to perform a review of the audit must be presented in a written report to the Commission. The Contractor must have the right to read the report prior to submission to the Commission and Contractor's written comments pertinent to the audit, if furnished, must be submitted to the Commission with the audit as a supplementary statement.</p>	
<p>D. The Contractor must conduct routine audits and control inspections of randomly selected claims under the Plan (Contractor must report quarterly on such audits to comply with Performance Standards Section K).</p>	

<p>E. The Contractor must conduct, on request, eligibility audits between the Commission’s master file and the Contractor’s eligibility files. The frequency of the audits will be established by the Commission. The Contractor must be able to accommodate various cutoff dates which may apply to specific experience groups. Currently, eligibility audits are conducted quarterly.</p>	
<p>F. Contractor must cooperate with all external audits related to the Contractor’s administration of the Plan at no extra charge.</p>	
<p>G. Contractor must annually submit to the Commission the American Institute of Certified Public Accountant’s Statement on Auditing Standards No. 70 II “Reports on the Processing of Transactions by Service Organizations," otherwise known as a "SAS 70 II." At the time of SAS 70 II submission the Contractor must also supply the Commission with a report of the actions taken to deal with any weaknesses or deficiencies identified in the SAS 70 II.</p>	

Requirement	Confirmation (✓)
<p>11. Record Keeping</p>	
<p>A. Subject to applicable law, all documents, records, reports, data, including data recorded by Contractor in its data processing systems, directly related to the receipt, processing and payment of claims and all claim histories (“Claim Records”) must at all times be the property of the Commission. Contractor has the right to possession and use of Claims Records during the term of this Contract and to maintain Claims Records following the termination of this Contract, as necessary to comply with its obligations under this Contract or as mandated by law. Upon request data must be provided in a mutually agreeable format.</p>	
<p>B. The Contractor must have no interest in, nor have any obligation to provide any aggregate claim or payment data maintained or copied by Contractor for its own uses outside of the scope of this Contract. Such information may not be used for any purposes which may be detrimental to the Commission.</p>	
<p>C. All Claims Records and other records possessed by Contractor as claims administrator under this Contract (“Records”) must be retained in accordance with applicable Federal and State record retention requirements, but in any case will be kept and retrievable for no less than seven (7) years. Records must be retained for two (2) years on-line from the date of service or from the date final payment is made on the claim, whichever is later.</p>	

D. If the Commission notifies Contractor a claim has become the subject of litigation, Contractor must not destroy the record without prior notice to the Commission.	
E. If a claim becomes the subject of litigation, then Contractor must provide the Commission all claim information related to that claim as necessary for litigation purposes and participate as fact or expert witnesses. In the case where an expert witness is necessary, then one must be provided at a reasonable and customary fee. This provision will survive termination of this Contract.	
F. The provisions of this Section must survive the termination of this Contract or termination of coverage of a member and must bind the Commission and the Contractor so long as they maintain any Personally Identifiable Information.	
G. Contractor must prepare all filings necessary and appropriate to comply with the New York Health Care Reform Act of 1996, if appropriate.	

Requirement	Confirmation (✓)
12. Renewal and Revision Services	
A. At renewal the Contractor must develop recommended premium rates necessary to cover claims and expenses anticipated for the next Plan Year and any necessary adjustments to IBNR.	
B. Contractor must develop cost projections upon renewal and cost projections for proposed benefit changes.	

Requirement	Confirmation (✓)
13. Medical Management/Utilization Management Services	
A. Contractor must provide Utilization Management (UM) services for both in-network and out-of-network treatment.	
B. The Contractor must compile and submit to the Commission and annual report on the UM activities it has undertaken, results and subsequent actions.	
C. The Contractor must provide disease management programs;	
D. Since the Prescription Employee Drug plan is administered separately, Contractor must be able to accept Prescription Drug data from the administrator of that plan to enable optimal use of data for disease and care management at no additional cost.	
E. A voluntary case management program must be provided by the Contractor.	

Requirement	Confirmation (✓)
14. Mental Health/Drug Abuse/Alcohol Abuse Treatment	
A. The Contractor will ultimately be responsible for the provision and administration of all covered mental health, alcohol abuse and drug abuse services to all eligible enrollees.	
B. The State provides, to its employees, access to Employee Assistance Programs. These programs are staffed by professional counselors who assist employees and their dependents in handling problems such as stress, drug and alcohol abuse, and mental health conditions. One of the duties of the counselors is to assist employees in obtaining referrals to the appropriate health care providers and in day-to-day contact with health carriers. The Commission expects the Contractor to fully cooperate with the EAP in their assistance to State employees.	
C. The Contractor must have a network capacity which includes sufficient health care providers, including doctors, hospitals, and the range of specialty providers, necessary for treatment of mental health, drug abuse, and alcohol abuse to adequately provide high quality services to the enrollees of the SHBP across the entire approved area where services are to be provided.	
D. The Contractor must agree to use the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition (ASAM PPC-2) or the most recent update of same.	
E. The Contractor must provide a description of its criteria for mental health service placement for adults, adolescents and for children. The criteria must be comparable to generally accepted standards for such determinations.	
F. SHBP members must have telephone access 24 hours a day, 7 days a week to qualified, professional staff for intake, assessment and referral to services.	
G. When making referrals for inpatient or outpatient services for covered enrollees, if the enrollee does not have reasonable transportation available, the Contractor must provide reasonable transportation arrangements so that the enrollee may successfully participate in the services. If no transportation is made available, the enrollee must be provided with the next higher level of care, even if that level requires that inpatient treatment be provided when it is not necessarily “needed”.	
H. The network must include accessible mental health/alcohol treatment/drug abuse treatment providers for inpatient care; residential services; intensive outpatient; day/partial	

hospitalization; outpatient evaluative, crisis intervention and short-term therapy.	
I. The Contractor must be responsible to inform all providers of the SHBP rules and requirements.	

Requirement	Confirmation (✓)
15. Unified Provider Directory (UPD) on the Internet	
A. Participation in the UPD is a contractual requirement of this procurement. Participation entails monthly electronic submission of certain information regarding network providers available to our membership to the third-party vendor who operates and maintains the directory.	
B. Contractor(s) must pay annually for their proportionate share of costs of operating and maintaining the UPD based on the number of records submitted and the cost of start up, software, programming, and marketing of the UPD. See required data fields in the following exhibit.	
C. In order to achieve our goal of “flattening” the file to show each provider only once and thereby returning more meaningful search results for our members, the medical license numbers of providers should be submitted. This is the unique identifier we will use to assure that two providers with the same name, but with two addresses, are or are not one and the same individual.	
D. Contractor(s) must fix data problems; however, if additional measures must be taken to remedy on-going problems, costs incurred in making these fixes will be charged back to the Contractor(s). These charges will be in addition to any penalties addressed elsewhere in this RFP.	

Requirement	Confirmation (✓)
16. Network Access and Network Management	
A. Contractor must pass the full discounted amounts that are negotiated with providers to the SHBP and plan participants. In addition, the dollar for dollar reimbursement paid to providers is the exact amount that will be charged to the SHBP for claims. Any and all fees based on a percentage of savings must be included in the per employee per month administrative fees.	
B. Contractor must provide for access to medical care and health services that satisfy all applicable requirements of the federal and state statutes and regulations pertaining to medical care and services	

<p>C. The Contractor must maintain a network of hospitals and providers that have agreed to discount their charges for in-network admissions and services.</p>	
<p>D. Contractor must provide for access to medical care and health services that satisfy all applicable requirements of the federal and NJ statutes and regulations pertaining to medical care and services.</p>	
<p>E. Contractor must in the performance of its network management duties verify initially and routinely (at least every three years) thereafter that all contracted facilities are appropriately licensed by the state in which they operate.</p>	
<p>F. Contractor must in the performance of its network management duties verify initially and routinely thereafter (at least every three years) professional education, training, quality of care, licenses and other credentials and where applicable the admitting and other privileges granted by a facility to each Network Provider.</p>	
<p>G. In regard to additions and deletions of Network Providers, Contractor must provide at least 45 days advance written notification to the Commission of any change in provider networks that will effect a 1% or greater change in the number of providers in the network or a disruption that would impact 3% or greater of the members. Contractor will provide the Commission, at the same time, with a list of the names and social security numbers of the members that will be affected by the discontinuation of the Network Provider Contracts involved in the network change. The Commission may establish a special open enrollment for those affected.</p> <p>Contractor must abide by the provisions of N.J.S.A. 26:2J:11.1 whether or not providing services under an HMO or PPO. N.J.S.A. 26:2J:11.1 provides for the continuation of services for covered members for four months after the termination of a contract with a provider hospital.</p>	
<p>H. Contractor must require that each and every licensed Network Provider contracted in connection with this Agreement maintain professional liability (medical malpractice) insurance with limits of at least \$1 million for each occurrence and \$3 million in the aggregate, except where in any identified geographic area, other professional liability coverage limits are appropriate and usual for the Network Provider’s clinical specialty and/or services in that Network Provider’s geographic area. It is Contractor’s responsibility to ensure that the insurance is valid at the time of credentialing and recheck credentials routinely thereafter in accordance with the National Committee for Quality Assurance (NCQA) standard</p>	

Requirement	Confirmation (✓)
17. Management Reporting	
A. The SHBP is taking the Medicare Part D drug subsidy. Contractor is required to produce all the necessary monthly cost reports and reconciliation files necessary to obtain the subsidy at no additional cost.	

Requirement	Confirmation (✓)
18. Prescription Drugs	
A. If the Participating Local Employer does not provide a separate prescription drug plan, then drug coverage is provided through the health plan and the rates charged to the employer reflect the presence of prescription drug coverage. The Contractor must therefore be able to track employee eligibility for prescription drug coverage, by employer.	
B. All plans that include prescription drugs offered to Local Employers and retirees by the SHBP will feature a three-tiered design (Generic/Preferred/Other Brands) with copayments for up to a 30-day supply at a participating pharmacy with an annual maximum out-of-pocket maximum. The copayment amount and the annual out-of-pocket maximum will be reviewed annually and may be increased by the rate of increase above the average wholesale price for a one day supply of prescription drugs covered under the plan. Certain drugs may require a pre-certification. A mail order service must also be provided with copayments for up to a 90-day supply with an annual maximum out-of-pocket maximum.	

Requirement	Confirmation (✓)
19. PPO Requirements	
A. Please confirm that you have read the PPO scope of services in Section F and can comply with the requirements	
B. Extension of health benefits must be made at no cost to totally disabled members who do not elect COBRA coverage and to those whose coverage terminates at the end of the COBRA continuation period including cessation of premium payments. The extension is made available to those members who are totally disabled on the date their coverage terminates and need	

not require hospital confinement, and is only applicable to expenses incurred in the treatment of the disabling condition. The extension period will end on the earliest of:	
i. The date the total disability ends;	
ii. The end of the calendar year after the one in which coverage ends ;	
iii. The date the person has received the maximum benefits under the HMOs Plan for the disabling condition; or	
iv. The date on which the person becomes covered under any replacement Plan established by the employer.	

Requirement	Confirmation (✓)
20. HMO Requirements - Please confirm that you have read the HMO scope of services in Section F and can comply with the requirements	
A. The SHBP has established minimum coverage requirements and operating standards for all participating HMOs that safeguard our members against unexpected benefit limitations and exclusions and make it easier to compare and choose between plans. The following is not a benefit summary but a listing of areas among benefit coverage for which the State has imposed a mandatory expectation or requirement.	
B. Referrals	
i. All physician referrals will be valid for a minimum of 90 days from the date of authorization.	
ii. Certain treatments requiring numerous visits (e.g. chemotherapy) must not require repeated referrals.	
iii. Network referral restrictions will not be permitted.	
C. Primary Care Physicians – the right to change Primary Care Providers (PCPs) must be permitted on at least a monthly basis.	
D. OB/GYN Provisions – the scope of services covered under the well-woman OB/GYN provisions must be clearly defined, including the explicit services which must be authorized by the member’s PCP. It is required that two or more well-woman OB/GYN examinations be available during the Benefit Plan Year (January 1 to December 31), and that a mammogram not require a PCP authorization.	
E. Extension of health benefits must be made at no cost to totally disabled members who do not elect COBRA coverage and to those whose coverage terminates at the end of the COBRA continuation period including cessation of premium payments. The extension is made available to those members who are totally disabled on the date their coverage terminates and need not require hospital confinement, and is only applicable to	

expenses incurred in the treatment of the disabling condition. The extension period will end on the earliest of:	
i. The date the total disability ends;	
ii. The end of the calendar year after the one in which coverage ends ;	
iii. The date the person has received the maximum benefits under the HMOs Plan for the disabling condition; or	
iv. The date on which the person becomes covered under any replacement Plan established by the employer.	
F. Required Quality Management Program Reporting	
i. The HMO must provide a description of their quality management program.	
ii. The HMO must monitor, evaluate and take action to address improvements in the quality of health care delivered by all network providers through the implementation of a continuous quality assurance program.	
G. The HMO must provide mental health/alcohol abuse/drug abuse treatment without requiring a referral from the Primary Care Provider.	

SECTION F

SCOPE OF WORK PPO (SCHEDULE B)

The State Health Benefits Commission will accept bids from qualified sources to provide a Preferred Provider plan which will include a network of health care providers and an organization that will provide claim and customer service administration, network management, marketing services to SHBP members and other services specified in this RFP. Your proposed plan should offer a combination of your best discounts and broadest networks without a gatekeeper. The successful Bidder will act as the claim administrator and network manager of a new plan that may have as many as three (3) distinct benefit designs offered to distinct groups. As claim administrator, the successful bidder must administer Plan Benefits and provide administrative and other services as described in this RFP. As the network manager the successful bidder must provide members with access to health services, including hospitalization, medical, surgical services and other covered health care services and prescription drug coverage for retirees and Local Employer employees who do not have prescription drugs through their employer. Significant weight in the rating of proposals will accrue to bidders who can offer this PPO product in New Jersey and in other states to provide adequate access to retirees. The Commission may award multiple contracts as a result of the RFP, pursuant to N.J.S.A. 52:34-12.1.

Below is a general description of the new plan designs (A, B, and C) – including: deductibles, copayments, penalties, coinsurance, plan maximums etc. This plan is a replacement product for the Traditional Plan and the NJ PLUS plan for certain groups of employees and retirees.

	PPO A	
	In-network	Out-of-network
SERVICE AREA	Potentially nationwide	Unrestricted
HOSPITAL INPATIENT	100%	80% after \$200 per hospital stay deductible.
SKILLED NURSING FACILITY	100% up to 120 days per calendar year	80% for up to 60 days per calendar year
HOSPITAL PRE-ADMISSION TESTING	100%	80% after deductible
PHYSICIAN (SURGERY)	100%	80% after deductible
PHYSICIAN (OFFICE VISITS)	100% after \$10 copayment per visit	80% after deductible; No coverage for wellness care
CHIROPRACTIC	100% after \$10 per visit copayment; 30 visits per calendar year	80% after deductible for up to 30 visits per calendar year combined in-network and out-of-network
HOSPITAL EMERGENCY ROOM	100% after \$25 copayment (waived if admitted) if reported within 48 hours;	100% after \$25 copayment (waived if admitted) if reported within 48 hours; if not reported within 48 hours, subject to deductible and coinsurance
IMMUNIZATIONS	100% after \$10 copayment per visit (except for travel and/or job related)	80% for children under 12 months, after deductible
MATERNITY	\$10 copayment for first prenatal office visit then 100% covered	80% after deductible
PHYSICAL EXAMS	100% after \$10 copayment per visit	Not covered
WELL BABY	100% after \$10 copayment per visit	Not covered
RADIATION/CHEMOTHERAPY OUTPATIENT	100%	80% after deductible
HOSPICE	100%	80% after deductible
PHYSICAL/SPEECH THERAPY	100% after \$10 copayment per visit	80% after deductible
LAB TESTS	100%	80% after deductible
ROUTINE VISION EXAM	100% after \$10 copayment; one exam per calendar year, no referral needed	None
ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness
DRUG ABUSE (INPATIENT)	Same as any other illness	Same as any other illness
ALCOHOL ABUSE (OUTPATIENT)	100%, no visit limit	80% after deductible
DRUG ABUSE (OUTPATIENT)	100%, no visit limit	80% after deductible
MENTAL HEALTH ¹ (INPATIENT)	100% up to 25 days per calendar year; balance at 90% up to annual and/or lifetime maximums	50 days per calendar year at 50% after deductible up to annual lifetime maximums
MENTAL HEALTH ¹ (OUTPATIENT)	90% up to annual and/or lifetime maximums	80% after deductible up to annual and/or lifetime maximums
HOME HEALTH CARE	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered; subject to out-of-network insurance and deductible
DISEASE MANAGEMENT	Yes	N/A
PRIVATE DUTY NURSING (Must be Medically Necessary)	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities

INFERTILITY SERVICES	Diagnosis covered; treatment covered with limitations	Treatment covered with limitations; subject to out-of-network insurance and deductible
DEDUCTIBLES (INDIVIDUAL)	None	\$100 per calendar year; \$200 per hospital admission
DEDUCTIBLES (FAMILY MAXIMUM)	None	\$250 per calendar year; \$200 per hospital admission
MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME	Unlimited; \$15,000 annual mental health; \$50,000 lifetime mental health; up to \$2,000 restoration feature each year, up to \$50,000 ³	\$1,000,000 lifetime (major medical expense only); \$15,000 annual mental health; \$50,000 lifetime mental health; up to \$2,000 restoration feature each year up to \$50,000 ³

¹Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.

	PPO B	
	Proposed PPO	
	In-network	Out-of-network
SERVICE AREA	Potentially nationwide	Unrestricted
HOSPITAL INPATIENT	100%	70% after \$200 per hospital stay deductible
SKILLED NURSING FACILITY	100% up to 120 days per calendar year	70% for up to 60 days per calendar year
HOSPITAL PRE-ADMISSION TESTING	100%	70% after deductible
PHYSICIAN (SURGERY)	100%	70% after deductible
PHYSICIAN (OFFICE VISITS)	100% after \$15 copayment per visit	70% after deductible; No coverage for wellness care
CHIROPRACTIC	100% after \$15 per visit copayment; 30 visits per calendar year	70% after deductible for up to 30 visits per calendar year combined in-network and out-of-network
HOSPITAL EMERGENCY ROOM	100% after \$50 copayment (waived if admitted) if reported within 48 hours,	100% after \$50 copayment (waived if admitted) if reported within 48 hours; if not reported within 48 hours, subject to deductible and coinsurance
IMMUNIZATIONS	100% after \$15 copayment per visit (except for travel and/or job related)	70% for children under 12 months, after deductible
MATERNITY	\$15 copayment for first prenatal office visit then 100% covered	70% after deductible
PHYSICAL EXAMS	100% after \$15 copayment per visit	Not covered
WELL BABY	100% after \$15 copayment per visit	Not covered
RADIATION/CHEMOTHERAPY OUTPATIENT	100%	70% after deductible
HOSPICE	100%	70% after deductible
PHYSICAL/SPEECH THERAPY	100% after \$15 copayment per visit	70% after deductible
LAB TESTS	100%	70% after deductible
ROUTINE VISION EXAM	100% after \$15 copayment; one exam per calendar year, no referral needed	None
ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness
DRUG ABUSE (INPATIENT)	Same as any other illness	Same as any other illness
ALCOHOL ABUSE (OUTPATIENT)	100%, no visit limit	70% after deductible
DRUG ABUSE (OUTPATIENT)	100%, no visit limit	70% after deductible
MENTAL HEALTH ¹ (INPATIENT)	100% up to 25 days per calendar year; balance at 90% up to annual and/or lifetime maximums	50 days per calendar year at 50% after deductible up to annual lifetime maximums
MENTAL HEALTH ¹ (OUTPATIENT)	90% up to annual and/or lifetime maximums	70% after deductible up to annual and/or lifetime maximums
HOME HEALTH CARE	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered; subject to out-of-network insurance and deductible
DISEASE MANAGEMENT	Specific programs to be determined	N/A

PRIVATE DUTY NURSING (Must be Medically Necessary)	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities
INFERTILITY SERVICES	Diagnosis covered; treatment covered with limitations	Treatment covered with limitations; subject to out-of-network insurance and deductible
DEDUCTIBLES (INDIVIDUAL)	None	\$100 per calendar year; \$200 per hospital admission
DEDUCTIBLES (FAMILY MAXIMUM)	None	\$250 per calendar year; \$200 per hospital admission
MAXIMUM OUT-OF-POCKET (INDIVIDUAL)	\$400 per calendar year (coinsurance only)	\$2,000 per calendar year (coinsurance only)
MAXIMUM OUT-OF-POCKET (FAMILY)	\$1,000 per calendar year (coinsurance only)	\$5,000 per calendar year (coinsurance only)
MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME	Unlimited; \$15,000 annual mental health; \$50,000 lifetime mental health; up to \$2,000 restoration feature each year, up to \$50,000 ³	\$1,000,000 lifetime (major medical expense only); \$15,000 annual mental health; \$50,000 lifetime mental health; up to \$2,000 restoration feature each year up to \$50,000 ³
¹ Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.		

	PPO C	
	Proposed PPO for Actives	
	In-network	Out-of-network
SERVICE AREA	Potentially nationwide	Unrestricted
HOSPITAL INPATIENT	100%	70% after \$200 per hospital stay deductible
SKILLED NURSING FACILITY	100% up to 120 days per calendar year	70% for up to 60 days per calendar year
HOSPITAL PRE-ADMISSION TESTING	100%	70% after deductible
PHYSICIAN (SURGERY)	100%	70% after deductible
PHYSICIAN (OFFICE VISITS)	100% after \$10 copayment per visit	70% after deductible; No coverage for wellness care
CHIROPRACTIC	100% after \$10 per visit copayment; 30 visits per calendar year	70% after deductible for up to 30 visits per calendar year combined in-network and out-of-network
HOSPITAL EMERGENCY ROOM	100% after \$25 copayment (waived if admitted) if reported within 48 hours	100% after \$25 copayment (waived if admitted) if reported within 48 hours; if not reported within 48 hours, subject to deductible and coinsurance.
IMMUNIZATIONS	100% after \$10 copayment per visit (except for travel and/or job related)	70% for children under 12 months, after deductible
MATERNITY	\$10 copayment for first prenatal office visit then 100% covered	70% after deductible
PHYSICAL EXAMS	100% after \$10 copayment per visit	Not covered
WELL BABY	100% after \$10 copayment per visit	Not covered
RADIATION/CHEMOTHERAPY OUTPATIENT	100%	70% after deductible
HOSPICE	100%	70% after deductible
PHYSICAL/SPEECH THERAPY	100% after \$10 copayment per visit	70% after deductible
LAB TESTS	100%	70% after deductible
ROUTINE VISION EXAM	100% after \$10 copayment; one exam per calendar year, no referral needed	None
ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness
DRUG ABUSE (INPATIENT)	Same as any other illness	Same as any other illness
ALCOHOL ABUSE (OUTPATIENT)	100%, no visit limit	70% after deductible
DRUG ABUSE (OUTPATIENT)	100%, no visit limit	70% after deductible
MENTAL HEALTH ¹ (INPATIENT)	100% up to 25 days per calendar year; balance at 90% up to annual and/or lifetime maximums	50 days per calendar year at 50% after deductible up to annual lifetime maximums
MENTAL HEALTH ¹ (OUTPATIENT)	90% up to annual and/or lifetime maximums	70% after deductible up to annual and/or lifetime maximums
HOME HEALTH CARE	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered; subject to out-of-network insurance and deductible
DISEASE MANAGEMENT	Yes	N/A

PRIVATE DUTY NURSING (Must be Medically Necessary)	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities
INFERTILITY SERVICES	Diagnosis covered; treatment covered with limitations	Treatment covered with limitations; subject to out-of-network insurance and deductible
DEDUCTIBLES (INDIVIDUAL)	None	\$100 per calendar year; \$200 per hospital admission
DEDUCTIBLES (FAMILY MAXIMUM)	None	\$250 per calendar year; \$200 per hospital admission
MAXIMUM OUT-OF-POCKET (INDIVIDUAL)	\$400 per calendar year (coinsurance only)	\$2,000 per calendar year (coinsurance only)
MAXIMUM OUT-OF-POCKET (FAMILY)	\$1,000 per calendar year (coinsurance only)	\$5,000 per calendar year (coinsurance only)
MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME	Unlimited; \$15,000 annual mental health; \$50,000 lifetime mental health; up to \$2,000 restoration feature each year, up to \$50,000 ³	\$1,000,000 lifetime (major medical expense only); \$15,000 annual mental health; \$50,000 lifetime mental health; up to \$2,000 restoration feature each year up to \$50,000 ³
¹ Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.		

PRESCRIPTION DRUGS – PPO

Currently, if a participating Local Employer provides a separate, freestanding prescription drug plan for employees, either through the SHBP Employee Prescription Drug Plan or a comparable program, then the employer receives health plan rates that reflect the absence of prescription drug coverage and there is no coordination of benefits for prescription drugs. If the participating Local Employer does not provide a separate prescription drug plan, then drug coverage is provided through the health plan and the rates charged to the employer reflect the presence of prescription drug coverage. The Contractor must therefore be able to track employee eligibility for prescription drug coverage, by employer.

Currently, employees of participating Local Employers enrolled in the Traditional Plan, NJ PLUS or HMO, whose employers do not provide a separate prescription drug program, and all State and Local retirees, have access to a card program through their medical plans.

All PPO plans that include prescription drugs offered to Local Employers by the SHBP will feature a three-tiered design (Generic/Preferred/Other Brands) with copayments (\$5/\$10/\$20) for up to a 30-day supply at a participating pharmacy. The copayment amount will be reviewed annually and may be increased. Certain drugs may require a pre-certification. A mail order service is also provided with copayments (\$5/\$15/\$25) for up to a 90-day supply.

All PPO plans offered to retirees will include prescription drugs and feature a three-tiered design (Generic/Preferred/Other Brands) with copayments (\$8/\$17/\$34) for up to a 30-day supply at a participating pharmacy. Certain drugs may require a pre-certification. A mail order service is also provided with copayments (\$8/\$25/\$42) for up to a 90-day supply. Retirees have an annual maximum prescription drug out-of-pocket expense of \$1,082 for 2007. The copayment amount and the annual out-of-pocket maximum will be reviewed annually and may be increased.

PPO Requirements

1. The Plan must have the normal components of a PPO; namely in-network discounted providers and an out-of-network indemnity approach where services from any provider are reimbursed according to a reasonable and customary approach using the Prevailing Healthcare Charges System (PHCS) reasonable and customary allowance schedule.
2. The in-network services will be reimbursed according to the discount agreement with network providers. The member will be charged copayments for most in-office services and additional copayments for other specialized services such as diagnostic tests, use of emergency rooms, etc. Out-of-network provider services will be subject to deductibles and coinsurance based on the 90th percentile of the PHCS reasonable and customary allowance schedule. The copayments, deductibles and coinsurance may be based on experience groups.

Several In-network medical services and all inpatient admissions will be covered provided they are pre-certified. Failure to pre-certify will result in services being paid at the out-of-network benefit levels without regard to coinsurance maximums.

For additional information concerning the scope of work for the PPO, please see Heading entitled: “Access to Health Care Services Network Standards for PPOs and HMOs in New Jersey and Contiguous Counties” on page 99.

SCHEDULE B

SCOPE OF WORK

HMOs

The State Health Benefits Commission will accept bids from qualified sources to provide a Health Maintenance Organization plan(s) which will include a network of Primary Care Physicians (PCPs) and an organization that will provide claim and customer service administration, network management, marketing services and other services specified in this RFP. The successful bidder(s) must provide members with access to health services, including hospitalization, medical, surgical services and other covered health care services. The Commission may award multiple contracts as a result of the RFP, pursuant to N.J.S.A. 52:34-12.1. Significant weight in the rating of proposals will accrue to bidders who can offer this HMO product in New Jersey and in other states to provide adequate access to retirees.

The HMO must provide for access to medical care and health services that satisfy all applicable requirements of the Federal and State statutes and regulations pertaining to medical care and services.

BENEFIT SUMMARY

Minimum HMO Benefits Required

Type of Service or Supply	HMO A: Required Minimum SHBP Benefit Level – State & Local	HMO B (if established)
OUT-OF-POCKET MAXIMUMS	None	None
INPATIENT HOSPITAL SERVICES		
· Pre-admission Testing	Covered in full	Covered in full
· Room and Board	Covered in full	Covered in full
· X-ray and Lab Tests	Covered in full	Covered in full
· Special Care Units	Covered in full	Covered in full
· Skilled Nursing Facilities	Covered in full—min. 120 days/confinement	Covered in full—min. 120 days/confinement
· Newborn Nursery	Covered in full	Covered in full
· Maternity Care	Covered in full	Covered in full
· Birthing Centers	Covered in full	Covered in full
· Hospice Care	Covered in full—no limits	Covered in full—no limits
SURGERY AND ANESTHESIA		
Inpatient Surgery	Covered in full	Covered in full

Type of Service or Supply	HMO A: Required Minimum SHBP Benefit Level – State & Local	HMO B (if established)
Outpatient Surgery	Covered in full	Covered in full
OUTPATIENT TREATMENTS		
Office Visit Copayments: · PCP · Specialists · Well baby Care	\$15 copayment/visit \$15 copayment/visit \$15 copayment/visit	\$10 copayment/visit \$10 copayment/visit \$10 copayment/visit
X-ray and Lab Tests	\$15 copayment	\$10 copayment
Cardiac rehabilitation, chemotherapy, dialysis or radiation	\$15 copayment/visit	\$10 copayment/visit
Physical, cognitive, occupational or speech therapy	Min. 60 visits/ per condition per calendar year	Min. 60 visits/ per condition per calendar year
Licensed Chiropractor	\$15 copayment-min. 20 visits/year	\$10 copayment-min. 20 visits/year
Routine Examinations	\$15 copayment	\$10 copayment
Immunizations	\$15 copayment	\$10 copayment
Eye Examinations (No Hardware)	\$15 copayment	\$10 copayment
Hearing Examinations	\$15 copayment	\$10 copayment
Home Health Care	Min. 120 visits/year	Min. 120 visits/year
Podiatry (Non-routine)	\$15 copayment	\$10 copayment
NON-BIOLOGICALLY BASED MENTAL AND NERVOUS CONDITIONS		
Inpatient Treatment	Min. 30 days/year, 100%	Min. 30 days/year, 100%
Outpatient Treatment	Min. 30 visits/year, max. \$15 copayment/visit	Min. 30 visits/year, max. \$10 copayment/visit
TREATMENT OF ALCOHOL AND DRUG ABUSE		
Inpatient Treatment	Min. 28 days/occurrence	Min. 28 days/occurrence
Outpatient Treatment	Min. 60 visits/year; no copayment	Min. 60 visits/year; no copayment
Emergency Detoxification	Covered in full	Covered in full
OTHER SERVICES		
Infertility Services · Diagnosis and Treatment	\$15 copayment	\$10 copayment
Durable Medical Equipment	Maximum copayment \$100/year- covered in full	Maximum copayment \$100/year- covered in full
Prosthetic Devices (Includes Repair and Replacement)	Maximum deductible \$100/year- covered in full	Maximum deductible \$100/year- covered in full
Emergency Care	Maximum \$50 copayment, waived if admitted	Maximum \$50 copayment, waived if admitted
Dental Services · Oral Surgery	Removal of bony impacted wisdom teeth covered in full.	Removal of bony impacted wisdom teeth covered in full.

Type of Service or Supply	HMO A: Required Minimum SHBP Benefit Level – State & Local	HMO B (if established)
Wigs in connection with hair loss resulting from treatment of disease with radiation or chemicals	Minimum benefit \$500/year	Minimum benefit \$500/year
Vision Hardware	Not Covered	Not Covered

PRESCRIPTION DRUGS - HMOs

Currently, if a participating Local Employer provides a separate, freestanding prescription drug plan for employees, either through the SHBP Employee Prescription Drug Plan or a comparable program, then the employer receives health plan rates that reflect the absence of prescription drug coverage and there is no coordination of benefits for prescription drugs. If the participating Local Employer does not provide a separate prescription drug plan, then drug coverage is provided through the health plan and the rates charged to the employer reflect the presence of prescription drug coverage. The Contractor must therefore be able to track employee eligibility for prescription drug coverage, by employer.

Currently, employees of participating Local Employers enrolled in the Traditional Plan, NJ PLUS or HMO, whose employers do not provide a separate prescription drug program, and all State and Local retirees, have access to a card program through their medical plans.

All HMO plans that include prescription drugs offered to Local Employers by the SHBP will feature a three-tiered design (Generic/Preferred/Other Brands) with copayments (\$5/\$10/\$20) for up to a 30-day supply at a participating pharmacy. The copayment amount will be reviewed annually and may be increased. Certain drugs may require a pre-certification. A mail order service is also provided with copayments (\$5/\$15/\$25) for up to a 90-day supply.

All HMO plans offered to retirees will include prescription drugs and feature a three-tiered design (Generic/Preferred/Other Brands) with copayments (\$8/\$17/\$34) for up to a 30-day supply at a participating pharmacy. Certain drugs may require a pre-certification. A mail order service is also provided with copayments (\$8/\$25/\$42) for up to a 90-day supply. Retirees have an annual maximum prescription drug out-of-pocket expense of \$1,082. The copayment amount and the annual out-of-pocket maximum will be reviewed annually and may be increased.

Access to Health Care Services Network Standards for PPOs and HMOs in New Jersey and Contiguous Counties

1. PPO/HMO must maintain primary, specialty, ancillary, and institutional services sufficient at a minimum to provide or arrange for the provision to Members the services described in the Plan Document.
2. At a minimum, the network of primary, specialty and ancillary providers. Providers must include:

- a. Medical and other professional staff, as follows:

- i. There must be a sufficient number of licensed Primary Care Providers (PCP) under contract with PPO/HMO to provide basic comprehensive health care services;
- ii. There must be a sufficient number of licensed medical specialists available to Members to provide medically necessary specialty care. PPO/HMO must have a policy assuring access to such specialists with 45 miles or one hour driving time, which ever is less, of 90 percent of Members within each county or approved sub-county service area.

1. Cardiologist;
2. Dermatologists;
3. Endocrinologist;
4. ENT;
5. General surgeon;
6. Neurologist;
7. Obstetrician/gynecologist;
8. Oncologist;
9. Ophthalmologist;
10. Orthopedist;
11. Oral surgeon;
12. Psychiatrist; and
13. Urologist

- b. For specialists not identified. above, PPO/HMO must have a policy assuring access to such specialists within 45 miles or one hour driving time, whichever is less, of 90 percent of the Members within each county or approved sub-county service area.

- c. There must be a sufficient number of other health professional staff, including but not limited to, licensed nurses and other professionals available to Plan Members to provide basic health care services;
 - d. There must be sufficient licensed optometrists associated with or available to Plan Members to assure that, unless referral to an ophthalmologist is determined by the PCP to be medically required and outside the scope of practice of an optometrist, the Member can choose to have vision care services provided by a licensed optometrist. PPO/HMO must have a policy assuring access to these providers, as set forth above.
 - e. Where PPO/HMO provides pharmacy services, prescription drugs, or a prescription drug plan, no registered pharmacy or pharmacist must be denied the right to participate as a preferred provider pursuant to the terms of N.J.S.A. 26:2J-4.7.
3. Physicians qualified to function as primary care providers include the following categories:
- a. Licensed physicians who have successfully completed a residency program accredited by the American Council for Graduate Medical Education or approved by the American Osteopathic Association in family practice, internal medicine, general practice, obstetrics and gynecology or pediatrics;
 - b. Licensed physicians who do not meet the qualifications noted above, but have been evaluated by PPO/HMO and found to demonstrate through training, education and experience, equivalent expertise in primary care;
 - c. At the direction of PPO/HMO, exceptions may be made for appropriate licensed medical specialists to be designated as a primary care provider for specified individual members of patient groups who, due to health status or chronic illness, would benefit from medical care management by such a medical specialist.
4. Health care professionals qualified as Primary Care Providers include the following categories:
- a. Nurse practitioners/clinical nurse specialists certified by the New Jersey Board of Nursing, or similarly licensed by the state in which care is being rendered, in advance practice categories comparable to family practice, internal medicine, general

practice, obstetrics and gynecology or pediatrics; and in hospitals or other facilities;

- b. Physician assistants licensed by the State of New Jersey Board of Medical Examiners or another the state other than New Jersey in which care is being rendered, which licenses physician assistants; and,
 - c. Certified nurse midwives registered by the State of New Jersey Board of Medical Examiners or another state other than New Jersey, in which care is being rendered, which grants such certification.
5. Geographic access and availability standards for primary care providers must be as follows:

- a. There must be at least two (2) PCPs within 10 miles or 30 minutes average driving time or public transit (if available) whichever is less of 90 percent of the enrolled population;

PPO/HMO must demonstrate that the PCP network is sufficient to meet adult, pediatric and primary ob/gyn needs of the projected enrolled population on the basis of the following assumptions:

- b. Four primary care visits per year per member, averaging one hour per member, and;
 - c. Four patient visits per hour, per PCP;
6. In order to demonstrate PCP availability, PPO/HMO must verify that the PCP has committed to provide a specific number of hours for new patients that cumulatively add up to the projected clinic hours of the projected enrollment by county or service area.
7. PPO/HMO must demonstrate that the network of PCPs is sufficient to assure that the following criteria will be met:
- a. Emergencies must be triaged immediately through the PCP or by a hospital emergency room through medical screening or evaluation;
 - b. Urgent care must be provided within 24 hours of notification of the PCP or PPO/HMO;

- c. In both emergent and urgent care, PCPs must be required to provide seven day, 24 hour access to triage services;
- d. Routine appointments must be scheduled within two (2) weeks; and
- e. Routine physical exams must be scheduled within four (4) months.

8. Institutional services

- a. PPO/HMO must maintain contracts or other arrangements acceptable to the Commission with institutional providers which have the capability to meet the medical needs of Members and are geographically accessible. Network Providers must include:
 - i. At least one (1) licensed acute care hospital including at least licensed medical-surgical, pediatric, obstetrical, and critical care services in any county or service which are no greater than 20 miles or 30 minutes driving time, whichever is less, from 90 percent of Members within the county or service area;
 - ii. Surgical facilities including acute care hospitals, licensed ambulatory surgical facilities, and/or Medicare-certified physician surgical practices which are available in each county or service area and which are no greater than 20 miles or 30 minutes driving time, whichever is less, from 90 percent of the Members within the county or service area;
 - iii. Tertiary and specialized services as follows:
 - 1. PPO/HMO must have a contract or otherwise agree to cover medically necessary trauma services at a reasonable cost with all Level I or Level II trauma centers designated by the New Jersey Department of Health and Senior Services as such, and in states other than New Jersey where such a designation exists. The Member must not be balanced billed for any covered trauma services provided by such designated trauma centers;

2. PPO/HMO must have a policy assuring access to the following specialized services, as determined to be medically necessary. Such services will be available within 45 miles or 60 minutes average driving time, whichever is less, of 90 percent of the Members within each county or approved sub-county area:

- a. At least one (1) hospital providing regional perinatal services;
- b. A hospital offering tertiary pediatric services;
- c. In-patient psychiatric services for adults, adolescents and children;
- d. Residential substance abuse treatment center;
- e. Diagnostic cardiac catheterization services in a hospital;
- f. Specialty out-patient centers for HIV/AIDS, sickle cell disease hemophilia, and craniofacial and congenital anomalies; and
- g. Comprehensive rehabilitation services.

iv. PPO/HMO must have a policy assuring access, as evidenced by contract or other agreement acceptable to the Commission, to the following specialized services, as determined to be medically necessary. Such services will be available within 20 miles or 30 minutes driving time, whichever is less, of 90 percent of Members within each county or approved sub-county area:

1. A licensed long term care facility with Medicare-certified skilled nursing beds;
2. Therapeutic radiation provider;
3. Magnetic resonance imaging center;
4. Diagnostic radiology provider, including x-ray, ultrasound, and CAT scan;
5. Emergency mental health service, including a short term care facility for involuntary psychiatric admissions;
6. Out-patient therapy providers for mental health and substance abuse conditions;
7. Licensed renal dialysis provider; and

8. At least one (1) appropriately licensed home health agency to serve each county where 1,000 or more PPO/HMO Members reside; and at least one (1) hospice program certified by Medicare in any county where 1,000 or more PPO/HMO Members reside
9. PPO/HMO may request, and may be granted relief from the time and mileage requirements as stated above where it can document that appropriate access to alternative sites is available. Such documentation must address travel accommodations and travel times, financial hardship placed on families and other logistical details as requested by the Commission or the Division.
10. In any county or approved sub-county service area in which 20 percent of PPO/HMO's projected or actual membership must rely upon public transportation to access health care services, as documented by the U.S Census Data, the driving times in the criteria above must be based upon average transit time using public transportation.

SECTION G

ADMINISTRATIVE SERVICE FEES (SCHEDULE C)

Bidder is to complete the administrative service fee chart(s) below.

**Per Employee/Retiree per Month (PEPM)
Assume 50,000 Employees/Retirees
4/1/08 – 12/31/08**

Bidder is to complete the administrative service fee chart below.

<i>Administrative Service Fees</i>		
# Employees / Retirees	PEPM Fees 4/1/08 – 12/31/08	
	<u>PPO</u>	<u>HMO</u>
	Less than 10,000	
10,000 but less than 20,000		
20,000 but less than 30,000		
30,000 but less than 40,000		
40,000 but less than 50,000		
50,000 but less than 75,000		
75,000 but less than 100,000		
100,000 but less than 125,000		
125,000 but less than 150,000		
150,000 or more		

Please fill in the following information for the 50,000 to 75,000		
SERVICE	PPO	HMO
General Administration		
Claims Administration		
Network Management		
Medical Management (Pre-certification, Concurrent Review, Discharge Planning, Case Management)		
Other (Specify)		
TOTAL		

Disease Management (DM) Programs:

1. Indicate the fee for each program offered; indicate on what basis the fee is charged – i.e. per case, PMPM, per enrolled member per month, etc.

a. Coronary Artery Disease	
b. Heart Failure	
c. Chronic Obstructive Pulmonary Disease	
d. Asthma	
e. Chronic Kidney Disease	
f. Diabetes	
g. Hepatitis C	
h. Multiple Sclerosis	
i. Weight Management	
j. Other (Specify)	

Please provide a projected total DM fee for the period 4/1/08 to 12/31/08 on these bases. The fees above apply to enrollment at all levels.

2. An alternative to individual program rates, provide a total PEPM ASO fee that would apply to all covered employee/retirees in the plan for the DM programs listed above in items a through i.

Note the following fee requirements:

- Fees are mature and assume that no further administrative expenses would be charged to the plan at termination. The Contractor would be required to administer the plan for a minimum of twelve months at plan termination and continue to process all claims incurred before plan termination.

In addition, all customer service, medical and network management and reporting services would also be required for a period of a minimum of twelve months at plan termination. No additional fees would be charged at termination for these services.

- Fees for calendar year 2009, 2010, 2011 and 2012 administrative service fees and DM fees will increase by a maximum of the lesser of 5% or the change in the CPI.
- Fees will be based on the aggregate enrollment with your organization, i.e., if your company were to enroll 20,000 PPO employees / retirees and 8,000 HMO employees / retirees, fees for both your PPO and HMO offerings would be based on total SHBP enrollment of 28,000 employees / retirees.
- Network Access fees, if any, must be included in your administrative fee and can not be added to claim charges.

- Brokers' fees may not be charged to the State in any form.
- An exhibit will be provided at the pre-bid conference to be completed for the prescription drug financial proposal.

SECTION H

HIPAA BUSINESS ASSOCIATE AGREEMENT (SCHEDULE D)

Preamble – This Business Associate Agreement (“Agreement”) is Schedule D to the Contract for the administration of the _____ Plan, awarded to _____ by the State Health Benefits Commission (“Commission”).

Whereas, pursuant to the terms of the Contract, the Commission will be disclosing certain information to _____, which may also otherwise be receiving and/or creating certain information on behalf of the Commission, some of which may constitute Protected Health Information (PHI), as this term is defined by the Health Insurance Portability and Accountability Act of 1996, 42 U.C.S.A. 1301 et seq. (“HIPAA”) and the regulations promulgated thereunder by the U.S. Department of Health and Human Services (the “HIPAA Regulations”); and

Whereas, the Commission and _____ must protect the privacy and provide for the security of PHI disclosed to _____ pursuant to the Contract in compliance with HIPAA and the HIPAA Regulations and other applicable laws; and

Whereas, the purpose of this Agreement is to satisfy certain standards and requirements of HIPAA and the HIPAA Regulations, including but not limited to those contained in Title 45, §164.504(e) of the Code of Federal Regulations (“CFR”), as the same may be amended from time to time.

NOW THEREFORE, in consideration of the promises and mutual covenants contained in the Contract and this Agreement, the Commission and _____ agree as follows:

Article 1 – Definitions

Terms used, but not otherwise defined, must have the same meaning as those terms in 45 CFR §160.103 and §164.501.

“Agreement” shall mean this Business Associate Agreement.

“Business Associate” shall mean _____.

“Contract” shall mean the Contract to provide _____ awarded by the Commission to _____. The Contract incorporates this Business Associate Agreement as Schedule D.

“Covered Entity” shall mean the State Health Benefits Commission and the State Health Benefits Program, N.J.S.A. 52:14-17.25.

“Data Aggregation” shall have the meaning given to such term under the Privacy Rule, including but not limited to 45 CFR §164.501.

“Designated Record Set” shall have the meaning given to such term under the Privacy Rule, including but not limited to 45 CFR §164.501.

“Emergency” The following definition for emergency care will be adhered to by all plans:

- a. Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - 1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - 2) Serious impairment to bodily function; or
 - 3) Serious dysfunction of any bodily organ or part.
- b. With respect to emergency services furnished in a hospital emergency department, a health plan shall not require prior authorization for the provision of such services if the member arrived at the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson, regardless of whether the hospital was affiliated with the HMO or PPO. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition must be covered by the HMO or PPO.

“Health Care Operations” shall have the meaning given to such term under the Privacy Rule, including but not limited to 45 CFR §164.501.

“Individual” shall have the meaning given to such term in 45 CFR §164.103 and must include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

“Privacy Rule” shall mean the HIPAA Regulation that is codified at 45 CFR Parts 160 and part 164, sub parts A and E.

“Protected Health Information” or “PHI” means any information, whether oral or recorded in any form or medium; that (1) is created or received by a covered entity and (2) relates to the past, present, or future payment for the provision of health care to an individual; and (3) identifies an individual or with respect to which there is a reasonable basis to believe the information can be used to identify an individual, and shall have the meaning given to such term under the Privacy Rule, including but not limited to 45 CFR §164.501.

“Required by Law” shall have the meaning given to such term in 45 CFR §164.103.

“Secretary” shall mean the Secretary of the federal Department of Health and Human Services or his designee.

“State Health Benefits Commission” or “Commission” shall mean the body created by N.J.S.A. 52:14-17.27 and charged with the responsibility to establish a health benefits program for State and participating Local Employers and to establish rules and regulations necessary to administer the State Health Benefits Act, 52:14-17.25 to 52:14-17.45. The Division of Pensions and Benefits administers the State Health Benefits Program, N.J.S.A. 52:14-17.35, and the Director of the Division of Pensions and Benefits is the Secretary of the Commission.

“State Health Benefits Program” (“SHBP”) means the health benefits program created pursuant to N.J.S.A. 52:14-17.25 to 52:14-17.45.

Article 2 – Obligations of Business Associate

A. *Permitted Uses and Disclosures.* Business Associate may use or disclose PHI received by Business Associate in accordance with the terms of this Agreement.

B. *Nondisclosure.* Business Associate shall not use or further disclose the Covered Entity’s PHI otherwise than as permitted or required by this Agreement, or as required by law, 45 CFR §164.504(e)(2)(ii)(A).

C. *Safeguards.* Business Associate shall implement appropriate safeguards as are necessary to prevent the use or disclosure of PHI otherwise than as permitted by this Agreement, 45 CFR §164.504(e)(2)(ii)(B). Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate’s operations and the nature and scope of its activities.

D. *Duty to Mitigate.* Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of this Agreement.

E. *Reporting of Improper Use or Disclosure.* Business Associate shall report to the Covered Entity in writing any use or disclosure of the Covered Entity's PHI otherwise than as provided for by this Agreement within two business days of Business Associate becoming aware of such use or disclosure, 45 CFR §164.504(e)(2)(ii)(C).

F. *Business Associate's Agents.* Business Associate shall ensure that any agents, including subcontractors, to whom it provides PHI agree in writing to the same restrictions and conditions that apply to Business Associate under this Agreement with respect to such PHI, 45 CFR §164.504(e)(2)(D).

G. *Availability of Information to Covered Entity.* Upon the request of an Individual, or as directed by the Covered Entity, Business Associate agrees to provide access to PHI to an Individual in a manner consistent with 45 CFR §164.524, provided Business Associate has not issued a denial pursuant to 45 CFR §164.524(a)(2) or (a)(3).

H. *Amendment of PHI.* Upon the request of an Individual, or the Covered Entity, Business Associate agrees to make any amendments to PHI in a Designated Record Set, in a manner consistent with 45 CFR §164.526, unless Business Associate has issued a denial pursuant to 45 CFR §164.526(2).

I. *Appeals Procedure for Denial of Access or Amendment of PHI.* Business Associate shall create and maintain an appeal process described in 45 CFR §164.524 and §164.526 that Individuals can utilize, if their request for access to or amendment of their PHI is denied.

J. *Internal Practices.* Business Associate shall make its internal practices, books and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by, the Business Associate on behalf of the Covered Entity available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Business Associate's compliance with the Privacy Rule.

K. *Availability of PHI to Covered Entity.* Business Associate shall make available to the Covered Entity such information as the Covered Entity may require to fulfill the Covered Entity's obligations to provide access to, provide a copy of, and account for disclosures with respect to PHI pursuant to the Privacy Regulations, including but not limited to 45 CFR §164.526 and 45 CFR §164.528.

L. *Minimum Necessary.* Business Associate and its agents or subcontractors shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure, 45 CFR §164.514(d)(3).

M. *Retention of Protected Health Information.* Notwithstanding any provision to the contrary in the Contract, Business Associate and its agents or subcontractors shall retain all PHI throughout the term of the Contract and shall continue to maintain the information required under Article 2, Section J, Internal Practices, except any PHI

returned or destroyed in accordance with Article 4, Section E, for a period of six (6) years after the termination of the Contract, 4 CFR §164.530(j)(2).

N. *Notification of Breach.* During the term of the Contract, the Business Associate shall notify the Covered Entity within two business days of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. Business Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and State laws and regulations.

O. *Audits, Inspection and Enforcement.* In addition to the Covered Entity's rights under the Contract to review and audit all records, including claim files, associated with the administration of the Plan to ensure Contract compliance, among other express provisions, upon notice of a material breach of any of the terms of this Agreement, the Covered Entity, or its authorized agents or contractors, has the right upon reasonable notice to the Business Associate, to inspect the facilities, systems, books and records of the Business Associate, to inspect the facilities, systems, books and records of the Business Associate, 45 CFR §164.530. Business Associate shall promptly remedy any violation of any term of this Agreement and shall notify the Covered Entity of such in writing. The fact that the Covered Entity or its designee, inspects, or fails to inspect, or has the right to inspect, the Business Associate's facilities, systems and procedures does not relieve the Business Associate of its responsibility to comply with this Agreement, nor does the Covered Entity's (i) failure to detect or (ii) detection, but failure to notify the Business Associate or require the Business Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this Agreement. Nothing in this paragraph is deemed to waive the provisions of the New Jersey Tort Claims Act, 59:1-1 et seq. as they apply to the Covered Entity.

Article 3 – Obligations of Covered Entity

A. *Safeguards.* The Covered Entity shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to the Business Associate pursuant to this Agreement, in accordance with the standards and requirements of the Privacy Rule, until such PHI is received by the Business Associate.

B. *Limitations in Privacy Notice.* The Covered Entity agrees to notify the Business Associate of any limitations(s) in its notice of privacy practices of the Covered Entity in accordance with 45 CFR §164.520(2)(i) to the extent that such limitation may affect the Business Associate's use or disclosure of PHI.

C. *Revocation of Permissions.* The Covered Entity agrees to notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect the Business Associate's disclosure of PHI.

D. *Request for Restrictions.* Covered Entity agrees to notify the Business Associate of any restriction to the use or disclosure of PHI that the Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

Article 4 – Termination

A. *Term.* This Agreement shall terminate following Contract transition, as provided under, “Contract Transition,” of Schedule A of the Contract, and when all the PHI provided by the Covered Entity to the Business Associate, or created or received by the Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity. If the Business Associate determines pursuant to the Subsection E below that it is infeasible to return or destroy PHI received from, or created or received by the Business Associate on behalf of the Covered Entity, the protections of this Agreement with respect to such PHI shall remain in effect.

B. *Material Breach.* A breach by the Business Associate of any material provision of this Agreement, as determined by the Covered Entity, shall constitute a material breach of the Contract and shall provide grounds for termination of the Contract by the Covered Entity, pursuant to the termination provisions of the Contract, and indemnification of the Covered Entity by the Business Associate, pursuant to the indemnification provisions of the Contract.

C. *Reasonable Steps to Cure Breach.* If the Covered Entity knows of a pattern of activity or practice of the Business Associate that constitutes a material breach or violation of the Business Associate's obligations under the provisions of this Agreement and does not terminate the Contract, then the Covered Entity shall provide the Business Associate time to take reasonable steps to cure such breach or end such violation, as applicable. If the Business Associate's efforts to cure such breach or end such violation within the time accorded by the Covered Entity, are unsuccessful, the Covered Entity shall either (i) terminate the Contract, if feasible, or (ii) if termination of the Contract is not feasible, then the Covered Entity shall report the Business Associate's breach or violation to the Secretary of the federal Department of Health and Human Services, 45 CFR §164.504(e)(1)(ii).

D. *Judicial or Administrative Proceedings.* Covered Entity may terminate the Contract, if (i) the Business Associate is named as a defendant in a criminal proceeding for a violation of HIPAA or other security or privacy laws or (ii) a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate has been joined.

E. *Effect of Termination.* Upon termination of the Contract for any reason, the Business Associate shall comply with the “Contract Transition,” section of Schedule A of the Contract. Thereafter, the Business Associate shall return or destroy all PHI that the

Business Associate or its agents or subcontractors still maintain in any form, and shall retain no copies of such PHI.

(i) In the event that the Business Associate determines that return or destruction is not feasible, the Business Associate shall provide the Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall continue to extend the protections of this Agreement to such PHI that was infeasible to return or destroy, and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as the Business Associate maintains such PHI. 45 CFR §164.504(e)(2)(I).

(ii) If the Business Associate elects to destroy the PHI, the Business Associate shall certify in writing to the Covered Entity that the PHI has been destroyed.

(iii) The rights and obligations of Covered Entity and Business Associate established under this Agreement, HIPAA and the Privacy Rule in regard to PHI shall survive the termination of the Agreement and continue for as long as Business Associate maintains such PHI.

Article 5 – Disclaimer.

Covered Entity makes no warranty or representation that compliance by the Business Associate with this Agreement, HIPAA, or the Privacy Rule will be adequate or satisfactory for the Business Associate's own purposes. Business Associate is solely responsible for all decisions made by the Business Associate regarding the safeguarding of PHI.

Article 6 – Amendment

A. *Amendment to Comply with Law.* The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Covered Entity to comply with the requirements of the Privacy Rule. The parties understand and agree that the Covered Entity shall receive satisfactory written assurance from the Business Associate that the Business Associate will adequately safeguard all PHI that is received or created pursuant to the Contract. Upon the Covered Entity's request, the Business Associate agrees to promptly enter into negotiations with the Covered Entity concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of the Privacy Rule. The Covered Entity may initiate termination of the Contract in accordance with the termination provisions of the Contract upon 30 days written notice in the event (i) the Business Associate does not promptly enter into negotiations to amend this Agreement when requested by the Covered Entity pursuant to this Section or (ii) the Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that the Covered Entity deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Regulations.

B. *Regulatory References.* A reference in this Agreement to a section in the Privacy Rule means the section in effect or as amended.

Article 7 – Assistance in Litigation or Administrative Proceedings.

Business Associate shall make itself, and any subcontractors, employees or agents assisting the Business Associate in the performance of its obligations under this Contract, available at no cost to the Covered Entity, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Covered Entity, its officers or employees based upon a claimed violation of HIPAA, the Privacy Rule or other laws relating to security and privacy, except where the Business Associate or its subcontractor, employee or agent is a named adverse party.

Article 8 – No Third Party Beneficiaries.

Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Covered Entity, the Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

Article 9 – Effect on Contract

All terms of the Contract shall remain in force and effect except where they might conflict with the terms of this Agreement and then the terms of this Agreement shall control.

Article 10 – Interpretation

This Agreement and the Contract of which it is part shall be interpreted as broadly as necessary to implement and comply with HIPAA, the Privacy Rule and applicable state laws.

The Parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the Privacy Rule.

Article 11 – Notices

Any notices required pursuant to this Agreement shall be given in the same manner required under the Contract in the “Notices,” section of Schedule A, “Standard Terms and Conditions.”

Article 12 – Authority to Execute and Signatures

The Parties each understand and agree to the terms of this Agreement. Each undersigned representative of the Parties certifies that he or she is fully authorized to enter into the

terms and conditions of this Agreement and to execute and legally bind such Party to this Agreement.

BY: _____

Frederick J. Beaver

Director of the Division of Pensions and Benefits and Secretary to the
State Health Benefits Commission

DATED: _____

BY: _____

NAME: _____

TITLE: _____

DATED: _____

SECTION I

CONTRACT (SCHEDULE E)

Contract Administration

This Contract is made and entered into the ___ day of _____, 2007, between the New Jersey State Health Benefits Commission, with offices at 50 West State Street, Trenton, New Jersey 08625-0295, hereinafter referred to as the COMMISSION, and _____, with offices at _____, hereafter referred to as the Contractor.

Whereas, the COMMISSION desires to contract for services, as set forth in the attached Schedule A, "Standard Terms and Conditions", Schedule B, "Scope of Work", Schedule C, "Rates," and Schedule D, and the "HIPAA Business Associate Agreement;" and

Whereas, the Contractor has represented that it is qualified by training and experience to perform these services in the manner and on the terms and conditions set forth in the attached Schedules A, B, C and D.

Now therefore, in consideration of the mutual promises herein, the parties hereto covenant and agree as follows:

ARTICLE 1-WORK

The Contractor shall at its own cost and expense furnish all labor, services, equipment and incidentals necessary to perform all Work set forth in the attached Schedules A, B, C and D.

ARTICLE 2- CONTRACT DOCUMENTS

The Contractor and the COMMISSION hereby agree that all of the provisions, terms, conditions, specifications and scope of work set forth in Schedules A, B, C and D, together with the terms herein, comprise the entire Contract between the COMMISSION and the Contractor.

ARTICLE 3- CONFLICT

The Contractor and the COMMISSION agree that, in the event it is necessary to interpret the Contract documents or resolve any inconsistencies between or among them, the Contract documents shall have the following order of precedence:

1. The "Contract."
2. Schedule D, "HIPAA Business Associate Agreement."
3. Schedule A, "Standard Terms and Conditions."
4. Schedule B, "Scope of Work."
5. Schedule C, "Rates."

ARTICLE 4- CONTRACT PRICE

The COMMISSION will pay the Contractor for performance of the work in accordance with Schedule C, "Rates."

ARTICLE 5-Contractor’S REPRESENTATIONS

As part of the inducement for the COMMISSION to enter into the Contract, the Contractor makes the following representations:

- 1.The Contractor has familiarized itself with the nature and extent of the Contract documents and with all federal and State laws, rules and regulations that may affect cost, progress or performance of the Work.
2. The Contractor accepts the Contract documents in their entirety.
3. The Contractor binds itself, its partners, successors and assigns to all covenants, agreements and obligations contained in the Contract documents.

IN WITNESS WHEREOF, Contractor has duly signed this Contract; and, the COMMISSION, through the Director, Division of Pensions and Benefits, has signed this Contract.

Contractor

COMMISSION

By: _____

By: _____
Director, Division of Pensions and Benefits

Title: _____

SECTION J
PLAN DOCUMENTS

Refer to the SHBP Web site for copies of current plan documents:

Summary Program Documents
Medical Handbooks for all Plans

<http://www.state.nj.us/treasury/pensions/shbp.htm>

SECTION K

PERFORMANCE STANDARDS AND FINANCIAL GUARANTEES PPO

Evaluation Period. The evaluation period for performance standards under this Contract will be executed on a calendar year basis except for the initial contract period which will be from the effective date through December 31, 2008.

The following summarizes the minimum standards and financial guarantees, more aggressive guarantees are encouraged. Each category and each corresponding amount of the fee that will remain unearned if Contractor fails to perform within the performance standards set are forth below:

I. Claims Administration/Customer Service

A. *Turnaround Time for Claims (TAT)*

1. Bidder must guarantee that the average annual turnaround time for claims will not exceed twelve (12) calendar days for 90.0% of processed claim transactions on a cumulative basis each Plan Year.
2. TAT will be measured from the date a claim is received in the claim office to the date it is processed (paid, denied or pended)
3. TAT must be documented on a monthly basis and reported to the Commission on a quarterly basis.
4. Fee at risk- If Contractor fails to meet the turnaround time for claims guarantee then 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

B. *Financial Accuracy*

1. Bidder will guarantee that the average annual financial accuracy of paid claims will be 99.0% or higher.
2. Financial accuracy is calculated as follows: the total dollars of audited claims paid minus the sum of the absolute dollar value of all overpayments and underpayments is divided by the total dollars of audited claims paid.
3. Financial accuracy must be documented on a monthly basis and reported to the Commission on a quarterly basis.

4. Fee at risk- If Contractor fails to meet the financial accuracy guarantee then 3.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

C. Payment Incidence Accuracy

1. Bidder will guarantee that the average annual payment incidence accuracy will be 97.5% or higher.
2. Payment incidence accuracy is determined by the number of correct audited payments divided by the total number of payments audited.
3. Payment incidence accuracy must be documented on a monthly basis and reported to the Commission on a quarterly basis.
4. Fee at risk - If Contractor fails to meet the payment incidence accuracy guarantee then 1.5% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

D. Coding Accuracy

1. Bidder will guarantee that the average quarterly coding accuracy will be 97.0% or higher.
2. Coding errors are defined as any errors which do not result in an incorrect payment of a claim. It is determined by dividing the total number of correct claims by the total number of audited claims.
3. Coding Accuracy must be documented on a monthly basis and reported to the Commission on a quarterly basis.
4. Fee at risk - If Contractor fails to meet the coding accuracy guarantee then 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

E. *Turnaround time for Written Complaints*

1. Contractor must respond to ninety-five percent (95.0%) of the written concerns or complaints received by it in connection with its delivery of services during the evaluation period within twenty-one (21) calendar days on a quarterly basis, as calculated under the Time-to-Respond Formula set forth below.
2. Time-to-Respond will be calculated by counting the number of calendar days from the day the complaint is received by Contractor to, and including, the date a written response is mailed to the complainant.
3. Time-to-Respond to written complaints must be reported to the Contract Manager quarterly.
4. Fee at Risk. If Contractor fails to meet the 21 Day Time to Respond then 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

F. *Telephone Response Time Calls*

1. The elapsed time between the time a telephone caller to a Contractor customer service call or claim center servicing members (Call Center) makes the selection to speak with a customer service representative and the time the caller speaks with a customer service representative (Response Time) must, on average, be no longer than thirty (30) seconds, on a quarterly basis.
2. The formula for calculating the Response Time will be the sum of the time for each telephone call received during the evaluation period to be connected to a customer service representative, measured from the time the caller selects to speak with a customer service representative, divided by the total number of telephone calls received by the Call Centers during the evaluation period for all calls received by the Call Centers.
3. Time-to-Respond to telephone calls will each be calculated automatically by the automatic telephone call distribution system used by each Call Center.
4. Time-to-Respond to telephone calls must be reported to the Contract Manager quarterly.

5. Fee at Risk. Telephone-Time-to-Respond. If Contractor fails to meet the Time-to-Respond performance standard, then 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

G. *Call Abandonment Rate*

1. Telephone Call Abandonment Performance Standard. The percentage of calls received by the Call Center resulting in the caller terminating the call before speaking with a customer service representative (Abandonment Rate) must, on average, be no greater than three percent (3.0%) on a quarterly basis for all calls received by a Call Center in connection with Contractor's delivery of services under the Plan.
2. Abandonment rate will each be calculated automatically by the automatic telephone call distribution system used by each Call Center.
3. Abandonment rate must be reported to the Contract Manager quarterly.
4. Fee at Risk. If Contractor fails to meet the Call Abandonment performance standard, then 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

II. **Reporting**

- A. All reports required to be submitted to the Commission by Contractor pursuant to this Contract will be submitted in a complete and timely fashion. In all cases, accurate reports must be due within forty-five days of the close of the reporting period unless otherwise agreed upon, in writing, by the Commission, and Contractor.
- B. Fee at Risk. If Contractor fails to meet the Reporting performance standard by not submitting accurate reports when due, up to a maximum of 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

III. **Account Management Satisfaction**

- A. The Commission will be satisfied with the services and professionalism of Contractor's account management team as reflected by an average aggregate score of at least 3.0 on each of the performance measures listed below and recorded on the Client Satisfaction Evaluation Form at the end of this section.

The Client Satisfaction Evaluation Form will be completed by an evaluation team whose members shall include, but not be limited to, the Director of the Division of Pensions and Benefits, Deputy Director of Health Benefits, Manager of Policy and Planning, Chief of the Health Benefits Bureau and the Deputy Director of Financial Services, and the Division's consultants, or their designees. The evaluation team members will meet semi-annually to determine if the contractor is satisfactorily meeting the service needs of the Division of Pensions and Benefits.

Each evaluation team member will rate Contractor's performance on each performance measure with a score from 1 to 5. Each evaluator's scores given for each performance measure will then be aggregated and averaged to arrive at the average aggregate score. The average aggregate score will not be less than 3.0 on any two performance measures.

The Client Satisfaction Evaluation Form will be based on an evaluation of the following performance measures:

1. Accessibility: Has the account executive been reachable in moments of need? If not immediately reachable, has the account executive established an effective mechanism for reaching a suitable alternative? Does the account executive make their best effort to assure attendance of proper personnel at prescribed meetings?
2. Responsiveness: In times when issues or problems arise does the account executive expeditiously and effectively address the issue and resolve the problem? Are resolutions adequately communicated to the Division of Pension and Benefits and Commission?
3. Timely notification: The account executive, with adequate time for response by the Division of Pensions and Benefits and Commission, fully informs the Division of Pensions and Benefits of changes of significant staff members or internal policies, pending mergers or new financial arrangements with contractors that may have an affect on the State Health Benefits Program, e.g. loss of Providers, hospitals or significant physician groups.
4. Coordination: The account executive appropriately coordinates the resources of their organization to meet the needs of the Division of Pensions and Benefits in a timely and effective manner both in the provision of services and in the resolution of problems or issues.

5. Compliance: The account executive makes sure that their organization follows Division of Pensions and Benefits and Commission procedures and directives concerning marketing, attendance at health fairs, timeliness and accuracy of materials available to members, reporting (financial and other), and other procedural and contractual requirements.
6. Account Team Working Skills: The account executive demonstrates interpersonal skills and communicates effectively and professionally handles and facilitates meetings by being prepared, organized and able to communicate a well thought-out agenda. Appropriately responds, understands issues and is innovative when developing solutions when issues and problems are raised by the Division of Pensions and Benefits or the Commission.

B. Client Satisfaction Form:

If at the semi-annual review, Contractor is found to have failed the performance guarantee by receiving a score of less than an aggregate average score of 3.0 on any two performance measures, the Division of Pensions and Benefits will issue a warning letter to Contractor advising them of their failure to meet standards and that a potential penalty will be applied if this performance continues.

The year-end evaluation will not be an average of the two ratings but will be a true reflection of the whole year service. If enough improvement occurs in the second half of a year the penalty may not be applied.

A rating of less than 3.0 on any two performance measures will result in forfeiture of the fee at risk.

- C. Fee at Risk. If Contractor fails to achieve an aggregate average score of 3 or greater on any two performance measures on the Client Satisfaction Form as set forth above, then 2.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

IV. **Network Management and Development**

- A. Contractor must credential all network providers every three years. A letter verifying that credentialing is completed must be provided to the Commission at the end of every other contract year.
- B. The Contractor must provide to the Commission annually a report verifying the adequacy of the PPO network with regard to the distribution of members

and the access of members to all standard specialties by area. The report should be accompanied with a strategic plan to improve those areas where access is substandard. The penalty would be applied if areas deemed to be inadequate by the Commission do not show improvement over each yearly period. During the implementation period access parameters will be established through discussions between the Contract Manager and the Contractor. The ability to develop and offer the plan to retirees wherever retirees reside may offset inadequacies of the existing panel.

- C. Fee at Risk. If Contractor fails to complete credentialing in a timely manner then 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the ASO fee.
- D. Contractor must strive to continue to maintain and improve the network of providers available to members. A report will be provided to the Commission indicating the growth and maintenance of the panel. Failure to sustain and/or grow the panel will constitute failure of the contractor to meet this requirement.
- E. Fee at Risk. If Contractor fails to sustain and/ grow the panel of available providers, then 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the ASO fee.

V. **Financial Guarantees**

The following types of guarantees are encouraged to be set by the Bidder (in the Performance Guarantee Form that follows). The annual guarantee for “Discounts off Medical Charges”, “In-Network Utilization”, “Disease Management” and “Trend” will be based on SHBP claims incurred in a calendar year and paid through March of the following year, and will apply separately for each and every year of the contract. The guarantees for “Discount off AWP”, “Rebates and Other Pharmaceutical Revenue”, and “Dispensing Fees” would be based on claims incurred in a calendar year and paid through January of the following year. All guarantees should be for the length of the contract. Insert guarantee amounts into the table that follows.

A. *Medical - Discounts off Medical Charges*

Provide a guaranteed discount off of in-network charges. (The guarantee should include all in-network covered services for non-Medicare participants. It should exclude capitation charges as well as out-of-hospital prescription drugs.)

Fee at risk - If contractor fails to meet its guarantee, then 10.0% of the administrative fee due and owing under the Contract(s) for the evaluation period shall be withheld from the administrative fee.

B. Medical - In-Network Guarantee

Provide a guaranteed percentage of claims paid on an in-network basis. (The guarantee should include all in-network covered services for non-Medicare participants. It should exclude capitation charges as well as out-of-hospital prescription drugs.)

Fee at risk - If contractor fails to meet its guarantee, then 5.0% of the administrative fee due and owing under the Contract(s) for the evaluation period shall be withheld from the administrative fee.

C. Medical - Trend Guarantee

Provide a guaranteed rate of annual increase of claim costs, measured on a per member per month basis.

Fee at risk - If contractor fails to meet its guarantee, then 5.0% of the administrative fee due and owing under the Contract(s) for the evaluation period shall be withheld from the administrative fee.

D. Prescription Drug - Discounts off AWP

Please provide annual guaranteed discounts off AWP as follows -

- Retail Brand
- Retail Generic
- Mail Order Brand
- Mail Order Generic

All drugs, including specialty drugs, should be included in these guarantees.

Fee at risk - If contractor fails to meet its guarantee, then an amount equal to the missed guarantee shall be withheld due and owing under the Contract(s) for the evaluation period.

E. Prescription Drug - Rebates and other Pharmaceutical Revenue

The SHBP requires that 100% of all prescription drug rebates and other pharmaceutical revenue be returned to the SHBP. Provide a guaranteed minimum average rebate, per script, that applies annually, for the length of the contract. When measuring the average annual rebate per script, all covered scripts with claim payments equal to or greater than \$0 would be included in the denominator.

Fee at risk - If contractor fails to meet its guarantee, then an amount equal to the missed guarantee shall be withheld from the administrative fee due and owing under the Contract(s) for the evaluation period.

F. Prescription Drug - Dispensing Fees

Please provide the guaranteed maximum average dispensing fee per script for the length of the contract period. When measuring the annual averages, all scripts would be included in the denominator.

- Retail Brand
- Retail Generic
- Mail Order Brand
- Mail Order Generic

Fee at risk - If contractor fails to meet its guarantee, then an amount equal to the missed guarantee shall be withheld from the administrative fee due and owing under the Contract(s) for the evaluation period.

G. Disease Management

Guaranteed Annual (ROI)

Please provide a guaranteed Return on Investment (ROI) for proposed Disease Management programs. The guarantees should apply annually for each year of the contract period. Please fully explain how savings will be measured and documented.

Fee at risk - If contractor fails to meet its guarantee, then an amount equal to 20.0% of the annual Disease Management fees shall be withheld due and owing under the Contract(s) for the evaluation period.

VI. Evaluation of Services and Forfeiture of Fees at Risk

- A. If Contractor fails to meet any of the performance standards or financial guarantees, Contractor must pay to the State Health Benefits Program the penalty set forth for the performance standard that was not met.
- B. Any amounts due and owing to Contractor under this Contract, whether then existing or thereafter arising, must be paid by check made payable to the State Health Benefits Program.
- C. Resolution of disputes. In the event of any dispute arising regarding the scoring of the performance standards, each party agrees to send an authorized representative to meet, upon the request of the other party, to negotiate in good faith to resolve the matter. In the event that the dispute

is not resolved within sixty (60) days of the commencement of negotiations, either party may pursue all available legal and equitable rights and remedies. This provision will survive the termination of this Contract.

VII. **Total Fee At Risk**

Notwithstanding individual fees at risk set forth herein to the contrary, the total (cumulative) amount of fees at risk will not exceed 15.0% of the administrative fee under this Contract for any one evaluation period, an evaluation period being a calendar year (with the exception of the initial contract period which will be from the contract effective date through 12/31/08) This limit does not apply to the Prescription Drug or implementation guarantees.

CLIENT SATISFACTION EVALUATION FORM

Rating Methodology:

- 5 = Exceeds Expectations
- 4 = Always Meets Expectations
- 3 = Usually Meets Expectations
- 2 = Sometimes (once in a while) Meets Expectations
- 1 = Consistently Does Not Meet Expectations

Please complete the box with the score that most closely reflects Evaluator's opinion of the local account management team with respect to:

Measurable Need	6 Months	One Year
a) Accessibility		
b) Responsiveness		
c) Timely notification		
d) Coordination		
e) Compliance		
f) Account Team Working Skills		

Action Arising from Semi-Annual review:

End of Year Comments:

PERFORMANCE AND FINANCIAL GUARANTEE FORM

I. Claim Administration/Customer Service

Claim Administration/ Customer Service	Standard	Measurement period	Actual	Fee at Risk
Turnaround Time for Claims	90.0% processed within 12 Calendar Days	Quarterly		1.0%
Financial Accuracy	99.0% accuracy for claims paid	Quarterly		3.0%
Payment Incidence Accuracy	97.5% average year end accuracy	Quarterly		1.5%
Coding Accuracy	97.0% coding accuracy	Quarterly		1.0%
Turnaround time for Written Complaints	95.0% within 21 Calendar Days	Quarterly		1.0%
Telephone Calls Response Time	30 seconds	Quarterly		1.0%
Call Abandonment Rate	3.0%	Quarterly		1.0%

Above standards will be measured quarterly and penalties will be assessed annually.

II. Reporting

Reporting	Standard	Measurement Period	Actual	Fee at Risk
Reporting	Complete and Timely Submission of accurate reports	Annual		Up to a max of 1% of the fee

III. Account Management

Account Management	Standard	Measurement Period	Actual	Fee at Risk
Account Management Satisfaction	Score of 3.0 or higher	Annual		2.0%

IV. **Network Management and Development**

Network Management and Development	Standard	Measurement Period	Actual	Fee at Risk
Credentialing	Every three years	Annual		1.0%
Maintenance and Growth of Network	Actual Growth or status quo	Annual		1.0%

V. **Financial Guarantees** - Complete the attached chart with the commitments you are willing to make for this program:

Financial Guarantees	Bidder's Standard	Measurement Period	Actual	Fee at Risk
Discount off Medical Charges		Annual		10.0%
In-Network Guarantee (PPO Only)		Annual		5.0%
Trend Guarantee		Annual		5.0%
Discount off AWP (Rx)	Retail Brand - Retail Generic - Mail Order Brand - Mail Order Generic -	Annual		Amount equal to the missed guarantee
Rebates (Rx) and other Pharmaceutical Revenue		Annual		Amount equal to the missed guarantee
Dispensing Fee	Retail Brand - Retail Generic - Mail Order Brand - Mail Order Generic -	Annual		Amount equal to the missed guarantee
Disease Management (ROI)		Annual		Amount equal to 20% of annual DM fees

Total Fee At Risk

Notwithstanding individual fees at risk set forth herein to the contrary, the total (cumulative) amount of fees at risk will not exceed 15.0% of the administrative fee under this Contract for any one evaluation period, an evaluation period being a calendar year (with the exception of the initial contract period which will be from the contract effective date through 12/31/08) This limit does not apply to the Prescription Drug or implementation guarantees.

IMPLEMENTATION GUARANTEE

Provide a description of how your organization will guarantee implementation of this program.

The following summarizes a sample list of implementation guarantees, more aggressive and detailed guarantees are encouraged.

Implementation Performance Guarantee Including, But Not Limited To, the Categories Below

<u>Category</u>	<u>Implementation Date</u>	<u>Amount at Risk</u>
Account Management		
A. Account management, responsiveness and problem resolution		
Systems Preparation		
A. Accurate loading of plan design		
B. Accurate loading of year-to-date deductibles and maximum limits		
C. Development of required accounting systems		
Enrollment Support		
A. Enrollment materials and provider directories-accuracy, quantity and timeliness		
B. ID cards		
C. Customer Service open 3 months before plan effective date to respond to participants questions.		
D. Accurate loading of enrollment information on eligibility files		
Network Capabilities		
A. Recruitment of additional practitioners to provide adequate coverage		

PERFORMANCE STANDARDS AND FINANCIAL GUARANTEES FOR HMOS

Evaluation Period. The evaluation period for performance standards under this Contract will be executed on a calendar year basis except for the initial contract period which will be from the effective date through December 31, 2008.

The following sets forth the criteria for minimum performance standards and Financial guarantees – more aggressive standards and guarantees are encouraged. The criteria for each performance standard, establishes the percentage of the Contractor's total administrative fee, paid the Contractor during the evaluation period pursuant to the Contractor's HMO Contract with the Commission, that is at risk in the event the Contractor fails to meet the performance standard during the evaluation period.

I. Claim Administration

A. *Turnaround Time for Claims (TAT)*

1. Bidder must guarantee that the average annual turnaround time for claims will not exceed fourteen (14) calendar days for 90.0% of processed claim transactions on a cumulative basis each Plan Year.
2. TAT will be measured from the date a claim is received in the claim office to the date it is processed (paid, denied or pended)
3. TAT must be documented on a monthly basis and reported to the Commission on a quarterly basis.
4. Fee at risk- If Contractor fails to meet the turnaround time for claims guarantee then 0.5% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

B. *Financial Accuracy*

1. Bidder will guarantee that the average annual financial accuracy of paid claims will be 99.0% or higher.
2. Financial accuracy is calculated as follows: the total dollars of audited claims paid minus the sum of the absolute dollar value of all overpayments and underpayments is divided by the total dollars of audited claims paid.
3. Financial accuracy must be documented on a monthly basis and reported to the Commission on a quarterly basis.

4. Fee at risk- If Contractor fails to meet the financial accuracy guarantee then 2.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

C. Payment Incidence Accuracy

1. Bidder will guarantee that the average annual payment incidence accuracy will be 97.5% or higher.
2. Payment incidence accuracy is determined by the number of correct audited payments divided by the total number of payments audited.
3. Payment incidence accuracy must be documented on a monthly basis and reported to the Commission on a quarterly basis.
4. Fee at risk- If Contractor fails to meet the payment incidence accuracy guarantee then 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

D. Coding Accuracy

1. Bidder will guarantee that the average annual coding accuracy will be 97.0% or higher.
2. Coding errors are defined as any errors which do not result in an incorrect payment of a claim. It is determined by dividing the total number of correct claims by the total number of audited claims.
3. Coding Accuracy must be documented on a monthly basis and reported to the Commission on a quarterly basis.
4. Fee at risk- If Contractor fails to meet the coding accuracy guarantee then 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

E. Turnaround time for Written Complaints

1. Contractor must respond to ninety-five percent (95.0%) of the written concerns or complaints received by it in connection with its delivery of services during the evaluation period within twenty-one (21) calendar days on a quarterly basis, as calculated under the Time-to-Respond Formula set forth below.
2. Time-to-Respond will be calculated by counting the number of calendar days from the day the complaint is received by Contractor to, and including, the date a written response is mailed to the complainant.
3. Time-to-Respond to written complaints must be reported to the Contract Manager quarterly.
4. Fee at Risk. If Contractor fails to meet the 21 Day Time to Respond then 0.5% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

F. Telephone Response Time Calls

1. The elapsed time between the time a telephone caller to a Contractor customer service call or claim center servicing members (Call Center) makes the selection to speak with a customer service representative and the time the caller speaks with a customer service representative (Response Time) must, on average, be no longer than thirty (30) seconds, on a quarterly basis.
2. The formula for calculating the Response Time will be the sum of the time for each telephone call received during the evaluation period to be connected to a customer service representative, measured from the time the caller selects to speak with a customer service representative, divided by the total number of telephone calls received by the Call Centers during the evaluation period for all calls received by the Call Centers.
3. Time-to-Respond to telephone calls will each be calculated automatically by the automatic telephone call distribution system used by each Call Center.
4. Time-to-Respond to telephone calls must be reported to the Contract Manager quarterly.

5. Fee at Risk. Telephone-Time-to-Respond. If Contractor fails to meet the Time-to-Respond performance standard, then 0.5% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

G. *Call Abandonment Rate*

1. Telephone Call Abandonment Performance Standard. The percentage of calls received by the Call Center resulting in the caller terminating the call before speaking with a customer service representative (Abandonment Rate) must, on average, be no greater than three percent (3.0%) on a quarterly basis for all calls received by a Call Center in connection with Contractor's delivery of services under the Plan.
2. Abandonment rate will each be calculated automatically by the automatic telephone call distribution system used by each Call Center.
3. Abandonment rate must be reported to the Contract Manager quarterly.
4. Fee at Risk. If Contractor fails to meet the Call Abandonment performance standard, then 0.5% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

II. **Reporting**

- A. All reports required to be submitted to the Commission by Contractor pursuant to this Contract will be submitted in a complete and timely fashion. In all cases, accurate reports must be due within forty-five days of the close of the reporting period unless otherwise agreed upon, in writing, by the Commission, and Contractor.
- B. Fee at Risk. If Contractor fails to meet the Reporting performance standard by not submitting accurate reports when due, up to a maximum of 1.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

III. **Account Management Satisfaction**

- A. The Commission will be satisfied with the services and professionalism of Contractor's account management team as reflected by an average aggregate score of at least 3.0 on each of the performance measures listed below and recorded on the Client Satisfaction Evaluation Form at the end of this section.

The Client Satisfaction Evaluation Form will be completed by an evaluation team whose members shall include, but not be limited to, the Director of the Division of Pensions and Benefits, Deputy Director of Health Benefits, Manager of Policy and Planning, Chief of the Health Benefits Bureau and the Deputy Director of Financial Services, and the Division's consultants, or their designees. The evaluation team members will meet semi-annually to determine if the contractor is satisfactorily meeting the service needs of the Division of Pensions and Benefits.

Each evaluation team member will rate Contractor's performance on each performance measure with a score from 1 to 5. Each evaluator's scores given for each performance measure will then be aggregated and averaged to arrive at the average aggregate score. The average aggregate score will not be less than 3.0 on any two performance measures.

The Client Satisfaction Evaluation Form will be based on an evaluation of the following performance measures:

1. Accessibility: Has the account executive been reachable in moments of need? If not immediately reachable, has the account executive established an effective mechanism for reaching a suitable alternative? Does the account executive make their best effort to assure attendance of proper personnel at prescribed meetings?
2. Responsiveness: In times when issues or problems arise does the account executive expeditiously and effectively address the issue and resolve the problem? Are resolutions adequately communicated to the Division of Pension and Benefits and Commission?
3. Timely notification: The account executive, with adequate time for response by the Division of Pensions and Benefits and Commission, fully informs the Division of Pensions and Benefits of changes of significant staff members or internal policies, pending mergers or new financial arrangements with contractors that may have an affect on the State Health Benefits Program, e.g. loss of Providers, hospitals or significant physician groups.
4. Coordination: The account executive appropriately coordinates the resources of their organization to meet the needs of the Division of Pensions and Benefits in a timely and effective manner both in the provision of services and in the resolution of problems or issues.

5. Compliance: The account executive makes sure that their organization follows Division of Pensions and Benefits and Commission procedures and directives concerning marketing, attendance at health fairs, timeliness and accuracy of materials available to members, reporting (financial and other), and other procedural and contractual requirements.
6. Account Team Working Skills: The account executive demonstrates interpersonal skills and communicates effectively and professionally handles and facilitates meetings by being prepared, organized and able to communicate a well thought-out agenda. Appropriately responds, understands issues and is innovative when developing solutions when issues and problems are raised by the Division of Pensions and Benefits or the Commission.

B. Client Satisfaction Form:

If at the semi-annual review, Contractor is found to have failed the performance guarantee by receiving a score of less than an aggregate average score of 3.0 on any two performance measures, the Division of Pensions and Benefits will issue a warning letter to Contractor advising them of their failure to meet standards and that a potential penalty will be applied if this performance continues.

The year-end evaluation will not be an average of the two ratings but will be a true reflection of the whole year service. If enough improvement occurs in the second half of a year the penalty may not be applied.

A rating of less than 3.0 on any two performance measures will result in forfeiture of the fee at risk.

- C. Fee at Risk. If Contractor fails to achieve an aggregate average score of 3.0 or greater on any two performance measures on the Client Satisfaction Form as set forth above, then 2.0% of the administrative fees due and owing under the Contract for the evaluation period shall be withheld from the administrative fee.

IV. **Department of Health and Senior Services (DHSS) “Report Card.”**

(A) DHSS Surveyed Categories Performance Standards.

The Contractor must be reported as average or above average in 70.0% of the DHSS **consumer satisfaction** measures indicated in their annual publication “New Jersey HMO Performance Report” (DHSS Report Card). Any of the DHSS measures for which the Contractor received a rating below the NJ HMO average will require that the Contractor

to submit a correction plan to the Division within 60 days of the date the report is published.

Fee at Risk- If the Contractor fails to achieve an average or above average score in 70% of the DHSS consumer satisfaction measures, then 2.0% of the total administrative fee paid the Contractor during the evaluation period, pursuant to the Contractor's HMO Contract with the Commission, must be paid by the Contractor to the Commission.

(B). DHSS HEDIS Measures Performance Standards

The Contractor must be reported average or above average in 70.0% of the DHSS **HEDIS measures** indicated in the DHSS Report Card. Any of the DHSS HEDIS measures which fall below the NJ HMO Average in any category will require submission of a correction plan by the Contractor to the Commission within 60 days of the date the report is published.

Fee at Risk- If the Contractor fails to achieve an average or above average score in 70.0% of the DHSS HEDIS measures, then 3.0% of the total administrative fee paid the Contractor during the evaluation period, pursuant to the Contractor's HMO Contract with the Commission, must be paid by the Contractor to the Commission.

The DHSS will clarify any items in the DHSS Report Card that are unfamiliar to the Contractor. Any amendments or new items required by the DHSS and included in the published DHSS Report Card will automatically become part of this Performance Standards Agreement.

Failure by the Contractor to collect or report required information will result in a grade of zero for the measured sub-category.

The Contractor will not be penalized if it does not have enough measurable encounters within a specific category to meet statistical measurement thresholds.

V. **Financial Guarantees**

The following types of guarantees are encouraged to be set by the Bidder (in the Performance Guarantee Form that follows). The annual guarantee for "Discounts off Medical Charges", "In-Network Utilization", "Disease Management" and "Trend" will be based on SHBP claims incurred in a calendar year and paid through March of the following year, and will apply separately for each and every year of the contract. The guarantees for "Discount off AWP", "Rebates and Other Pharmaceutical Revenue", and "Dispensing Fees" would be based on claims incurred in a calendar year and paid through January of the following year. All guarantees should be for the length of the contract. Insert guarantee amounts into the table that follows.

1. *Medical - Discounts off Medical Charges*

Provide a guaranteed discount off of in-network charges. (The guarantee should include all in-network covered services for non-Medicare participants. It should exclude capitation charges as well as out-of-hospital prescription drugs.)

Fee at risk - If contractor fails to meet its guarantee, then 10.0% of the administrative fee due and owing under the Contract(s) for the evaluation period shall be withheld from the administrative fee.

2. *Medical - Trend Guarantee*

Provide a guaranteed rate of annual increase of claim costs, measured on a per member per month basis.

Fee at risk - If contractor fails to meet its guarantee, then 5.0% of the administrative fee due and owing under the Contract(s) for the evaluation period shall be withheld from the administrative fee.

3. *Prescription Drug - Discounts off AWP*

Please provide annual guaranteed discounts off AWP as follows -

- Retail Brand
- Retail Generic
- Mail Order Brand
- Mail Order Generic

All drugs, including specialty drugs, should be included in these guarantees.

Fee at risk - If contractor fails to meet its guarantee, then an amount equal to the missed guarantee shall be withheld due and owing under the Contract(s) for the evaluation period.

4. *Prescription Drug - Rebates and other Pharmaceutical Revenue*

The SHBP requires that 100% of all prescription drug rebates and other pharmaceutical revenue be returned to the SHBP. Provide a guaranteed minimum average rebate, per script, that applies annually, for the length of the contract. When measuring the average annual rebate per script, all covered scripts with claim payments equal to or greater than \$0 would be included in the denominator.

Fee at risk - If contractor fails to meet its guarantee, then an amount equal to the missed guarantee shall be withheld from the administrative fee due and owing under the Contract(s) for the evaluation period.

5. *Prescription Drug - Dispensing Fees*

Please provide the guaranteed maximum average dispensing fee per script for the length of the contract period. When measuring the annual averages, all scripts would be included in the denominator.

- Retail Brand
- Retail Generic
- Mail Order Brand
- Mail Order Generic

Fee at risk - If contractor fails to meet its guarantee, then an amount equal to the missed guarantee shall be withheld from the administrative fee due and owing under the Contract(s) for the evaluation period.

6. *Disease Management*

Guaranteed Annual (ROI)

Please provide a guaranteed Return on Investment (ROI) for proposed Disease Management programs. The guarantees should apply annually for each year of the contract period. Please fully explain how savings will be measured and documented.

Fee at risk - If contractor fails to meet its guarantee, then an amount equal to 20.0% of the annual Disease Management fees shall be withheld due and owing under the Contract(s) for the evaluation period.

VI. **Evaluation of services and forfeiture of Fees at Risk**

- D. If Contractor fails to meet any of the performance standards or financial guarantees, Contractor must pay to the State Health Benefits Program the penalty set forth for the performance standard that was not met.
- E. Any amounts due and owing to Contractor under this Contract, whether then existing or thereafter arising, must be paid by check made payable to the State Health Benefits Program.
- F. Resolution of disputes. In the event of any dispute arising regarding the scoring of the performance standards, each party agrees to send an authorized representative to meet, upon the request of the other party, to negotiate in good faith to resolve the matter. In the event that the dispute is not resolved within sixty (60) days of the commencement of negotiations, either party may pursue all available legal and equitable

rights and remedies. This provision will survive the termination of this Contract.

VII. **Total Fee At Risk**

Notwithstanding individual fees at risk set forth herein to the contrary, the total (cumulative) amount of fees at risk will not exceed 15.0% of the administrative fee under this Contract for any one evaluation period, an evaluation period being a calendar year. This limit does not apply to the Prescription Drug guarantees.

CLIENT SATISFACTION EVALUATION FORM

Rating Methodology:

- 5 = Exceeds Expectations
- 4 = Always Meets Expectations
- 3 = Usually Meets Expectations
- 2 = Sometimes (once in a while) Meets Expectations
- 1 = Consistently Does Not Meet Expectations

Please complete the box with the score that most closely reflects your opinion of the local account management team with respect to:

Measurable Need	6 Months	One Year
Accessibility		
Responsiveness		
Timely notification		
Coordination		
Compliance		
Account Team Working Skills		

Action Arising from Semi-Annual review:

End of Year Comments:

PERFORMANCE STANDARD FORM
Health Maintenance Organizations

I. Claim Administration/Customer Service

Claim Administration/ Customer Service	Standard	Measurement period	Actual	Fee at Risk
Turnaround Time for Claims	90.0% processed within 14 Calendar Days	Quarterly		0.5%
Financial Accuracy	99.0% accuracy for claims paid	Quarterly		2.0%
Payment Incidence Accuracy	97.5% average year end accuracy	Quarterly		1.0%
Coding Accuracy	97.0% coding accuracy	Quarterly		1.0%
Turnaround time for Written Complaints	95.0% within 21 Calendar Days	Quarterly		0.5%
Telephone Calls Response Time	30 seconds	Quarterly		0.5%
Call Abandonment Rate	3.0%	Quarterly		0.5%

Above standards will be measured quarterly and penalties will be assessed annually.

II. Reporting

Reporting	Standard	Measurement Period	Actual	Fee at Risk
Reporting	Complete and Timely Submission of accurate reports	Annual		a max of 1% of the fee

III. Account Management

Account Management	Standard	Measurement Period	Actual	Fee at Risk
Account Management Satisfaction	Score of 3.0 or higher	Annual		2.0%

IV. **DHSS Report Card**

DHSS Report Card	Standard	Measurement Period	Actual	Fee at Risk
Surveyed Satisfaction Items	Average or above in 70%	Annual		2.0%
Measured Data Items	Average or above in 70%	Annual		3.0%

V. **Financial Guarantees** - Complete the attached chart with the commitments you are willing to make for this program:

Financial Guarantees	Bidder's Standard	Measurement Period	Actual	Fee at Risk
Discount off Medical Charges		Annual		10.0%
Trend Guarantee		Annual		5.0%
Discount off AWP (Rx)	Retail Brand - Retail Generic - Mail Order Brand - Mail Order Generic -	Annual		Amount equal to the missed guarantee
Rebates (Rx) and other Pharmaceutical Revenue		Annual		Amount equal to the missed guarantee
Dispensing Fee	Retail Brand - Retail Generic - Mail Order Brand - Mail Order Generic -	Annual		Amount equal to the missed guarantee
Disease Management (ROI)		Annual		Amount equal to 20% of annual DM fees

Total Fee At Risk

Notwithstanding individual fees at risk set forth herein to the contrary, the total (cumulative) amount of fees at risk will not exceed 15.0% of the administrative fee under this Contract for any one evaluation period, an evaluation period being a calendar year. This limit does not apply to the Prescription Drug guarantees.

IMPLEMENTATION GUARANTEE

Provide a description of what how your organization will guarantee implementation of this program.

The following summarizes a sample list of implementation guarantees, more aggressive and detailed guarantees are encouraged.

Implementation Performance Guarantee Including, But Not Limited To, the Categories Below

<u>Category</u>	<u>Implementation Date</u>	<u>Amount at Risk</u>
Account Management		
A. Account management, responsiveness and problem resolution		
Systems Preparation		
A. Accurate loading of plan design		
B. Accurate loading of year-to-date deductibles and maximum limits		
C. Development of required accounting systems		
Enrollment Support		
A. Enrollment materials and provider directories-accuracy, quantity and timeliness		
B. ID cards		
C. Customer Service open 3 months before plan effective date to respond to participants questions.		
D. Accurate loading of enrollment information on eligibility files		
Network Capabilities		
A. Recruitment of additional practitioners to provide adequate coverage		

The aggregate amount at risk for this guarantee is 20% of the annual administrative fee.

SECTION L
REPORTING

Contractor must report to the Contract Manager on any required modifications to the Plan's benefit provisions and/or administrative procedures for compliance with Federal or State enacted legislation and if requested provide an estimated cost associated therewith.

Contractor must cooperate with SHBP designated Consultants on all areas of reporting.

Commission staff should be able to review manipulate claims data on-line. Verify you currently have this ability and can offer it to the Commission or when such ability will be operational? Furnish sample copies of standard on-line in- and out-of-network utilization reports. The cost of on-line access should be included in Bidder's quoted fee.

Contractor must provide the Commission's designated consultants with the reports described below:

1. **Monthly and Quarterly Paid Claim Summary Reports.** The reports should include claims paid in the quarter and a rolling prior twelve months of past paid claims including the past quarter, by the following variables:

Employer Type = State, Local Education, Local Government
Employee Type= Active or Retired (early, non-Medicare, separate from Medicare)
Payment Type= Medical Claim, Capitation Payment, Rx Claim
Rx Plan Type= No Rx Card, State Rx Card, Other Rx Card

2. **Quarterly Enrollment Summary Reports.** The reports should split enrollment by the following variables:

Month of the Quarter, rolling past twelve months (including the past quarter).
Employer Type= State, Local Education, Local Government
Employee Type= Active or Retired (early, non-Medicare, separate from Medicare)
Rx Plan Type= No Rx Card, State Rx Card, Other Rx Card

3. **Standard Utilization Reports** that show utilization patterns and compare Plan experience with Contractor's book of business, (inclusive and exclusive of the Plan). The content, duration and frequency of these reports will be discussed and agreed upon with each Contractor. Initially, reports should be provided by month on a quarterly basis. Some Contractors can provide reports on line with some ad hoc ability which would be the optimum vehicle. If that tool is available inform the Division.

Operations Reports

A. Enrollment Reporting

1. Nightly enrollment updates of additions, changes and terminations.
2. Enrollment errors reported on a weekly or on an as needed basis.
3. Report of the results of a quarterly audit of enrollment.

Financial Reports

- ### A. Banking reconciliation packages provided on a monthly basis. These should be available to the Division's Financial Section on or before the tenth (10th) day of the succeeding month.

B. Daily Reports

1. Notification of the daily total of checks cleared, including an additional monthly billing for any capitation due under this Agreement. This information may be provided by fax, telephone followed by details, or agreed upon electronic format. It must be reported before 11AM on State work days.
2. Daily report showing the state and local breakdown of the above mentioned daily total of checks cleared, including a State and Local breakdown of additional monthly billing for any capitation due under this Agreement.

C. Monthly Reports

1. Paid Detail Register. List of checks cleared by account type via a secure electronic format. The register should be available on or before the tenth (10th) day of the succeeding month.
2. Summary of Paid Claims
3. Issued but Uncleared Checks

D. Annual Reports – estimate of:

1. Incurred unpaid claims
2. administrative fees
3. outstanding check amounts as of June 30

Fraud Reports (semi-annual)

1. Fraud cases investigated and closed (no fraud involved)
2. Fraud cases currently under investigation
3. Fraud cases confirmed and disposition of findings

Annual Reporting

After the completion of the Calendar Year, Contractor will meet with officials of the Division and the Division's consultant to review the Plan's claim experience. The following items may be included in the discussion:

- Medical Management- Management Summary Reports and Highlights
- Summary by Reporting Division. Displays amount paid by Commission, paid by employees, provider discounts, and COB savings.
- Claimant Characteristics (demographics)
- Experience by Diagnostic Grouping – Total Inpatient, Outpatient
- Claimant Cost Analysis By age and sex – All Records
- Large Claims report
- Summary Statistics By Type of Service – All Records
- Prescription drug claims summary
- Case management
- Plan Utilization compared to Contractor's book of business
- Report of estimated incurred but unpaid claims, administrative fees and amounts of outstanding checks as of June 30
- Annual Rate Renewal Report

Data Elements

a) Indicate by checking off in the blank column below which of the following categories can be reported upon request of the Commission.

Accident Code		Accident Date	
Adjustment Reason Code		Adjustment Type	
Admission Count UDB		Admission Date	
Allowable Charges		Amount Paid (Plan Payment)	
Benefit Cutoff Amount		Bill (Item) Number	
Capitation Payments		Claim Type	
Claim Count (Cases)		Claim Number	
Claim Sequence Number		COB Amount	
Coinsurance Amount		Coinsurance Percent	
Copayment Amount		Incentive/Bonus Payment	
Commercial Amount		Coinsurance Days	
Contract Type		CopaymentAmount	
Coverage Code		CPT-IV Code	
Deductible amount		Department Code	
Patient Relationship		Diagnosis Code (ICD-9)	
Tertiary Procedure Code		Secondary Procedure Code	
Diagnosis Class		Discharge Date	
Diagnosis Related Group No.		DRG Amount Paid	
Discharge Status Code		DRG Non-covered Charges	
DRG Outliner Indicator		Eligible Charges	
DRG Status Code		Financial Arrangement Code	
Fee Schedule Amount		Group Liability Amount	
Full Days		Hri Indicator	
Group Section Code		Input source Code	
Incurred Date		Item (Bill) charges	
Item Disposition Code		Main Group Number	
Last Incurred Date		Medical Savings Amount	
Medical Record Number		Method of Payment	
Message Code		Tertiary Diagnosis	
Method of Treatment		Paid Date YYMMDD Format	
Not Covered Amount		Patient's Birth Date	
Patient's Age		Patient's Last Name	
Patient's First Name		Patient's Sex	
Patient's Middle Initial		Place of Service	
Pay Code		Post Payment Indicator	
Post Payment Amount		Procedure Type Code	
Primary Procedure Code		Provider Network Indicator	
Professional Comp. Changes		Provider Name	
Provider Area Code		Provider Participating Status	

Provider County		Provider Number	
Provider Specialty Code		Record Code	
Provider Discount Amount		Self Referred Indicator	
Referral In-network Ind.		Service Count	
Service Code		Subscriber Employment Status	
Sub Group Number		Subscriber Last Name	
Subscriber ID Number		Total Bill (Item) Count	
Time Count		Unit Count	
Type of Service Code		Would Pay Amount	
Withhold Amount			

Additional Service Related Data Specific to Prescription Drugs

- Quantity of drugs dispensed
- Number of days supply
- Drug type-Formulary/Preferred Brand, Non-Formulary/Preferred Brand, Generic
- National Drug Code
- Drug name including strength
- Copayment amount
- Paid Amount
- Dispensing fees
- Specialty indicator
- Mail order indicator

State and Participating Employer Experience groups

Example of SHIPS Coverage groups

- State Monthly - Active
- State Bi-Weekly - Active
- State Monthly - Cobra with a separate RX plan
- State Bi-Weekly - Cobra with a separate RX plan
- State Monthly - Cobra without a separate RX plan (RX included with Medical)
- State Bi-Weekly - Cobra without a separate RX plan (RX included with Medical)
- State Monthly - Retirees Dependent or member Medicare
- State Bi-Weekly - Retirees Dependent or member Medicare
- State Monthly - Medicare only
- State Bi-Weekly - Medicare only
- State Monthly - Early Retirees
- State Bi-Weekly - Early Retirees
- Local Gov't - Active with a separate RX plan
- Local Gov't - Active without a separate RX plan (RX included with

Medical)
Local Gov't - Cobra with a separate RX plan
Local Gov't- Cobra without a separate RX plan (RX included with
Medical)
Local Gov't- Retirees Dependent or member Medicare
Local Gov't - Medicare only
Local Gov't - Early Retirees
Local Education - Active with a separate RX plan
Local Education - Active without a separate RX plan (RX included
with Medical)
Local Education - Cobra with a separate RX plan
Local Education - Cobra without a separate RX plan (RX included
with Medical)
Local Education - Medicare only
Local Education - Early retirees
Local Education - Retirees Dependent or member Medicare

note: Monthly cleared check subtotals will be needed by group by plan
A difference in co pay will require a separate group and subtotal

SECTION M

DATA ELEMENTS-UNIFIED PROVIDER DIRECTORY ALL CONTRACTS

Required Data Elements for Unified Provider Directory

PCP Identification # (if applicable)
State Medical License #
National Provider Identifier (NPI)
Last Name
First Name
Middle Initial
Degree
Gender
Medical Group
Address1
Address2
Address3
City
State
Zip
Phone
Practicing Specialty (ies)
Specialty (ies) in which Certified
Accepting New Patients
Languages Spoken
Hospital Affiliations
Residency (name of Hospital)
Medical School (name of school attended)
Graduation Year
Office Hours
Handicapped Accessible
Facility Name
Facility License Number
Facility Address1
Facility Address2
Facility Address3
Facility City
Facility State
Facility Zip
Facility Phone
Facility Plan type
Facility type

Clarifications

For "Residency" we expect to see the name of the hospital(s) where the residency (ies) took place.

For "Medical School" we expect to see the name of the graduate school attended, not the undergraduate school.

All fields should be completed. If a provider did not complete a residency program, that field must state "Did not complete a residency program."

If a plan subcontracts with another organization, the plan will be held accountable for any deficiencies in the data provided by the subcontractor; any cost incurred by the Division to correct the data will be charged back to the health plan; and any such charge will be independent of any performance penalties invoked by the Commission.

NOTE: The State License Number is **REQUIRED** to be submitted. Failure to submit 100% of these license numbers will result in the assessment of the **ENTIRE** performance guarantee percentage at risk. Providers whose records are submitted without license numbers will not be included in the data displayed on the UPD.

The National Provider Identifier (NPI) is **REQUIRED** to be submitted. Providers whose records are submitted without NPIs will not be included in the data displayed on the UPD.

SECTION N

CENSUS, Claims Utilization Data

CD TO BE SUPPLIED AT THE BIDDERS CONFERENCE

SECTION O

TECHNICAL INTERFACE

- 1 Plan Eligibility File
- 2 Conversion Report Requirements
- 3 Enrollment Audit File Layout
- 4 Daily Return File Layout
- 5 Employer File

**Documents for this section will be distributed
at the mandatory Bidder's Conference.**

SECTION P

DEFINITIONS

Administrative Services Fee (“ASO Fee”) - The fee for services paid by the Commission to the Contractor. The ASO Fee is the only compensation due the Contractor under the Contract. The Contractor’s monthly compensation is a function of the Contractor’s ASO Fee multiplied by the number of participating public employees/retirees.

Agreement - means this Administrative Services Agreement and the Exhibits attached hereto which are incorporated into and made a part of the Agreement.

Amendment - A change in the Scope of Work. An amendment is not effective until signed by the Contractor and the Director on behalf of the Commission.

Capitation – A method of paying for healthcare services on the basis of the number of patients who are covered for specific service over a specified period of time rather than the cost or number of services that are actually provided.

Claim – does not include network access fees or other fees charged as a percentage of savings.

Claim Record - means all documents, records, reports, data, related to the receipt, processing and payment of claims and all claim histories. This includes, but is not limited to, data recorded by the Contractor in its data processing systems.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C.A. 1161-1168.

Commission – see “State Health Benefits Commission”

Contract Effective Date – The date the Contract is signed by the Director and the Contractor.

Contract Manager – The individual assigned from the Division as the SHBP’s primary interface with the Contractor.

Contractor – Refers to a bidder who is awarded the contract(s).

Copayment – A fixed dollar amount paid by the Member to the Participating Provider

Coverage Date – The date that the Contractor is obligated to start processing claims on behalf of Members.

Director – Refers to the Director, Division of Pensions and Benefits.

Disease Management Programs – Programs developed to identify and categorize patients (especially those with chronic conditions) and to direct these patients towards a specific treatment protocol.

Division – Refers to the Division of Pensions and Benefits established pursuant to N. J.S.A. 52:18A-95. The Director of the Division is the Secretary to the Commission. The Division is responsible for the day to day administration of the SHBP on behalf of the Commission.

Health Maintenance Organization (HMO) – a healthcare system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area.

HIPAA – The Health Insurance Portability and Accountability act of 1996, 42 U.S.C.A. 1301 et seq. See Schedule D, “HIPAA Business Associate Agreement.”

Identification Card - means a wallet-size card issued by the Contractor identifying the individual named thereon as a member of the Plan. A Network Provider may ask any person claiming entitlement to Plan Benefits to identify him/herself by presenting his or her membership Identification Card. A toll-free number for the Contractor’s member Services will appear on the card.

Mail Order Service – A service designed for maintenance drugs taken by Members on a regular basis, such as medication to reduce blood pressure or treat asthma, diabetes, or any chronic heart condition.

May - denotes that which is permissible, not mandatory.

Medical Director - means a physician charged with the direction and management of the Contractor’s Provider Network.

Member - means an individual who meets the conditions for eligibility in the SHBP and who is enrolled in the Plan. It includes employees, retired employees, employees on approved leave of absence, their enrolled dependents; and qualified beneficiaries under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S. §§1161-1168 (“COBRA”) or similar state health benefit continuation laws.

Must- denotes a mandatory requirement. Failure to satisfy a mandatory requirement will result in the automatic rejection of a bid proposal as materially non-responsive.

Network Provider - means practitioners and providers of the healing arts; suppliers of tangible medical goods; and health care facilities that have directly, or through a third party, entered into a written agreement with the Contractor to provide one or more health care services to persons who have enrolled in the Plan.

Network Provider Contract - means a written agreement directly or indirectly through a third party, between the Contractor and a Network Provider or facility requiring the Network provider or facility to perform specific services, and to fulfill certain obligations in accordance with the terms of that agreement.

Parties - means the State Health Benefits Commission and the Contractor.

Participating Employers - means Employers, other than the State, participating in the SHBP in accordance with the law and rules governing the SHBP.

Preferred Provider Organization (PPO) – a healthcare benefit arrangement designed to supply services at a discounted cost by providing incentives for members to use designated healthcare providers (who contract with the PPO at a discount), but which also provides coverage for services rendered by healthcare providers who are not part of the PPO network.

Personally Identifiable Information - means any information that, if disclosed, would specifically identify an individual member, including but not limited to a member's name, address, social security number, member identification number, and telephone number.

Plan - refers to a specific plan under the SHBP such as the PPO or one of the HMO plans.

Plan Benefits - means payment for services to members rendered in accordance with the Plan.

Plan Document - means the document issued to each member, which describes the benefits, limitations and rights of membership under the Plan.

Plan Eligibility File - means the file created by the Commission and transmitted to the Contractor listing the names and other pertinent information necessary for the HMO to enroll a member and that member's dependents into the Plan, to terminate enrollment, or to make changes to existing member records.

Primary Care Physician or Primary Care Provider - means a physician engaged in general practice, family practice, internal medicine or pediatrics who, in accordance with an agreement with the Contractor provides basic health services to and arranges specialized services for those members who select him or her as their Primary Care Physician. In accord with the standards of the Contractor, the term may also encompass nurse practitioners/clinical nurse specialists operating within the scope of their respective licenses.

Program – The State Health Benefits Program (SHBP)

Provider - means an insurance company, hospital, medical, or health service corporation, or health maintenance organization under agreement or contract with the Commission.

Shall - denotes a mandatory requirement. Failure to satisfy a mandatory requirement will result in the automatic rejection of a bid proposal as materially non-responsive.

Should - denotes that which is recommended, not mandatory.

State Health Benefits Commission (Commission) – Refers to the entity created by N.J.S.A. 52:14-17.27 and charged with the responsibility of establishing and overseeing the State Health Benefits Program (SHBP). The Division of Pensions and Benefits administers the SHBP, N.J.S.A. 52: 14-17.25 et seq.

State Health Benefits Program (SHBP) – The health benefits program established pursuant to N.J.S.A. 52: 14-17.25 et seq.

Subscriber - An employee, retiree, any qualified dependent age 23 to 30 or COBRA participant who is enrolled in the SHBP.

Prescription Drug Definitions

Brand name - means the proprietary or trade name assigned to a drug product by the manufacturer or distributor of the drug product.

Generic drug products - means prescription drug products and insulin approved and designated by the U.S. Food and Drug Administration as therapeutic equivalents for reference listed drug products. It includes drug products listed in the New Jersey Generic Formulary by the Drug Utilization Review Council pursuant to *N.J.S.A. 24:6E-1* et seq.

Mail-order pharmacy means the mail order program available through the provider.

Preferred brands - means brand name prescription drug products and insulin determined by the provider, to be more cost effective alternatives for prescription drug products and insulin with comparable therapeutic efficacy within a therapeutic class, as defined or recognized in the United States Pharmacopeia or the American Hospital Formulary Service Drug Information, or by the American Society of Health Systems Pharmacists. A drug product for which there is no other therapeutically equivalent drug product must be a preferred brand. Determinations of preferred brands by the provider must be subject to review and modification by the Commission.

Prescription drug plan - means the plan for providing payment for eligible prescription drug expenses of retired members of the State Health Benefits Program and their eligible dependents .

Retail pharmacy - means a pharmacy, drug store or other retail establishment in this State at which prescription drugs are dispensed by a registered pharmacist under the laws of

this State, or a pharmacy, drug store or other retail establishment in another state at which prescription drug products are dispensed by a registered pharmacist under the laws of that state if expenses for prescription drug products dispensed at the pharmacy, drug store or other retail establishment are eligible for payment under the prescription drug plan.

Other brands - means prescription drug products which are not preferred brands or generic drug products. A new drug product approved by the U.S. Food and Drug Administration which is not a generic drug product must be included in this category until the provider makes a determination concerning inclusion of the drug product in the list of preferred brands.

SECTION Q

FORMS

(A) BIDDER DATA SHEET

(1) Bidder's Name/Address:

(2) Bidder's telephone number:

(3) Bidder's fax number:

(4) Bidder's E-mail address:

(5) Bidder's Federal Identification Number:

(6) Bidder agrees that, should the State Health Benefits Commission act to award a Contract(s) to the bidder, the attached Contract(s) and, by reference therein, Schedule A, "Standard Terms and Conditions," "Additional Contract Requirements", Schedule B, "Scope of Work", Schedule C, "Rates" and Schedule D, "HIPAA Business Associate Agreement" set forth the terms of the engagement.

Signature of Bidder's Authorized Representative

Print/type Name and Title

Date: _____

NEW JERSEY STATE HEALTH BENEFITS COMMISSION

Non-Disclosure Agreement

Pertaining to the Request for Proposal for:

- ***Preferred Provider Organization (PPO); and***
- ***Health Maintenance Organization (HMOs)***

This Agreement is made and entered into effective _____, 2007, between **(Vendor)**, whose office is located at _____ and The State Health Benefits Commission (**The Commission**), the governing body of the New Jersey State Health Benefits Program, whose office is located at 50 West State Street, Trenton, New Jersey 08625.

WHEREAS, all parties, for their mutual benefit, are desirous of having The Commission disclose to **(Vendor)** certain records and information or other business and/or technical information (collectively referred to herein as the "INFORMATION") related to the administration of the New Jersey State Health Benefits Program (SHBP).

WHEREAS, (Vendor) shall use the INFORMATION only for the purposes of responding to the above mentioned Request for Proposal from The Commission for the provision of health care services through a PPO and/or an HMO for the SHBP.

WHEREAS, the INFORMATION is proprietary to The Commission; and

WHEREAS, (Vendor) agrees that the INFORMATION shall be kept confidential.

NOW, THEREFORE, in consideration of the mutual promises made herein, **(Vendor)** and The Commission agree as follows:

1. **(Vendor)** shall hold such INFORMATION in confidence and shall use such INFORMATION only for assisting in preparation of the RFP.
2. **(Vendor)** shall reproduce such INFORMATION only to the extent necessary for the purpose of assisting in the preparation of the RFP and shall not disclose any such INFORMATION to any third party without prior written approval from The Commission.
3. **(Vendor)** shall not use such INFORMATION or results thereof for any purpose other than for the purpose of assisting in the preparation of the RFP.
4. The use or disclosure of INFORMATION shall not be prohibited by this Agreement in the following circumstances:
 - (a) The INFORMATION has become generally available to the general public without breach of this Agreement by (Vendor);
 - (b) The INFORMATION, which at the time of the disclosure to (Vendor) was known to (Vendor) free and clear of restriction and evidenced by documentation in (Vendor's) possession at the time of such disclosure; or

- (c) The Commission agrees in writing that the INFORMATION is free of the restriction as set forth in this Agreement.

(Vendor) agrees to hold The Commission and its representatives, and agents harmless from any and all claims (including claims for attorneys' fees and costs), charges, actions, causes of action, demands, settlements, judgments, costs, penalties, expenses, damages, and liabilities of any kind or character, in law or equity, suspected or unsuspected, past or present, arising from or in connection with (Vendor's) breach of any provision(s) of this Agreement.

All INFORMATION shall remain the property of The Commission.

- 5. This Agreement shall be governed by the laws of the State of New Jersey without regard to the conflict of laws principles thereof. All parties agree to comply with all applicable federal, state, and local laws regarding the divulgence of health care information.
- 6. All obligations undertaken herein to keep confidential the INFORMATION shall continue in effect until such time as The Commission no longer believes that the INFORMATION is proprietary.
- 7. This Agreement may be executed in counterparts and shall bind each party at the time of their execution of the Agreement.
- 8. This is the complete Agreement between the parties regarding the treatment of any INFORMATION exchanged between them.

IN WITNESS WHEREOF, each of the parties cause this Agreement to be executed by a duly-authorized representative.

SHBC

_____,2007
(Date)

by: _____
(Signature)

(Witness)

(Title)

(Vendor)

_____,2007
(Date)

by: _____
(Signature)

(Witness)

(Title)

REQUIRED FORMS

Additional forms required for the submission of bids for this RFP (and which are not included above in this section) are available at the following locations:

- Ownership Disclosure Form;
- Disclosure of Investigations and Actions Involving Bidder;
- MacBride Principles Certification; and
- Affirmative Action Employee Information Report or, in the alternative, a New Jersey Affirmative Action Certificate or evidence that the bidder is operating under a Federally-approved or sanctioned affirmative action program.

These forms are available in a single packet from the New Jersey Division of Purchase and Property at:

<http://www.state.nj.us/treasury/purchase/forms/StandardRFPForms.pdf>

- **Source Disclosure Certification Form/EO129.**

This form is available from the New Jersey Division of Purchase and Property at:

<http://www.nj.gov/treasury/purchase/forms/sdcert.pdf>

- **Tax Set-Off Form.**

This form is available from the New Jersey Division of Purchase and Property at:

<http://www.state.nj.us/treasury/purchase/forms/pbtax.pdf>

- Evidence of registration with the Division of Revenue, Department of the Treasury, State of New Jersey. Registration with the Division of Revenue is also required and can be done online at www.state.nj.us/treasury/revenue. Click on “Registering Your Business.”

