NEW JERSEY TURNPIKE AUTHORITY
REQUEST FOR PROPOSAL

FOR

SELF-FUNDED HEALTH BENEFITS PROGRAM SERVICES

RM-164138

APRIL 15, 2021

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SECTION I -- INTRODUCTION

Enclosed herewith is a Request for Proposal ("RFP") by the New Jersey Turnpike Authority ("Authority") for qualified healthcare provider(s) to administer one, all or a combination of the following Health Benefits plans for active Authority employees and eligible retirees ("Members"): 1) Medical, 2) Dental, 3) Pharmacy, 4) Vision, 5) COBRA, 6) Flexible Spending Accounts and 7) Health Spending Accounts (as further described in Section III, the "Services"). The target effective date of the program will be January 1, 2022 ("Effective Date"). The Scope of Services in Section III consists of five (5) sections (A-G) detailing each plan. The Proposal should detail the services to be provided, the provider's experience, personnel and any other relevant information relative to its capability to provide the services requested. Section VII is a questionnaire for each type of plan to be submitted by the Proposer(s).

The Successful Proposer (as hereinafter defined) will be awarded a Contract (the "Services Agreement") for a term of three (3) years, with the option to extend for two (2) one –year terms at the Authority's sole discretion.

The Authority seeks Proposals ("Proposals") from all interested and qualified providers ("Proposers"). Such Proposals must be responsive to all of the requirements of this RFP. The Authority intends to select one or more Proposer (s) (the "Successful Proposer(s)") to perform the Services based on the evaluation criteria set forth in Section IV.

The solicitation of Proposals is being conducted pursuant to the statutes and laws of the State of New Jersey, as found in *N.J.S.A.* 27:23-6.1, and Executive Order No. 37 (Corzine, 2006), and the regulations and policies of the Authority with regard to the procurement of professional services. Furthermore, Proposals are being solicited through a fair and open process in accordance with *N.J.S.A.* 19:44A-20.1, et seq. In addition, Proposers are required to comply with the Equal Employment Opportunity ("EEO") requirements of P.L. 1075, C.127 and *N.J.A.C.* 17:27.

Upon review of all Proposals, the Authority may request that one or more Proposers appear for an oral presentation focusing on how their proposed approach and solution will satisfy the requirements of this RFP. The Authority may limit the number of Proposers that can make oral presentations to permit efficient competition among the most highly rated Proposals. Should an oral presentation be requested, it will be an opportunity for each invited Proposer to introduce its staff to the Authority, address how the Proposer will provide the Services, and to present supplementary information regarding its Proposal and credentials as related to the specific needs of the Authority. The Proposer may use handouts, display boards, products and other materials during this oral presentation; provided, however, that the presentation will be restricted to a maximum time period specified by the Authority, including the time allotted for a question and answer period. Information relating to the Proposer's recent experience on similar assignments, approach to the Services and the use of innovative and/or cost effective measures should be included in the oral presentation.

Proposer(s) invited to make an oral presentation may submit a best and final offer ("BAFO") either during oral presentation or within **two (2)** business days following the presentation. The BAFO can modify any aspect of the Proposal provided the RFP requirements continue to be satisfied and provided further that the revised price Proposal of the BAFO is not higher than the original price Proposal.

After evaluating Proposals of those invited to make an oral presentation, an evaluation committee consisting of representatives of the Authority ("Evaluation Committee") may enter into negotiations with same. The primary purpose of negotiations is to maximize the Authority's ability to get the best value based on the requirements and evaluation criteria set forth in the RFP. Negotiations may involve the

identification of significant weaknesses ambiguities and other deficiencies in the Proposal, including price, which could preclude awarding a Services Agreement to the Proposer. More rounds of negotiations may be held with one Proposer than another. Negotiations will be structured to safeguard information and ensure that all Proposers in the competitive range are treated fairly.

After evaluation of the BAFO submissions and any subsequent negotiations, the Evaluation Committee will recommend to the Executive Director to award a Contract to the Proposer whose Proposal, conforming to the RFP, is most advantageous to the Authority, price and other factors considered. The Executive Director may accept, reject or modify the recommendation of the Evaluation Committee. The Executive Director may negotiate further reductions in price with the recommended Proposer.

Negotiations will be conducted only in those circumstances where they are deemed by the Authority to be in the Authority's best interests and to maximize the Authority's abilities to get the best value. Therefore, Proposers are advised to submit their best price Proposals in response to this RFP, because the Authority, may, after evaluation, make an award based solely on the content of these initial submissions, without further negotiations with the Proposer.

A DRAFT FORM OF THE SERVICES AGREEMENT IS ATTACHED. (See Appendix 1). ANY PROPOSED MODIFICATIONS TO THE SERVICES AGREEMENT MUST BE IDENTIFIED AND SUBMITTED WITH YOUR RESPONSE TO THIS RFP; OTHERWISE, BY SUBMISSION OF YOUR RESPONSE, YOU WILL BE DEEMED TO HAVE ACCEPTED THE SERVICES AGREEMENT ATTACHED HEREIN AND WILL BE FORECLOSED FROM NEGOTIATING ANY CHANGES TO THE SERVICES AGREEMENT.

End of Section I

SECTION II -- ADMINISTRATIVE AND CONTRACTUAL INFORMATION

A. PURPOSE

This RFP contains a Scope of Services (Section III) that outlines the Authority's needs.

B. PRE-PROPOSAL MEETING

A pre-proposal meeting will be conducted on April 22, 2021 commencing at 1:00 pm**.** The meeting will be held in the Board Room of the Authority's Administration Building, One Turnpike Plaza, Woodbridge, New Jersey 07095. Attendees will be provided with an overview of pertinent sections of the RFP as well as the opportunity to ask questions on the procurement.

Please notify Angela McNally in the Procurement and Materials Management Department of your intent to attend and the number of representatives planning to attend the pre-proposal meeting. Notify Angela McNally by via telephone 732-750-5300 Ext. 8628, or email mcnally@njta.com.

C. INQUIRIES

ONLY type-written inquiries concerning the RFP will be accepted. They should be directed to Dale Barnfield, Director, Procurement and Materials Management ("PMM") Department, New Jersey Turnpike Authority, P.O. Box 5042, Woodbridge, New Jersey 07095-5042. Inquiries by FAX or e-mail are acceptable. The FAX number is 732-750-5399. The email address is mcnally@njta.com. The inquiry deadline is **4:00 P.M. E.T., April 27, 2021**. Inquiries will not be entertained after this date and time.

A PROPOSER IS NOT PERMITTED TO MAKE INQUIRIES OF OR DISCUSS OR QUESTION ANY AUTHORITY EMPLOYEE, STATE EMPLOYEE OR COUNSEL OR CONSULTANT TO THE AUTHORITY ABOUT THIS RFP WHILE THIS RFP IS OUTSTANDING, EXCEPT AS OTHERWISE SET FORTH HEREIN. IT IS NOT APPROPRIATE FOR ANY PROPOSER TO CONTACT ANY AUTHORITY COMMISSIONER OR ANY STATE OFFICIAL OR EMPLOYEE DURING THE RFP PROCESS. FAILURE TO COMPLY WITH THIS GUIDELINE MAY RESULT IN DISQUALIFICATION OF THE PROPOSER.

All proposers must give notice in writing of their intent to propose using the form in Section III-E (Page 20) of this RFP. **Once the Authority and its representative ("Fairview Insurance Agency Associates") receive your form, you will be sent a link to the applicable data and summary plans descriptions for the lines of coverage you are proposing.**

D. CLOSING DATE

One (1) original and seven (7) copies of the Proposer's Proposal as well as one (1) electronic format proposal on flash drive must be received no later than **4:00 PM E.T., May 17, 2021** addressed to: Dale Barnfield, Director, Procurement and Materials Management Department as follows:

Regular Mail	OR	Federal Express or Other Overnight Delivery
New Jersey Turnpike Authority		New Jersey Turnpike Authority
P. O. Box 5042		One Turnpike Plaza
Woodbridge, NJ 07095		Woodbridge, NJ 07095

Proposals not delivered by the stated time and date shall not be considered unless the time is extended by the Authority pursuant to a written addendum issued by the Authority (the "Addendum").

Proposers mailing Proposals should allow for normal mail delivery time to ensure timely receipt of their RFP Responses. Please be advised that using overnight /next–day delivery service does not guarantee overnight/next-day deliveries to our location.

E. THE PROPOSALS

It is anticipated that the Proposal will provide a concise and precise delineation of the Proposer's ability to meet all of the requirements of the Authority as provided for in this RFP.

F. PROPOSER VS. CONSULTANT

The terms "Proposer" and "Consultant" are used frequently, and may be used interchangeably; however, "Proposer" is intended to identify the entity submitting a Proposal, while "Consultant" is the entity to whom a Services Agreement is awarded (also referred to as the Successful Proposer.)

G. SIGNATURES

Proposals must be signed by an officer authorized to make a binding commitment for the Proposer.

H. INCURRING COSTS

The Authority shall not be liable for any costs incurred by any Proposer in the preparation of its Proposal.

I. ADDENDUM TO RFP

If at any time prior to receiving Proposals it becomes necessary to revise any part of this RFP, or if the Authority determines that additional information is necessary to enable Proposers to adequately interpret the provisions of this RFP, the Authority will issue an Addendum to this RFP. Upon issuance, each such Addendum shall be deemed to be a part of this RFP.

J. ACCEPTANCE OF PROPOSALS

This RFP does not commit the Authority to make an award. The contents of the Proposal shall become a contractual obligation, if, in fact, a Proposal is accepted and a Services Agreement is entered into with the Authority. The Authority may award a Services Agreement solely on the basis of the Proposal submitted without any negotiations. The Authority reserves all rights to engage in negotiations as described in Section I if it deems it in its best interests. Failure of a Proposer to adhere to and/or honor any or all of the obligations of its Proposal may result in rescission of any award of Services Agreement by the Authority.

K. REJECTION OF PROPOSALS

The Authority reserves the right to reject any and all Proposals. The Authority shall not be obligated at any time to make an award to any Proposer.

L. FINAL AGREEMENT

Any Services Agreement entered into with a Successful Proposer shall be satisfactory to the Authority in accordance with the laws of the State of New Jersey. The provisions of the attached Services Agreement, not otherwise set forth in this RFP, are hereby incorporated into this RFP. It is understood that any Services Agreement that may be awarded will be on the basis of a professional agreement for services within the intent of the statutes and laws of the State of New Jersey, including, without limitations *N.J.S.A.* 27:23-6.1.

M. DISSEMINATION OF INFORMATION

Information included in this document or in any way associated with this RFP is intended for use only by the Proposer and the Authority and is to remain the property of the Authority. Under no circumstances shall any of said information be published, copied or used, except in replying to this RFP.

N. PUBLIC RECORDS

Any Proposal received from a Proposer in response to this RFP constitutes a public document that will be made available to the public upon request pursuant to New Jersey's Open Public Records Act, *N.J.S.A.* 47:1A-1 et seq. A Proposer may request the Authority's Director of Law to deem certain sections of its Proposal containing personal, financial or proprietary information non-disclosable, which determination shall be in accordance with such act.

O. NEWS RELEASES

No news releases pertaining to this RFP or any project to which it may relate shall be made without the Authority's approval.

P. **AFFIRMATIVE ACTION**

The Proposer must certify that it does not discriminate in the hiring or promotion of any minorities, as designated by the Equal Employment Opportunity Commission of the United States of America, or the Department of Civil Rights of the State of New Jersey; and that it does not discriminate against any person or persons on the basis of race, creed, age, color, sex, national origin, ancestry, marital status and affectional or sexual orientation or handicap.

In addition, the Proposer must complete the appropriate forms. The following are included in Section VI:

Exhibit A – Mandatory Equal Employment Opportunity Language
Exhibit B – Affirmative Action Information Sheet

However, if a Proposer maintains a current Letter of Federal Approval, or a current Certificate of Employee Information Report Approval as issued by the Department of the Treasury, State of New Jersey, it may be submitted in place of the State of New Jersey Affirmative Action Employee Information Report ("Form AA-302"). The appropriate form must be completed and submitted to

the Authority by the Successful Proposer immediately after being notified of award of the Agreement.

Q. SMALL BUSINESS AND DISABLED VETERAN OWNED BUSINESS ENTERPRISES REQUIREMENTS

It is the policy of the Authority that small businesses (each a "small business enterprise" or "SBE") as determined and defined by the State of New Jersey, Division of Minority and Women Business Development ("Division") and the New Jersey Department of the Treasury ("Treasury") should have the opportunity to participate in Authority contracts (*N.J.A.C.* 17:13-1.1, et seq.).

It is the policy of the Authority that disabled veteran owned businesses (each "disabled veteran owned business" or "DVOB") as determined and defined by the State of New Jersey, Department of Treasury, Division of Revenue and Enterprise Services should have the opportunity to participate in Authority contracts (*N.J.A.C.* 17:14-1.1, et seq.).

To the extent the Proposer engages subcontractors or sub-consultants to perform any of the Services for the Authority pursuant to the Services Agreement, the Proposer must demonstrate to the Authority's satisfaction that a good faith effort will be made to utilize subcontractors and sub-consultants who are registered with the Division as SBEs and DVOBs in the State of New Jersey.

As set forth in *N.J.A.C.* 17:13-4.3 and *N.J.A.C.* 17:14-4.3, a "good faith effort" is described as follows:

1. Proposers shall attempt to locate qualified potential small business subcontractors;

2. Proposers must obtain a listing of small businesses from the Treasury website if none are known to the Proposer;

3. Each Proposer shall keep a record of its efforts, including the names of businesses contacted and the means and results of such contacts;

4. Proposers shall provide all potential subcontractors with detailed information regarding the specifications; and

5. Proposers shall attempt, wherever possible, to negotiate prices with potential subcontractors submitting higher than acceptable price quotes.

Furthermore, the Proposer shall submit proof of its subcontractors' and/or sub-consultants' SBE registrations on the form attached as Exhibit K, if applicable, and shall complete such other forms as may be required by the Authority for reporting to the State of New Jersey as to SBE participation.

R. DIVISION OF REVENUE REGISTRATION

Pursuant to the terms of *N.J.S.A.* 52:32-44, the Successful Proposer is required to provide to the Authority proof of valid business registration with the Division of Revenue in the Department of the Treasury, prior to entering into an agreement with the Authority. **The Services Agreement shall not be entered into by the Authority unless the Proposer first provides proof of valid business registration.** In addition, the Successful Proposer is required to receive from any sub-

consultant it uses for goods and services under the Services Agreement, proof of valid business registration with the Division of Revenue and provide to the Authority proof thereof. The Authority shall not enter into a Services Agreement unless the sub-consultant first provides proof of valid business registration. Please include a copy of the Proposer's and any sub-consultants' Certificate of Registration with the Proposal submission. (Exhibit J).

All questions regarding this requirement should be referred to the Division of Revenue hotline at (609) 292-9292.

S. STATE POLITICAL CONTRIBUTIONS NOTICE: PUBLIC LAW 2005, CHAPTER 51 AND EXECUTIVE ORDER 117

The Successful Proposer will receive the applicable forms, Chapter 51 and E.O. 117, from the Authority's PMM Department to be completed and returned to the Authority for submission to the State Treasurer. Upon approval by the State Treasurer, the Authority will prepare a Service Agreement for execution**.** (Appendix 2)

T. AFFIDAVIT OF MORAL INTEGRITY

Together with the Proposal, the Proposer must submit an Affidavit of Moral Integrity on the form attached hereto for review by the Authority's General Counsel. (Exhibit C)

U. CODE OF ETHICAL STANDARDS

Applicants are advised that the Authority has adopted the New Jersey Uniform Code of Ethics ("Code"), a copy of which can be viewed by going to the following web site: http://nj.gov/ethics/docs/ethics/uniformcode.pdf. By submitting a response hereto, Proposer agrees to be subject to the intent and purpose of said Code and to the requirements of the New Jersey State ("State") Ethics Commission.

1. 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 any 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.

2. 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 shall be reported in writing forthwith by the vendor to the Attorney General and the Executive Commission on Ethical Standards.

3. 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 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 is employed or associated or in which he has an interest within the meaning of *N.J.S.A.* 52:13D-13g. Any relationships subject to this provision shall 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.

4. 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 his official capacity in any manner which might tend to impair the objectivity or independence of judgment of said officer or employee.

5. 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, his official position to secure unwarranted privileges or advantages for the vendor or any other person.

6. The provisions cited shall 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 promulgate as stated above.

V. TOLLS

It is the policy of the Authority not to offer toll free passage on its roadways for its contractors, providers or vendors. See *N.J.S.A.* 27:23-25 and *N.J.A.C.* 19:9-1.19.

W. PROPOSALS BECOME PROPERTY OF THE AUTHORITY

All Proposals shall become the property of the Authority upon receipt and will not be returned.

X. RIGHT TO AUDIT CLAUSE

The Successful Proposer shall keep and maintain proper and adequate books, records and accounts accurately reflecting all costs and amounts billed to the Authority with regard to this RFP. The Authority, its employees, officers, or representatives shall have the right upon written request and reasonable notice, to inspect and examine all books and records related to the Successful Proposer's books and records specific to the Proposal and Agreement. Such records shall be retained by Successful Proposer for at least five (5) years after termination of the Service Agreement. In no event shall books and records be disposed of or destroyed prior to five (5) years or during any dispute or claim between the Authority and the Successful Proposer with regard to the RFP.

In accordance with the New Jersey Office of the State Comptroller ("OSC") document retention policy *N.J.S.C.* 17:44-2.2, relevant records of private vendors or other persons entering into contracts with the Authority are subject to audit or review by the New Jersey Office of the State Comptroller. Therefore, the Successful Proposer shall maintain all documentation related to products, transactions or services under this Agreement for a period of five (5) years from the date of final payment. Such records shall be made available to the New Jersey Office of the State Comptroller upon request.

Y. OWNERSHIP DISCLOSURE FORM

Each Proposer shall return to the Authority with its Proposal a completed, Ownership Disclosure Form set forth as Exhibit D. Failure to include the completed and signed form may be grounds for rejection of a Proposers' Proposal.

Z. VENDOR DISCLOSURE FORM N.J.S.A. 52:34-13.2

Pursuant to *N.J.S.A.* 52:34-13.2, every Contract entered into by the Authority primarily for the performance of services shall specify that all services performed under the Contract or performed under any subcontract awarded under the Contract shall be performed within the United States. The statute requires all Proposers to disclose the origin and location of the performance of their services, including any subcontracted services that are the subject matter of the Contract. Each Proposer shall return to the Authority with its Proposal completed, dated and certified Vendor Disclosure Form set forth as Exhibit E.

AA. NOTICE TO ALL PROPOSERS OF SET-OFF FOR STATE TAX

Each Proposer shall return to the Authority with its Proposal a signed and dated "Notice of Set-Off for State Tax" set forth as Exhibit G which advises Proposers of the State of New Jersey's right to set-off any tax indebtedness from payments made under agreements with the Authority.

BB. AFFIDAVIT OF NON-COLLUSION

Each Proposer shall return to the Authority with its Proposal a completed, dated, signed and witnessed Affidavit of Non-Collusion set forth as Exhibit I. Failure to include the completed and signed form may be grounds for rejection of a Proposer's Proposal.

CC. DISCLOSURE OF INVESTMENT IN IRAN

Pursuant to *N.J.S.A.* 52:32-58, the Proposer must certify that neither the Proposer, nor one of its parents, subsidiaries, and/or affiliates (as defined in *N.J.S.A.* 52:32-56(e)(3)), is listed on the Department of the Treasury's List of Persons or Entities Engaging in Prohibited Investment Activities in Iran and that neither is involved in any of the investment activities set forth in *N.J.S.A.* 52:32-56(f). If the Proposer is unable to so certify, the Proposer shall provide a detailed and precise description of such activities. Each Proposer shall return to the Authority with its Proposal the completed dated form entitled "Disclosure of Investment Activities in Iran" as set forth in Exhibit F. Failure to include the completed and signed form may be grounds for rejection of Proposer's Proposal.

DD. LIABILITIES TO THE AUTHORITY

In the event of any liabilities and debts of the Proposer to the Authority, whether or not related to the Services that are unpaid past their due date at the time the Proposal was submitted, a Proposer's Proposal will be rejected.

EE. PROPOSAL SCHEDULE

Closing Date for Submission of Inquiries (4:00 PM, E.T.)	April 27, 2021
Closing Date of Receipt of Proposals (4:00 PM, E.T.)	May 17, 2021
Oral Presentation [Tentative]	Week of June 7, 2021
Tentative Commission Approval	June 22, 2021

End of Section II

SECTION III – SCOPE OF SERVICES

A. ORGANIZATION AND FUNCTION OF THE NEW JERSEY TURNPIKE AUTHORITY

The Authority owns and operates the New Jersey Turnpike, the Garden State Parkway and owns the PNC Bank Arts Center. It was created by the New Jersey Turnpike Authority Act of 1948, as amended and supplemented by N.J.S.A. 27:23-1 et seq. (the "Act"). The Act authorizes the Authority to construct, maintain, repair, and operate the New Jersey Turnpike, to collect tolls, and to issue Turnpike revenue bonds or notes, subject to approval of the Governor. On May 27, 2003, the Act was amended to empower the Turnpike to assume all powers, rights, obligations and duties of the New Jersey Highway Authority, which owned and operated the Garden State Parkway and owns the PNC Bank Arts Center. The Authority Board of Commissioners consists of eight members: five members appointed by the Governor, one appointed by the Governor upon the recommendation of the President of the Senate, one appointed by the Governor upon recommendation of the Speaker of the General Assembly, and the Commissioner of the State Department of Transportation. At this time, the Commissioner of the Department of Transportation serves as Chair of the Authority.

The Authority employs approximately 2,000 full-time employees of which 1,850 currently participate in the health and welfare benefit programs. The Authority has eight (8) unions for full-time employees and these unions cover about 96% of the 2,000 employees. The Authority also offers health coverage to eligible retirees and survivors of which approximately 2,300 participate.

The Authority also administers the vision and dental benefit programs for a small group of approximately 275 active employees and 75 retirees of the South Jersey Transportation Authority ("SJTA"). The South Jersey Transportation Authority operates and maintains the Atlantic City Expressway and the Atlantic City International Airport. Although part of the overall contract, the SJTA maintains its own benefit structure and separate banking agreements for all funding.

Authority employees and some retirees contribute to the cost of their health plans. The Authority currently contracts with Horizon Blue Cross Blue Shield, CVS/Caremark, Delta Dental and EyeMed Vision for third party claims administration and access to managed care networks for the Authority's self-funded medical, pharmacy, dental and vision plans respectively. The Authority pays Horizon, Delta Dental, and CVS/Caremark a per employee per month (PEPM) fee for administrative services. CVS/Caremark is also paid a per claim transaction fee for claims administration services. In addition, the Authority's COBRA and Direct Billing services are administered by HealthEquity/WageWorks. These contracts expire on December 31, 2021.

B. GENERAL INFORMATION

The New Jersey Turnpike Authority ("Authority") is soliciting Proposals from qualified healthcare provider(s) to administer one or more of seven (7) health benefits plans for the Authority's active employees and eligible retirees. The Effective Date of the program will be no later than January 1, 2022. The scope of services to be performed is expressly set forth in this Section III herein.

The seven (7) health benefits plans for which the Authority is soliciting Proposals to administer are as follows:

a) Medical

b) Dental

c) Vision

d) Prescription Drugs

e) COBRA

f) Flexible Spending Account ("FSA")

g) Health Savings Accounts ("HSA")

The Proposals for the medical, prescription drug, COBRA, FSA and HSA benefits (in **bold** above) are for the Members of the Authority only. The Proposal for the administration of dental and vision benefits will include Members of both the Authority and the South Jersey Transportation Authority ("SJTA Members"). **The Scope of Services in this Section is intended to outline the request of the Authority. Questionnaires for each of the seven (7) plan designs are contained in Section VII and must be submitted for each plan for which you want to be considered.**

C. GENERAL SCOPE

The Authority requests a Contract with an expected Effective Date of January 1, 2022. The resulting Contract(s) will be for a term of three (3) years with an option at the Authority's sole discretion to extend for two (2) additional one year extensions. Based on the Proposals received, the Authority will select one (or more) firms to perform the Services. The successful firm(s) will be based on the evaluation criteria described in Section IV herein.

The Scope of this RFP consists of five (5) sections (A, B, C, D and EFG) one for the Medical, Dental, Vision and Prescription health benefits plans, and one combined for COBRA, FSA and HSA in addition to as well as plan documents, census file and questionnaires. Proposers are advised to carefully read and review every component of this RFP.

Detailed descriptions of current plan designs will be provided upon receipt of the Intent to Propose Form. There are currently multiple plan designs offered, many of which are grandfathered plans, closed to new enrollment. Please propose based on administering ALL the in-force plan designs. Claims and enrollment history will also be provided upon receipt of the Intent to Propose Form.

Please refer to the Authority's website, https://www.njta.com for current information relating to organizational structure, functions and financial data.

Specific submission instructions are in Section IV of this RFP.

D. GENERAL PROPOSAL CONDITIONS

Below are the general requirements for submitting Proposals:

1. **Oral Explanations**: The Plan Sponsor ("Authority") will not be bound by oral explanations or instructions given by a Proposer before or after the award of the Contract.

2. **Time for Acceptance**: The Proposer(s) agrees to be bound by its Proposal for a period of at least 180 days, during which time the Plan Sponsor may request clarification of the Proposal for the purpose of evaluation. Late Proposals may not be accepted.

3. **Exceptions**: Any exceptions to terms, conditions, or other requirements in any part of these specifications must be clearly pointed out in the appropriate section of the Proposal. Otherwise, it will be considered that all items offered are in strict compliance with the

specifications. Amendments or clarifications shall not affect the remainder of the Proposal, but only the portion so amended or clarified.

4. **General Compliance**: All Proposer(s) services must adhere to relevant federal and state laws and regulations, including the Patient Protection and Affordable Health Care Act (PPACA or ACA) of 2010, as applicable.

5. **HIPAA Compliance**: All Proposer(s) systems and services must be in compliance with the HIPAA EDI, Privacy and Security regulations as well as the HITECH Act on the appropriate dates established by the Department of Health & Human Services.

E. INTENT TO PROPOSE FORM

All proposers must respond in writing of their intent to propose using the form on the following page. **Once the Authority and its representative ("Fairview Insurance Agency Associates") receive your form, you will be sent a link to the applicable data and summary plan descriptions for the lines of coverage you are proposing.**

F. SUBMISSION OF MULTIPLE COVERAGES

For those Proposers providing responses for more than one coverage, please provide bundled and unbundled pricing.

Intent to Propose Form for the New Jersey Turnpike Authority

Please return this acknowledgement form to the attention of those noted below by the indicated date. Your cooperation in returning this form promptly is appreciated **whether or not you are going to respond to the RFP.**

Attention:

Name:	**Dale Barnfield**
Address:	New Jersey Turnpike Authority, One Turnpike Plaza, Woodbridge, NJ 07095
E-mail:	dbarnfield@njta.com and copy mcnally@njta.com
Name:	**Joseph Graham**
Address:	Fairview Insurance Agency Associates, 25 Fairview Avenue, Verona, NJ 07044
E-mail:	jagraham@fairviewinsurance.com

Request for Proposal

Client Name:	New Jersey Turnpike Authority

This is to advise that we have received the above referenced RFP.

☐	We ***will*** be submitting a Proposal in response to this RFP. Please check all that apply: ☐Medical Claims Administration ☐Dental Claims Administration ☐Prescription Drug Administration ☐Vision Claims Administration ☐COBRA Administration ☐FSA Administration ☐HSA Administration
☐	We ***will not*** be submitting a Proposal in response to this RFP.
	Click here to enter text.

Contact Name:			
Title:			
Firm Name:			
Address:			
Telephone:			
Fax:			
E-mail:			
Signature:		**Date:**	

G. TIMETABLE

The following is the **proposed** timetable for the RFP process:

Task	Target Date
a. RFP Advertisement Date	April 15, 2021
b. Pre-Proposal Meeting	April 22, 2021
c. RFP Vendor Inquiries Due	April 27, 2021
d. Response to Inquiries Due	May 3, 2021
e. Response to Proposals Due	May 17, 2021
f. Oral Presentations (tentative)	Week of June 7
g. Best and Final Offers Due (tentative)	Week of June 14
h. Commission Approval (tentative)	June 22, 2021

SECTION III A – MEDICAL

A. GENERAL REQUIREMENTS

The Authority seeks Proposals from qualified healthcare provider(s) that can offer cost effective services with minimal disruption of member access to a national network. The Authority is seeking Proposals that duplicate the current Medical benefit plan designs, effective no later than January 1, 2022.

Please review this section thoroughly to determine your ability to meet these requirements. After the end of the questionnaire in Section VII A ("Questionnaire VII A"), you will find an *Acknowledgment and Statement of Exceptions Form* for your completion. If you are unable to meet any of the following requirements, you must note or reference them on that form. *That form must be returned with your Proposal.*

Your responses to Questionnaire VII A, the completed Acknowledgment and Statement of Exceptions Form (Attachment 1A in Section VII A) will constitute the essence of your Proposal and should be made in writing. Also, please note the following:

1. **References.** In Section VII A, you will be asked to provide a listing of three (3) Public Sector client references.

2. **Commissions**

   a. First Year: **None**

   b. Second Year and Subsequent Years: **None**

3. **Funding.** The Authority is interested in remaining under an Administrative Services Only ("ASO") Contract. The Authority currently provides its employees and eligible retirees with the following medical coverage types: a gated Point of Service ("POS"), Direct Access ("DA") POS, gated Health Maintenance Organization ("HMO"), Exclusive Provider Network ("EPO"), and Indemnity. Proposers need to be able to administer each type of plan on an "equal to or better than" benefit basis.

4. **Implementation.** The Successful Proposer(s) must be able and fully committed to support the Authority with all aspects of the implementation process. To this end, your Proposal must include a detailed implementation timetable and key task checklist. The Effective Date is no later than January 1, 2022.

5. Stay current on legal and regulatory changes affecting all plans and debit cards, and conduct internal audits of operations to assure compliance with policies and procedures.

B. CONFIDENTIALITY

The Authority requests that this document be kept in strictest confidence, and it is only under adherence to this request that we are delivering this document to the prospective Proposer(s). This document may be shared only within your organization for purposes of preparing your Proposal. As such, this document may not be copied or reproduced for other purposes without prior written consent and will not be disclosed to third parties to whom the Authority has not previously consented. The Authority and its representative, Fairview Insurance Agency Associates ("Fairview"), will keep all Proposals strictly confidential and will only use them in connection with this RFP.

C. REQUIRED CONTRACT PROVISIONS

The successful proposal must contain the following provisions:

1. **Maintenance and Ownership of Records**. Your company will be required to maintain all pertinent records related to the services provided under the Contract for five (5) years. This is in conjunction with prudent business practice and ERISA provisions. Your company would be charged with the safekeeping of plan experience information and, in the event of Contract termination, would be required to cooperate with the Authority, or their representative, in the orderly transfer of this plan experience information to the Authority or its designated succeeding health plan/provider. This data is owned by the Authority.

2. **Right to Audit**. The Authority reserves the right to review and audit the health plan's files and financial accounting data to ensure that claims that are subject to each proposed coverage are evaluated and paid in accordance with the plan's provisions. The Authority will require a comprehensive data file for use by an internal or external audit firm.

3. **Effective Date and Plan Anniversary**. On or about January 1, 2022 is the proposed Effective Date and anniversary thereafter. Please guarantee your quotes for this Effective Date

4. **Renewal Notification**. The health plan must provide notice of any rate changes in writing with full justification at least *180 days* prior to a Contract anniversary. The long lead-time is required due to the annual budget pricing, communications, and administration requirements associated with the Authority's benefit program.

5. **Variance Provision.** Any provisions, references, or guidelines relating to reevaluation of proposed rates due to variation in enrollment in the plan must not be included as a condition of your Proposal.

6. **Performance Guarantee.** As the Authority's Claims Administrator, you must agree to meet certain performance guarantees between the Authority and your company. The objective of the Performance Guarantees is not to reduce your client revenue by invoking penalties but rather to reinforce your verbal and written assurances of quality service with tangible measurements. Guarantees are client specific and reporting needs to be based on Authority only. At a minimum, this performance guarantee(s) must include, but is not limited to:

    a. Objective accuracy benchmarks and associated penalties for failure to consistently meet the following measurements:
        1) Member satisfaction
        2) Appointments wait time
        3) Network Access (Percentage open panels/taking new patients)
        4) Healthcare Effectiveness Data and Information Set ("HEDIS") & Consumer Assessment of Healthcare Providers and Systems ("CAHPS") performance measures
        5) Initial implementation and enrollment process
        6) On-time delivery of periodic and annual reports and delivery of information or notifications to the Authority.

    b. A subjective service measurement or measurements that will be solely determined by the Authority; and

    c. A level of financial risk to the Proposer.

7. **Staffing.** Proposer shall employ sufficient and appropriately trained dedicated staff, familiar with administering your proposed plan of benefits, to meet the service specifications outlined herein and subsequently detailed in a Performance Standards Agreement that would be executed between the Authority and your company.

    a. Benefit Staff shall include a dedicated Account Management staff that is always available during normal business hours. This Account Management team will meet with the Authority once a week to discuss the status of the program. It will be required for the Account Management team to make on-site visits at least once a month.

    b. Benefit Staff shall include a dedicated Claims Account Manager that will handle claim issues as designated by the Authority.

    c. Benefit Staff shall include a dedicated enrollment representative for processing electronic enrollment reports and work with Authority staff to address errors.

8. **Enrollment Materials.** Proposer shall be responsible for initial direct mailing of ID cards to all members, along with a copy of the applicable Summary Plan Document as part of the implementation process. Thereafter, and for the duration of the Agreement between the Proposer and the Authority, the Proposer shall maintain responsibility for direct mailing of ID cards and applicable Summary Plan Documents to all newly enrolled members and to all members who, pursuant to benefit actions, are moved into a different plan design and/or group/sub-group.

9. **Claims Funding and Reporting**:

    a. Claims to be funded by weekly wire transfer.

    b. Proposer must agree to replicate the existing account structure.

    c. Proposer must agree to the following requirements into the service agreement: Initial imprest fund, and future requests for increases to the imprest fund, shall be subject to mutual agreement, however- under no circumstances - shall be an amount exceeding the average weekly (seven consecutive calendar days') claims cost.

    d. Proposer must support weekly claims invoices with detail claim back-up reports in an editable format, the sums of which must reconcile to the totals of the previous/associated wire fund requests. The invoices and supporting detail will begin on the first of the month and end on the last day of the month. **See Appendix 3 for minimum required detail needed for weekly/monthly claims invoices.**

    e. All wires and reports must be itemized – with subtotals – by account structure. Monthly report can be aggregate or by account structure (account structure preferred).

    f. Proposer must be able to provide access to claim and utilization reports electronically.

    g. Standard reports must be archived indefinitely or available to be downloaded electronically from your site.

10. **Indemnity Run-In**. The incumbent carrier will pay run-out on incurred medical claims prior to the Effective Date. Your responsibility will be to provide services for claims incurred on or after the Effective Date only. Successful Proposer will also be responsible for coordinating historical information to address plan benefit accumulators for services incurred prior to the Effective Date.

11. **Eligibility Questions**. Communicate directly with the Authority staff regarding any uncertain claimant eligibility situations before notifying the claimant directly of an ineligible status.

12. **Member Inquiries and Requests**. Respond to all inquiries and requests made by the Authority's Members with a sense of urgency. Updated directories are to be mailed directly to the members upon request. Phone calls and all correspondence are to be handled by a reasonable number of service personnel who have been trained in the area of customer service and who are familiar with the Authority's programs.

13. **Phone Service.** An 800-telephone number is to be available for all members.

14. **System Capacity**. Maintain sufficient system capacity to meet the service specifications outlined herein and subsequently in the Agreement(s) between your company and the Authority.

15. **On-Line Historical Data**. Maintain at least three years of the Authority's claim (all fields indicated on the UB & HCFA) and eligibility information at all times.

16. **Client Notification of System Problems.** Notify the Authority if your claim system experiences, or is scheduled to experience delays or shut down that either: a) exceeds your internal standards in this area, or b) would have an adverse impact on claim payment or customer service.

17. **Turnaround Time**. Reimburse all clean claims (where all the necessary information is provided to make a benefit or reimbursement determination) to both providers and members within 14 calendar days or 10 business days. This should include all claims submitted for in-house reviews.

18. **Pended Claims**. Make available, upon request, reports regarding the number and nature of claims pended, if your organization is processing the claims.

19. **Telephone Quality Assurance (QA)**. Monitor the activity of the phones with emphasis on the frequency of busy lines and hold times and provide the Authority with periodic management information regarding the phone activity including, if possible, the number or frequency of all connected calls, unsuccessful or busy calls, calls placed on hold, the average duration of hold time, and some information indicating the general nature of member inquiries beyond merely anecdotal accounts.

20. **Internal Audit**. Conduct regular and diligent client-specific internal audits to monitor quality and communicate the findings of these audits and similar QA procedures to the Authority no less frequently than semi-annually.

21. **External Audit**. Cooperate with any outside audit firm the Authority selects to perform a claim administration audit. Such audit may require a comprehensive data file to facilitate electronic analyses and might include the provision of space and system terminals for a reasonable period of time to accomplish the audit objectives.

22. **Communication Materials**. The Authority must approve of all communication materials before forwarding to the members. Materials will be bilingual (English and Spanish).

23. **Plan Reporting**. Plan reports shall be available online. The online system should provide Authority with specific reports/data files, including but not limited to:

    a. Monthly, by plan—Medical—paid claim reports/files with year-to-date accruals broken down by member, spouse and children. These reports should give dollar and claim

incidence totals and identify network versus non-network experience. These reports/files should also include all information found on a UB or HCFA form;

b. Service and diagnostic specific reports capturing all multiple diagnoses for example, (primary, secondary) submitted by provider.

c. Utilization data including but not limited to: inpatient census, outpatient census, prior authorization approvals and denials, case management, concurrent reviews;

d. Lag report that identifies claims by incurred month to include all information found on a UB or HCFA form;

e. Monthly turnaround time statistics for the previous month's claims; and

f. Monthly claims files with all payment fields to be provided to the Authority.

24. **ERISA Claims and Appeals Regulations:** Where applicable, all Proposer(s) must be compliant with ERISA Claims and Appeals Regulations.

SECTION III B – DENTAL

A. GENERAL REQUIREMENTS

The Authority seeks Proposals from qualified healthcare provider(s) that can offer cost effective services with minimal disruption of member access to a national network. The Authority is seeking Proposals that duplicate the current Dental benefit plan designs, effective no later than January 1, 2022.

Please review this section thoroughly to determine your ability to meet these requirements. After the end of Section VII B you will find an *Acknowledgment and Statement of Exceptions Form* for your completion. If you are unable to meet any of the following requirements, you must note or reference them on that form. *That form must be returned with your Proposal.*

Your responses to Questionnaire, the completed Acknowledgment and Statement of Exceptions Form (Attachment 1B in Section VII B) will constitute the essence of your Proposal and should be made in writing. Also, please note the following:

1. **References**. In Section VII B, you will be asked to provide a listing of three (3) Public Sector client references.

2. **Commissions**.

   a. First Year: **None**

   b. Second Year and Subsequent Years: **None**

3. **Funding.** The Authority is interested in remaining under an ASO Contract. Please confirm your ability to administer the three existing programs on an "equal to or better than" basis.

4. **Implementation.** The Successful Proposer(s) must be able and fully committed to support the Authority with all aspects of the implementation process. To this end, your Proposal must include a detailed implementation timetable and key task checklist. The estimated Effective Date is no later than January 1, 2022.

5. Stay current on legal and regulatory changes affecting all plans and debit cards, and conduct internal audits of operations to assure compliance with policies and procedures.

B. CONFIDENTIALITY

The Authority requests that this document be kept in strictest confidence, and it is only under adherence to this request that we are delivering this document to the prospective Proposer(s). This document may be shared only within your organization for purposes of preparing your Proposal. As such, this document may not be copied or reproduced for other purposes without prior written consent and will not be disclosed to third parties to whom the Authority has not previously consented. The Authority and its representative, Fairview Insurance Agency Associates, will keep all Proposals strictly confidential and will only use them in connection with this RFP.

C. REQUIRED CONTRACT PROVISIONS

The Successful Proposal must contain the following provisions:

1. **Maintenance and Ownership of Records**. Your company will be required to maintain all pertinent records related to the services provided under the Contract for five (5) years. This is in conjunction with prudent business practice and ERISA provisions. Your company would be charged with the safekeeping of plan experience information and, in the event of Contract termination, would be required to cooperate with the Authority, or their representative, in the orderly transfer of this plan experience information to the Authority or its designated succeeding health plan/carrier. This data is owned by the Authority.

2. **Right to Audit**. The Authority reserves the right to review and audit the health plan's files and financial accounting data to ensure that claims that are subject to each proposed coverage are evaluated and paid in accordance with the plan's provisions. The Authority will require a comprehensive data file for use by an external audit firm.

3. **Effective Date and Plan Anniversary**. On or about January 1, 2022, (please guarantee your Proposals) is the proposed Effective Date and anniversary thereafter.

4. **Renewal Notification**. The health plan must provide any rate changes in writing with full justification at least *180 days* prior to a Contract anniversary. The long lead-time is required due to the annual budget pricing, communications, and administration requirements associated with the Authority's benefit program.

5. **Variance Provision.** Any provisions, references, or guidelines relating to reevaluation of proposed rates due to variation in enrollment in the plan must not be included as a condition of your Proposal.

6. **Performance Guarantee.** As the Authority's Claims Administrator, you must agree to meet certain performance executed between the Authority and your company. The objective of the Performance Guarantees is not to reduce your client revenue by invoking penalties but rather to reinforce your verbal and written assurances of quality service with tangible measurements. Guarantees are client specific and reporting needs to be based on Authority only. At a minimum, this performance guarantee(s) must include, but is not limited to:

    a. Objective accuracy benchmarks and associated penalties for failure to consistently meet but not limited to the following measurements:
        1) Member satisfaction
        2) Appointments wait time
        3) Network Access (Percentage open panels/taking new patients)
        4) Initial implementation and enrollment process
        5) On-time delivery of periodic and annual reports and delivery of information or notifications to the Authority.

    b. A subjective service measurement or measurements that will be solely determined by the Authority; and

    c. A level of financial risk to the Proposer.

7. **Staffing.** Proposer shall employ sufficient and appropriately trained dedicated staff, familiar with administering your proposed plan of benefits, to meet the service specifications outlined herein and subsequently detailed in a performance standards agreement that would be executed between the Authority and your company.

    a. Benefit Staff shall include a dedicated Account staff that is always available during normal business hours. This Account Management team will meet with the Authority

once a week to discuss the status of the program. It will be required for the Account Management team to make on-site visits at least once a month.

b. Benefit staff shall include a dedicated Claims Account Manager that will handle claim issues designated by the Authority.

c. Benefits staff shall include a dedicated enrollment representative for processing electronic enrollment reports and work with Authority staff to address errors.

8. **Enrollment Materials.** Proposer shall be responsible for initial direct mailing of ID cards to all members, along with a copy of the applicable Summary Plan Document as part of the implementation process. Thereafter, and for the duration of the Agreement between the Proposer and the Authorities, the proposer shall maintain responsibility for direct mailing of ID cards and applicable Summary Plan Documents to all newly enrolled members and to all members who, pursuant to benefit actions, are moved into a different plan design and/or group/sub-group.

9. **Claims Funding and Reporting**:

a. Claims to be funded by weekly wire transfer.

b. Proposer shall maintain separate accounts and banking agreements for the Authority and the SJTA, with all reporting broken out accordingly.

c. Proposer must be willing to replicate the existing account structure.

d. Proposer must agree to the following requirements in the Service Agreement: Initial imprest fund and future requests for increases to the imprest fund, shall be subject to mutual agreement, however- under no circumstances – shall be an amount exceeding the average weekly (seven consecutive calendar days') claims cost.

e. Proposer must support weekly claims invoices with detail claim back-up reports in an editable format separated by Authority/SJTA, the sums of which must reconcile to the totals of the previous/associated wire fund requests. The Invoices and supporting detail will begin on the first of the month and end on the last day of the month. **See Appendix 4 for minimum required details needed to support weekly claims invoices.**

f. All wires and reports must be itemized – with subtotals – by account structure. Monthly report can be aggregate or by account structure (account structure preferred).

g. Proposer must be able to provide Authority/SJTA access to claim and utilization reports electronically.

h. Standard reports must be archived indefinitely or available to download electronically from your site.

10. **Indemnity Run-In**. The incumbent carrier will pay run-out on incurred dental claims prior to the Effective Date. Your responsibility will be to provide services for claims incurred on or after the Effective Date only. Successful Proposer will also be responsible for coordinating historical information to address plan benefit accumulators for services incurred prior to the Effective Date.

11. **Eligibility Questions**. Communicate directly with the Authority staff regarding any uncertain claimant eligibility situations before notifying the claimant directly of an ineligible status.

12. **Member Inquiries and Requests**. Respond to all inquiries and requests made by the Authority's Members with a sense of urgency. Updated directories are to be mailed directly to the members upon request. Phone calls and all correspondence are to be handled by a reasonable number of

service personnel who have been trained in the area of customer service and who are familiar with the Authority's programs.

13. **Phone Service.** An 800-telephone number is to be available for all members.

14. **System Capacity**. Maintain sufficient system capacity to meet the service specifications outlined herein and subsequently in the agreement(s) between your company and the Authority.

15. **On-Line Historical Data**. Maintain at least three years of the Authority's claim and eligibility information at all times.

16. **Notification of System Problems.** Notify the Authority if your claim system experiences, or is scheduled to experience delays or shut down that either: a) exceeds your internal standards in this area, or b) would have an adverse impact on claim payment or customer service.

17. **Turnaround Time**. Reimburse all clean claims (where all the necessary information is provided to make a benefit or reimbursement determination) to both providers and members within 14 calendar days or 10 business days. This should include all claims submitted for in-house reviews.

18. **Pended Claims**. Make available, upon request, reports regarding the number and nature of claims pended, if your organization is processing the claims.

19. **Telephone Quality Assurance (QA)**. Monitor the activity of the phones with emphasis on the frequency of busy lines and hold times. Provide the Authority with periodic management information regarding the phone activity including, if possible, the number or frequency of all connected calls, unsuccessful or busy calls, calls placed on hold, the average duration of hold time, and some information indicating the general nature of member inquiries beyond merely anecdotal accounts.

20. **Internal Audit**. Conduct regular and diligent client-specific internal audits to monitor quality. Communicate the findings of these audits and similar QA procedures to the Authority no less frequently than semi-annually.

21. **External Audit**. Cooperate with any outside audit firm the Authority selects to perform a claim administration audit. Such audit may require a comprehensive data file to facilitate electronic analyses and might include the provision of space and system terminals for a reasonable period of time to accomplish the audit objectives.

22. **Communication Materials**. The Authority must approve will require prior approval of all communication materials before forwarding to the members. Materials will be bilingual (English and Spanish).

SECTION III C – VISION

A. GENERAL REQUIREMENTS

The Authority seeks Proposals from qualified healthcare provider(s) that can offer cost effective services with minimal disruption of member access to a national network. The Authority is seeking Proposals that duplicate the current Vision benefit plan designs, effective January 1, 2022.

Please review this section thoroughly to determine your ability to meet these requirements. After the end of Section VII C you will find an *Acknowledgment and Statement of Exceptions Form* for your completion. If you are unable to meet any of the following requirements, you must note or reference them on that form. *That form must be returned with your Proposal.*

Your responses to the Questionnaire, the completed Acknowledgment and Statement of Exceptions Form (Attachment 1C in Section VII C) will constitute the essence of your Proposal and should be made in writing. Also, please note the following:

1. **References**. In Section VII C, you will be asked to provide a listing of three (3) Public Sector client references.

2. **Commissions.**

   a. First Year: **None**

   b. Second Year and Subsequent Years: **None**

3. **Funding.** The Authority is interested in remaining under an ASO Contract. Please confirm your ability to administer the two existing programs on an "equal to or better than" basis.

4. **Implementation**. The Successful Proposer(s) must be able and fully committed to support the Authority with all aspects of the implementation process. To this end, your Proposal must include a detailed implementation timetable and key task checklist. The estimated Effective Date is no later than January 1, 2022.

5. Stay current on legal and regulatory changes affecting all plans and debit cards, and conduct internal audits of operations to assure compliance with policies and procedures.

B. CONFIDENTIALITY

The Authority requests that this document be kept in strictest confidence, and it is only under adherence to this request that we are delivering this document to the prospective Proposer(s). This document may be shared only within your organization for purposes of preparing your Proposal. As such, this document may not be copied or reproduced for other purposes without prior written consent and will not be disclosed to third parties to whom the Authority has not previously consented. The Authority and its representative, Fairview Insurance Agency Associates, will keep all Proposals strictly confidential and will only use them in connection with this RFP.

C. REQUIRED CONTRACT PROVISIONS

The Successful Proposal must contain the following provisions:

1. **Maintenance and Ownership of Records**. Your company will be required to maintain all pertinent records related to the services provided under the Contract for five (5) years. This is

in conjunction with prudent business practice and ERISA provisions. Your company would be charged with the safekeeping of plan experience information and, in the event of Contract termination, would be required to cooperate with the Authority, or their representative, in the orderly transfer of this plan experience information to the Authority or its designated succeeding health plan/carrier. This data is owned by the Authority.

2. **Right to Audit**. The Authority reserves the right to review and audit the health plan's files and financial accounting data to ensure that claims that are subject to each proposed coverage are evaluated and paid in accordance with the plan's provisions. The Authority will require a comprehensive data file for use by an external audit firm.

3. **Effective Date and Plan Anniversary**. No later than January 1, 2022, (please guarantee your Proposals) is the proposed Effective Date and anniversary thereafter.

4. **Renewal Notification**. The health plan must provide any rate changes in writing with full justification at least *180 days* prior to a Contract anniversary. The long lead-time is required due to the annual budget pricing, communications, and administration requirements associated with the Authority's benefit program.

5. **Variance Provision.** Any provisions, references, or guidelines relating to reevaluation of proposed rates due to variation in enrollment in the plan must not be included as a condition of your Proposal.

6. **Performance Guarantee.** As the Authority's Claims Administrator, you must agree to serve the Authority and its staff under the terms of a performance executed between the Authority and your company. The objective of the Performance Guarantees is not to reduce your client revenue by invoking penalties but rather to reinforce your verbal and written assurances of quality service with tangible measurements. Guarantees are client specific and reporting needs to be based on Authority only. At a minimum, this performance guarantee(s) must include, but is not limited to:

    a. Objective accuracy benchmarks and associated penalties for failure to consistently meet the following measurements:
        1) Member satisfaction
        2) Appointments wait time
        3) Network Access (Percentage open panels/taking new patients)
        4) Initial implementation and enrollment process
        5) On-time delivery of periodic and annual reports and delivery of information or notifications to the Authority.

    b. A subjective service measurement that will be solely determined by the Authority; and

    c. A level of financial risk to the Proposer.

7. **Staffing.** Proposer shall employ sufficient and appropriately trained dedicated staff, familiar with administering your proposed plan of benefits, to meet the service specifications outlined herein and subsequently detailed in a performance standards agreement that would be executed between the Authority and your company.

    a. Benefit Staff shall include a dedicated Account Management staff that is always available during normal business hours. This Account Management team will meet with the Authority once a week to discuss the status of the program. It will be required for the Account Management team to make on-site visits at least once a month.

b. Benefit Staff shall include a dedicated Claims Account Manager that will handle claim issues as designated by the Authority.

c. Benefit Staff shall include a dedicated enrollment representative for processing electronic enrollment reports and work with Authority staff to address errors.

8. **Enrollment Materials.** Proposer shall be responsible for initial direct mailing of ID cards to all members, along with a copy of the applicable Summary Plan Document as part of the implementation process. Thereafter, and for the duration of the Agreement between the Proposer and the Authorities, the Proposer shall maintain responsibility for direct mailing of ID cards and applicable Summary Plan Documents to all newly enrolled members and to all members who, pursuant to benefit actions, are moved into a different plan design and/or group/sub-group.

9. **Claims Funding and Reporting:**

a. Claims to be funded by weekly wire transfer.

b. Proposer shall maintain separate accounts and banking agreements for the Authority and the SJTA, with all reporting broken out accordingly.

c. Proposer must be willing to replicate the existing account structure.

d. Proposer must be willing to include the following requirements into the service agreement: Initial imprest fund, and future requests for increases to the imprest fund shall be subject to mutual agreement, however- under no circumstances - shall be an amount exceeding the average weekly (seven consecutive calendar days') claims cost.

e. Proposer must support weekly claims invoices with detail claim back-up reports in an editable format separated by Authority/SJTA, the sums of which must reconcile to the totals of the previous/associated wire fund requests. The Invoices and supporting detail will begin on the first of the month and end on the last day of the month. **See Appendix 5 for minimum required detail needed to support weekly claims invoices.**

f. All wires and reports must be itemized – with subtotals – by account structure. Monthly report can be aggregate or by account structure (account structure preferred).

g. Proposer must be able to provide Authority/SJTA access to claim and utilization reports electronically.

h. Standard reports must be archived indefinitely or available to be downloaded electronically from your site.

10. **Indemnity Run-In**. The incumbent carrier will pay run-out on incurred medical claims prior to the Effective Date. Your responsibility will be to provide services for claims incurred on or after the Effective Date. Successful Proposer will also be responsible for coordinating historical information to address plan benefit accumulators for services incurred prior to the Effective Date.

11. **Eligibility Questions**. Communicate directly with the Authority staff regarding any uncertain claimant eligibility situations before notifying the claimant directly of an ineligible status.

12. **Member Inquiries and Requests**. Respond to all inquiries and requests made by the Authority's Members with a sense of urgency. Updated directories are to be mailed directly to the members upon request. Phone calls and all correspondence are to be handled by a reasonable number of service personnel who have been trained in the area of customer service and who are familiar with the Authority's programs.

13. **Phone Service.** An 800-telephone number is to be available for all members.

14. **System Capacity**. Maintain sufficient system capacity to meet the service specifications outlined herein and subsequently in the Agreement(s) between your company and the Authority.

15. **On-Line Historical Data**. Maintain at least three years of the Authority's claim and eligibility information at all times.

16. **Client Notification of System Problems.** Notify the Authority if your claim system experiences, or is scheduled to experience delays or shut down that either: a) exceeds your internal standards in this area, or b) would have an adverse impact on claim payment or customer service.

17. **Turnaround Time**. Reimburse all clean claims (where all the necessary information is provided to make a benefit or reimbursement determination) to both providers and members within 14 calendar days or 10 business days. This should include all claims submitted for in-house reviews.

18. **Pended Claims**. Make available, upon request, reports regarding the number and nature of claims pended, if your organization is processing the claims.

19. **Telephone Quality Assurance (QA)**. Monitor the activity of the phones with emphasis on the frequency of busy lines and hold times. Provide the Authority with periodic management information regarding the phone activity including, if possible, the number or frequency of all connected calls, unsuccessful or busy calls, calls placed on hold, the average duration of hold time, and some information indicating the general nature of member inquiries beyond merely anecdotal accounts.

20. **Internal Audit**. Conduct regular and diligent client-specific internal audits to monitor quality. Communicate the findings of these audits and similar QA procedures to the Authority no less frequently than semi-annually.

21. **External Audit**. Cooperate with any outside audit firm the Authority selects to perform a claim administration audit. Such audit may require a comprehensive data file to facilitate electronic analyses and might include the provision of space and system terminals for a reasonable period of time to accomplish the audit objectives.

22. **Communication Materials**. The Authority must approve prior approval of all communication materials before forwarding to the members. Materials will be bilingual (English and Spanish)

SECTION III D – PRESCRIPTION DRUG

A. GENERAL

The Authority seeks Proposals from qualified Pharmacy Benefit Managers ("PBMs") that can offer cost effective services with minimal disruption of member access to a national network of retail pharmacies. The Authority is seeking Proposals that duplicate the current prescription drug benefit plan designs, effective no later than January 1, 2022. The PBM will also need to provide Medicare Part D subsidy support services (i.e., the PBM services will require coordination, data sharing, and reporting to CMS).

A Pass-through/Transparent pricing Proposal is requested for the Prescription Drug Plan. The pricing arrangements will be evaluated based on guaranteed discounts, fees, and minimum rebates.

The Plan will evaluate each Proposal considering the following criteria. These criteria are components of Section VII D Evaluation Factors and Criteria:

1. Overall Costs to the Plan and its members
2. Administrative, Member, Account Service Capabilities (that are not limited to services already included), Responsiveness and Flexibility
    a. PBM will be required to dedicate a qualified Account Management team that can meet weekly for telephonic status meetings and monthly for on-site meetings.
3. Clinical Support to the Plan
4. Demonstrated Ability to Manage Drug Mix – emphasis on specialty drug management, formulary management and generic utilization
5. Organizational Strength and Stability
6. Strength of Pharmacy Network and Formulary Management Programs
7. Demonstrated ability to provide consistent and superior customer service
8. Advancing Patient Safety and Population Health
9. Retiree Drug Subsidy and Medicare Prescription Drug Plan Services
10. Ability to administer a Medicare Part D Employer Group Waiver Program

B. OVERVIEW AND BACKGROUND

The current prescription drug benefit copayments are as follows:[1]

Retail / Mail Order Maximum 30 / 90 Days Supply			100 PILLS OR 30 DAYS SUPPLY (Whichever is Greater) AT RETAIL / 100 PILLS OR 90 DAYS SUPPLY (Whichever is greater) AT HOME DELIVERY								
RXACF/R RX PLAN DESIGN			RXC1A/R RX PLAN DESIGN			RXVF1/R RX PLAN DESIGN			RXC1 RX PLAN DESIGN		
	Retail	Home Delivery		Retail	Home Delivery		Retail	Home Delivery		Retail	Home Delivery
Generic	$3	$0	Generic	$3	$5	Generic	$3	$5	Generic	$5	$5
Formulary Brand	$10	$15	Single Source Brand	$10	$15	Single Source Brand	$10	$15	Single Source Brand	$5	$5
Formulary Brand	$10	$15	Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	$10	$15	Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	N/A	N/A	Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	$5	$5
Non-Formulary Brand	$25	$40	Multi-Source Brand	$25	$40	Multi-Source Brand	N/A	N/A	Multi-Source Brand	$15	$15
Multi-Source Brand (MSB) with Generic Available	$3 Copay + Cost Differential for MSB	$40	Multi-Source Brand and Member Requests MSB (MSB and DAW2)	$25	$40	Multi-Source Brand and Member Requests MSB (MSB and DAW2)	N/A	N/A	Multi-Source Brand and Member Requests MSB (MSB and DAW2)	$15	$15
OOP Max (Single/Family)	$1,000 / $2,000		OOP Max (Single/Family)	$1,000 / $2,000		OOP Max (Single/Family)	$1,000 / $2,000		OOP Max (Single/Family)	N/A	
Dispense as Written Penalties apply			"DAW1" => Physician does not want Generic Substituted for Brand Name; "DAW2" => Physician is OK with Generic Sustitution, but Member insists on Brand Name								

100 PILLS OR 30 DAYS SUPPLY (Whichever is Greater) AT RETAIL / 100 PILLS OR 90 DAYS SUPPLY (Whichever is greater) AT HOME DELIVERY											
RXC2 RX PLAN DESIGN			RXC3 RX PLAN DESIGN			RXC4 RX PLAN DESIGN			RXC5 RX PLAN DESIGN		
	Retail	Home Delivery		Retail	Home Delivery		Retail	Home Delivery		Retail	Home Delivery
Generic	$5	$0	Generic	$5	$0	Generic	$10	$10	Generic	0%	0%
Single Source Brand	$5	$0	Single Source Brand	$5	$0	Single Source Brand	$10	$10	Single Source Brand	0%	0%
Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	$5	$0	Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	$5	$0	Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	$10	$10	Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	0%	0%
Multi-Source Brand	$5	$0	Multi-Source Brand	$10	$0	Multi-Source Brand	$20	$20	Multi-Source Brand	10%	10%
Multi-Source Brand and Member Requests MSB (MSB and DAW2)	$5	$0	Multi-Source Brand and Member Requests MSB (MSB and DAW2)	$10	$0	Multi-Source Brand and Member Requests MSB (MSB and DAW2)	$20	$20	Multi-Source Brand and Member Requests MSB (MSB and DAW2)	10%	10%
OOP Max (Single/Family)	N/A		OOP Max (Single/Family)	N/A		OOP Max (Single/Family)	N/A		OOP Max (Single/Family)	N/A	
"DAW1" => Physician does not want Generic Substituted for Brand Name; "DAW2" => Physician is OK with Generic Sustitution, but Member insists on Brand Name											

100 PILLS OR 30 DAYS SUPPLY (Whichever is Greater) AT RETAIL / 100 PILLS OR 90 DAYS SUPPLY (Whichever is greater) AT HOME DELIVERY											
RXCD1 RX PLAN DESIGN			RXC15 RX PLAN DESIGN			RXC51 RX PLAN DESIGN			RXC6 RX PLAN DESIGN		
	Retail	Home Delivery		Retail	Home Delivery		Retail	Home Delivery		Retail	Home Delivery
Generic	$1	$0	Generic	$1	$1	Generic	$5	$5	Generic	$10	$0
Single Source Brand	$1	$0	Single Source Brand	$1	$1	Single Source Brand	$5	$5	Single Source Brand	$10	$0
Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	$1	$0	Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	$1	$1	Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	$5	$5	Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	$10	$0
Multi-Source Brand	$1	$0	Multi-Source Brand	$5	$5	Multi-Source Brand	$10	$10	Multi-Source Brand	$20	$0
Multi-Source Brand and Member Requests MSB (MSB and DAW2)	$1	$0	Multi-Source Brand and Member Requests MSB (MSB and DAW2)	$5	$5	Multi-Source Brand and Member Requests MSB (MSB and DAW2)	$10	$10	Multi-Source Brand and Member Requests MSB (MSB and DAW2)	$20	$0
OOP Max (Single/Family)	N/A		OOP Max (Single/Family)	N/A		OOP Max (Single/Family)	N/A		OOP Max (Single/Family)	N/A	
"DAW1" => Physician does not want Generic Substituted for Brand Name; "DAW2" => Physician is OK with Generic Sustitution, but Member insists on Brand Name											

[1] There is also a grandfathered group of retirees, whose pensions became effective on or before January 1, 1984, that are eligible for prescription drug benefits as follows: $5 copay for generic drugs and $10 copay for brand drugs at retail, $10 copay for generic drugs and $20 copay for brand drugs at mail. Point-of-sale rebates are not applicable for this group of grandfathered retirees.

100 PILLS OR 30 DAYS SUPPLY (Whichever is Greater) AT RETAIL / 100 PILLS OR 90 DAYS SUPPLY (Whichever is greater) AT HOME DELIVERY		
RXC1B/R RX PLAN DESIGN		
	Retail	Home Delivery
Generic	$3	$3
Single Source Brand	$50	$100
Multi-Source Brand with Dispensed as Written from the Physician (MSB and DAW1)	$50	$100
Multi-Source Brand	$50	$100
Multi-Source Brand and Member Requests MSB (MSB and DAW2)	$50	$100
OOP Max (Single/Family)	$1,000 / $2,000	
"DAW1" => Physician does not want Generic Substituted for Brand Name;		
"DAW2" => Physician is OK with Generic Sustitution, but Member insists on Brand Name		

Specialty prescriptions can be obtained either at retail pharmacies or through the Specialty Pharmacy Program at mail. The Plan participates in prior authorization, step therapy, quantity limitations and exclusions apply to some drugs.

C. REQUIRED PROPOSAL CONDITIONS

Please note that these instructions are to be read and followed by each Proposer(s) and that failure to follow these instructions may result in rejection of a Proposal offer for non-responsiveness.n**o Commissions** are to be included and all Proposals must be submitted directly from the contracting company, without any intermediary.

1. **Eligibility Rules:** The Proposer(s) agrees to the specified eligibility rules established by the Authority for covered parties.
2. **Rights to Claims Data:** All claims data is the property of the Plan Sponsor and must be returned upon request.
3. **Notice of Supplier Change**: The Proposer(s) must agree to 90-day advance notice of any changes in suppliers such as specialty pharmacy, mail-order facility and/or other products and services.
4. **Full Disclosure:** The Proposer(s) must fully disclose any and all sub-contracted work and off-shoring services (e.g., Member services, Call Centers, etc.)

D. CONFIDENTIALITY

The Authority requests that this document be kept in strictest confidence, and it is only under adherence to this request that we are delivering this document to the prospective Proposer(s). This document may be shared only within your organization for purposes of preparing your Proposal. As such, this document may not be copied or reproduced for other purposes without prior written consent and will not be disclosed to third parties to whom the Authority has not previously consented. The Authority and its representative, Fairview Insurance Agency Associates, will keep all Proposals strictly confidential and will only use them in connection with this RFP.

E. ADDITIONAL REQUIREMENTS FOR PRESCRIPTION DRUG

In order for your Proposal to be considered and accepted, your organization must provide answers to the questions presented in Section VII D of this RFP. Each question must be answered specifically and in detail. Reference should not be made to a prior response or to your Contract unless the question involved specifically provides such an option. Be sure to review this entire RFP before responding to any of the questions so that you have a complete understanding of all of the Plan's requirements with respect to the Proposal.

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

1. Provide an answer to each question even if the answer is "not applicable" or "unknown."
2. Answer the question as directly as possible.
   a. If the question asks "How many…" provide a number.
   b. If the question asks, "Do you…" indicate Yes or No followed by any additional narrative explanation.
3. Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments. However, direct responses to all of the RFP questions must be provided and will be looked upon favorably.
4. Proposer(s) will be held accountable for accuracy/validity of all answers.

If you are unable to perform any required service, indicate clearly: a) what you are currently unable to do, and, b) what steps will be taken (if any) to meet the requirement, the timetable for that process and who will be responsible for the implementation, along with that person's qualifications.

All products should be priced individually. If pricing terms are provided for combining services, show the pricing terms as a separate line item.

Financial Section: When displaying your proposed fees, the tables in the Financial Section included in this RFP must be used. Please note that pricing terms should be offered on a Hybrid Transparent basis. **Information provided in any other format will not be considered.** Footnotes to the form(s) may be used to provide supplemental explanations, if necessary.

Network & Formulary Disruption: Both a network and formulary disruption analysis are necessary in order to award a final Contract. The lack of disruption from the current network and formularies will be a major factor affecting the outcome of this proposing process. In order to be considered, your organization must provide data regarding your network and contracted pharmacies. **In addition, the basis of this evaluation will be the evaluation of your organization's formulary products and how they compare to the Authority's incumbent prescription drug program. The Authority currently incorporates CVS Caremark's Standard, Advance Control and Value formulary products.**

F. PBM SERVICES TO BE PROVIDED

A number of factors will be considered in the selection process. The primary factors include pricing, pharmacy network access, formulary management and formulary disruption, contractual compliance, account management services, reporting capabilities, financial stability, performance guarantees, flexibility, references, clinical programs, and customer service. Also, see Section IV Evaluation Factors and Criteria.

All Proposer(s) are required, at a minimum, to duplicate the plan features and levels of coverage presently offered to the Plan. The Authority will consider only proposed programs that provide an equal or better program from a cost, quality and service perspective.

Prospective vendors are to offer comprehensive PBM services including but not limited to the following:

1. Claims Adjudication
2. Ability to Integrate PBM services with other vendors (Pharmacy, Disease Management, Medical), if applicable
3. Eligibility Maintenance
4. Patient and Provider Education
5. Systematic Prospective, Concurrent, and Retrospective Drug Utilization Review
6. Network Pharmacy Management
7. Formulary Management and Rebate Sharing
8. Data Reporting (standard and ad-hoc reporting)
9. Distribution/Direct Mailing of ID Cards, applicable summary plan documents and Pharmacy Directories to all current and future enrollees for the life of the Contract
10. Mail Service Pharmacy
11. Specialty Pharmacy Program
12. Complete Availability of IT services, including Online/Real Time Availability to the Plan and/or its designee(s)
13. Pricing Administration
14. Member Services
15. Website with Membership Portal
16. Clinical Programs
17. Medicare Part D Retiree Drug Subsidy Services
18. Fully Insured or Self-Funded Medicare Part D Employer Group Waiver program option
19. Stay current on legal and regulatory changes affecting all plans and debit cards, and conduct internal audits of operations to assure compliance with policies and procedures.

SECTION III E F G – COBRA, FSA AND HSA

A. GENERAL

The Authority is seeking an administrator for its COBRA, FSA and HSA programs. On the Questionnaire in Section VII EFG you will indicate which lines of business you are submitting Proposals for and provide separate responses for each.

1. The Successful Proposer shall provide the following administration services, as follows:
    a. Provide properly staffed offices and provide all necessary facilities to carry out administrative duties.
        1) Assign an account representative/manager who will be familiar with day-to-day operations for the Authority and will be available to resolve problems and provide information to administration, Board of Commissioners, Consultant and Counsel.
        2) Apply plan provisions in a consistent, accurate manner.
        3) Implement plan rules (new/changes) adopted by the Board within a reasonable period.
        4) Provide debit card(s) and manage all debit card transactions.
        5) Maintain complete, accurate and detailed records for each member.
        6) Maintain records of all transactions under the Agreement during the term of the Agreement and subsequent periods in compliance with applicable Federal regulations.
        7) Provide online access to debit card account balance information via a secure Internet portal both to members and authorized Authority staff.
        8) Stay current on legal and regulatory changes affecting all plans and debit cards, and conduct internal audits of operations to assure compliance with policies and procedures.
2. In addition, the Successful Proposer shall provide the following additional services if selected for administration services:
    a. Process member requests for reimbursement according to Plan and IRS rules.
    b. Maintain records of individual account contributions (as provided by the Authority\), payments of benefits to, and resulting account balances of members and dependents and report the same to the Authority in a format and frequency acceptable to the Authority.
    c. Prepare and mail to participating employees quarterly and year end reports of all transactions (account contributions as reported by the Authority as well as benefits paid) made on behalf of participating employees under the Plan.
    d. Create, print, and stock all necessary forms to carry out plan operations.
3. The Successful Proposer shall provide the Authority with the information in its custody for use in preparing all returns and reports required by the Internal Revenue Service, the Department of Labor and any other federal or state agency. The Successful Proposer shall assist in the preparation of such returns and reports whenever called upon to do so by the Authority.
4. The Successful Proposer shall provide the following additional services:
    a. Provide support to the Authority in its efforts to promote employee use of debit cards and other information via direct outreach and other educational campaigns.

b. Provide employee communications material in ready-to-print format such as newsletter articles or similar informational materials, web-access to transactional information, new member welcome letters and informational packets, etc.

c. Stay current on legal and regulatory changes affecting the benefits and advise the Authority of any regulatory, legal, or procedural change requirements.

d. Handle the intake and review of all customer service inquiries.

B. INTERFACE WITH AUTHORITY

The Successful Proposer(s) shall provide "turn-key" services and perform all necessary administrative functions as requested in this RFP. The Authority will interact with the Successful Proposer(s) and provide appropriate support, as follows:

1. Determine eligibility and provide enrollment information to Successful Proposer.

2. Transmit contribution information to Successful Proposer(s), at the end of each contribution period.

3. Perform contribution money transfers to Successful Proposer.

4. Perform discriminatory testing.

SECTION IV – RFP RESPONSE, SUBMISSION REQUIREMENTS & EVALUATION FACTORS AND CRITERIA

A. GENERAL

1. A Proposal is requested from the Proposer(s). The Proposal shall detail the Proposer's experience, personnel, proposed scope and approach, and any other relevant information.

2. All portions of this RFP and the Proposal are considered to be part of the Services Agreement to be entered into between the Authority and the Successful Proposer (s) and shall be incorporated therein by reference.

B. PROPOSALS

The Scope of Services (Section III) is intended to outline the Authority's needs for services. Please provide your response in accordance with the detailed scope. The Proposal should thoroughly define the Proposer's approach to the Services for each line of coverage included within your submission.

Required Components of the Proposal:

1. **Executive Summary**. Provide an executive summary of not more than one page identifying and sustaining the basis of your contention that you are the best qualified firm to provide the requested services to the Authority.

2. **Proposal Contact Information**. Provide the name, title, business address, e-mail address, telephone number and fax number of the individual the Authority should contact regarding your Proposal.

3. **Brief Description of Firm**. Provide a brief description of your firm, its ownership structure and its state/country of incorporation or formation. Describe your firm's physical presence in the State of New Jersey, including the number of offices, the number of employees and the type of business activity conducted in the State. Also, please describe the participation of women and minorities in your firm. Please indicate the percentage of your firm that is owned by women and minorities.

4. **Services Liaison and Staff Information**. Set forth fully the anticipated assigned liaison contact, professional and sub-professional staff to be used in providing the Services. Individual's background and resumes should be included, as well as their anticipated respective functions and responsibilities. Sufficient responsible and professional personnel, with complete and capable supporting staff, must be provided to perform the Services.

5. **Conflicts of Interest.** Identify any existing or potential conflict of interest, or any relationships that might be considered a conflict of interest, that may affect or involve the provisions of Services to the Authority, including but not limited to conflicts with financial advisors, law firms providing services to the State or the Authority and State employees or Authority employees.

6. **Litigation, Investigations, Audits.** Describe any pending, concluded or threatened litigation, administrative proceedings or federal or state investigations or audits, subpoenas, or other information requests of or involving your firm or the owners, principals or employees thereof during the period beginning January 1, 2016 through the date of the Proposal. Describe the nature and status of the matter and the resolution, if any.

7. **Check List Documents**. All the documents listed in the (Check List in Section VI) must be submitted in order for a Proposal to be considered responsive to this RFP.

8. **Financial Information**. Proposers shall provide copies of audited financial statements or federal income tax returns for their firm for the past three years as well as any other financial documents indicated herein. Also, Proposers are encouraged to provide current independent financial ratings from New Jersey State and nationally recognized/consensus rating bureaus (e.g. AM Best, Moody's, Standard & Poor's), if applicable.

9. **Section VII Questionnaire(s).** Submit the relevant completed questionnaire from Section VII herein for each line of coverage for which you are proposing to provide services.

10. Vendor confirms that your organization has complied with all state insurance department filing requirements for all plans/products being offered in this quote in each state in which the Authority has employees.

11. Vendor agrees to monitor federal and state legislation affecting the delivery of healthcare benefits under the plan and to report to the Authority on those issues in a timely fashion prior to the effective date of any mandated plan changes.

C. SUBMISSION REQUIREMENTS

The Proposer's completed Proposal, including all applicable checklists, questionnaires and forms, should be submitted as detailed below. Cost Proposals should be submitted separate from the technical component for each line of coverage that is being proposed.

1. Medical

Proposers are required to submit one (1) original, seven (7) hardcopy completed Proposals and one (1) electronic proposal on a flash drive directly to the Authority. In addition, one hard copy and one electronic version should be sent directly to Fairview Insurance Agency Associates to the following attention. Please submit the electronic copy in Microsoft Word, not a PDF:

Mr. Dale Barnfield
Director, PMM
New Jersey Turnpike Authority
P.O. Box 5042
One Turnpike Plaza
Woodbridge, NJ 07095-5042
dbarnfield@njta.com

Mr. Joseph Graham
Fairview Insurance Agency Associates
25 Fairview Avenue
Verona, NJ 07042
jagraham@fairviewinsurance.com

2. Dental

Proposers are required to submit one (1) original, seven (7) hardcopy completed Proposals and one (1) electronic proposal on a flash drive directly to the Authority. In addition, one hard copy and one electronic version should be sent directly to Fairview Insurance Agency Associates to the following attention. Please submit the electronic copy in Microsoft Word, not a PDF:

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Verona, NJ 07042
jagraham@fairviewinsurance.com

Woodbridge, NJ 07095-5042
dbarnfield@njta.com

3. Vision

Proposers are required to submit one (1) original, seven (7) hardcopy completed Proposals and one (1) electronic proposal on a flash drive directly to the Authority. In addition, one hard copy and one electronic version should be sent directly to Fairview Insurance Agency Associates to the following attention. Please submit the electronic copy in Microsoft Word, not a PDF:

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Mr. Joseph Graham
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Verona, NJ 07042
jagraham@fairviewinsurance.com

4. Prescription Drug

Proposers are required to submit one (1) original, seven (7) hardcopy completed Proposals and one (1) electronic proposal on a flash drive directly to the Authority. In addition, one hard copy and one electronic version should be sent directly to Fairview Insurance Agency Associates to the following attention. Please submit the electronic copy in Microsoft Word, not a PDF:

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jagraham@fairviewinsurance.com

5. Cobra

Proposers are required to submit one (1) original, seven (7) hardcopy completed Proposals and one (1) electronic proposal on a flash drive directly to the Authority. In addition, one hard copy and one electronic version should be sent directly to Fairview Insurance Agency Associates to the following attention. Please submit the electronic copy in Microsoft Word, not a PDF:

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Mr. Joseph Graham
Fairview Insurance Agency Associates
25 Fairview Avenue
Verona, NJ 07042
jagraham@fairviewinsurance.com

6. FSA

Proposers are required to submit one (1) original, seven (7) hardcopy completed Proposals and one (1) electronic proposal on a flash drive directly to the Authority. In addition, one hard copy and one electronic version should be sent directly to Fairview Insurance Agency Associates to the following attention. Please submit the electronic copy in Microsoft Word, not a PDF:

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dbarnfield@njta.com

Mr. Joseph Graham
Fairview Insurance Agency Associates
25 Fairview Avenue
Verona, NJ 07042
jagraham@fairviewinsurance.com

7. HSA

Proposers are required to submit one (1) original, seven (7) hardcopy completed Proposals and one (1) electronic proposal on a flash drive directly to the Authority. In addition, one hard copy and one electronic version should be sent directly to Fairview Insurance Agency Associates to the following attention. Please submit the electronic copy in Microsoft Word, not a PDF:

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dbarnfield@njta.com

Mr. Joseph Graham
Fairview Insurance Agency Associates
25 Fairview Avenue
Verona, NJ 07042
jagraham@fairviewinsurance.com

D. EVALUATION CRITERIA

1. MEDICAL

a. Technical Criteria: 240 Points

All Proposals will be carefully evaluated for conformance with the requirements of this RFP. Selection of a Proposer(s) will be based on conformance to all of the RFP's requirements and the demonstration of competency and responsibility as presented in the Proposal. Proposers will be awarded a maximum of 200 points upon the following technical criteria:

1) **Response to RFP: Minimum requirements 40 points**

Responses will be evaluated based on Proposer's demonstrated understanding and capability to deliver the full Scope of Services as described in Section III of the RFP and as completed in Section VII.

2) **Response to RFP: Proposer capabilities 40 points**

Responses will be evaluated based on overall Proposer(s) qualifications and experience, references, implementation schedule and resources.

3) **Scope and integrity of preferred provider network 60 points**

Responses will be carefully evaluated to determine how well each Proposer's preferred provider network matches the geographical distribution of the Authorities' operations and enrolled population.

4) **Account service/account management capabilities 60 points**

Responses will be carefully evaluated with respect to the Proposer's demonstrated commitment to overall account service, at the account level and at the subscriber level. Performance guarantees will be evaluated as part of this component as well.

5) **Plan design adherence 40 points**

Responses will be carefully evaluated with respect to the Proposer's ability to duplicate existing plan designs as well as ability to administer potential plan design changes in the future.

b. Cost Proposal 160 Points

All Proposals will be carefully evaluated based on overall program cost, all elements of which are contained in the worksheets within Section VII, including, administration fees, projected net claim after network discount, Proposer's financial quotation, plan design deviations, provider reimbursement data, if requested. Proposer is expected to provide the requested information by completing all requested files. In addition, this file may also contain reference information (rate history, enrollment data, etc.) that will assist Proposer in putting together its quote.

2. Dental

a. Technical Criteria: 240 Points

All Proposals will be carefully evaluated for conformance with the requirements of this RFP. Selection of a carrier will be based on conformance to all of the RFP's requirements and the demonstration of competency and responsibility as presented in the Proposal. Proposers will be awarded a maximum of 200 points upon the following technical criteria:

1) **Response to RFP: Minimum requirements 40 points**

Responses will be evaluated based on Proposer's demonstrated understanding and capability to deliver the full Scope of Services as described in Section III of the RFP and as completed in Section VII.

2) **Response to RFP: Proposer capabilities 40 points**

Responses will be evaluated based on overall Proposer qualifications and experience, references, implementation schedule and resources.

3) **Scope and integrity of preferred provider network 60 points**

Responses will be carefully evaluated to determine how well each Proposer's preferred provider network matches the geographical distribution of the Authorities' operations and enrolled population.

4) **Account service/account management capabilities 60 points**

Responses will be carefully evaluated with respect to the Proposer's demonstrated commitment to overall account service, at the account level and at the subscriber level. Performance guarantees will be evaluated as part of this component as well.

5) **Plan design adherence 40 points**

Responses will be carefully evaluated with respect to the Proposer's ability to duplicate existing plan designs as well as ability to administer potential plan design changes in the future.

b. Cost Proposal 160 Points

All Proposals will be carefully evaluated based on overall program cost, all elements of which are contained in the worksheets within Section III and Section VII, including, administration fees, projected net claim after network discount, Proposer's financial quotation, plan design deviations, provider reimbursement data, if requested. Proposer is expected to provide the requested information by completing all requested files. In addition, this file may also contain reference information (rate history, enrollment data, etc.) that will assist Proposer in putting together its quote.

3. Vision

a. Technical Criteria: 240 Points

All Proposals will be carefully evaluated for conformance with the requirements of this RFP. Selection of a carrier will be based on conformance to all of the RFP's requirements and the demonstration of competency and responsibility as presented in the Proposal. Proposers will be awarded a maximum of 200 points upon the following technical criteria:

1) **Response to RFP: Minimum requirements 40 points**

Responses will be evaluated based on Proposer's demonstrated understanding and capability to deliver the full Scope of Services as described in Section III of the RFP and as completed in Section VII.

2) **Response to RFP: Proposer capabilities 40 points**

Responses will be evaluated based on overall Proposer qualifications and experience, references, implementation schedule and resources.

3) **Scope and integrity of preferred provider network 60 points**

Responses will be carefully evaluated to determine how well each Proposer's preferred provider network matches the geographical distribution of the Authorities' operations and enrolled population.

4) **Account service/account management capabilities 60 points**

Responses will be carefully evaluated with respect to the Proposer's demonstrated commitment to overall account service, at the account level and at the subscriber level. Performance guarantees will be evaluated as part of this component as well.

5) **Plan design adherence 40 points**

Responses will be carefully evaluated with respect to the Proposer's ability to duplicate existing plan designs as well as ability to administer potential plan design changes in the future.

b. Cost Proposal 160 Points

All Proposals will be carefully evaluated based on overall program cost, all elements of which are contained in the worksheets within Section III and Section VII, including, administration fees, projected net claim after network discount, Proposer's financial quotation, plan design deviations, provider reimbursement data, if requested. Proposer is expected to provide the requested information by completing all requested files. In addition, this file may also contain reference information (rate history, enrollment data, etc.) that will assist Proposer in putting together its quote.

4. Prescription Drug

a. Technical Criteria: 240 Points

All Proposals will be carefully evaluated for conformance with the requirements of this RFP. Selection of a carrier will be based on conformance to all of the RFP's requirements and the demonstration of competency and responsibility as presented in the Proposal. Proposers will be awarded a maximum of 200 points upon the following technical criteria:

1) **Response to RFP: Minimum requirements 40 points**

Responses will be evaluated based on Proposer's demonstrated understanding and capability to deliver the full Scope of Services as described in Section III of the RFP and as completed in Section VII.

2) **Response to RFP: Proposer capabilities 40 points**

Responses will be evaluated based on overall Proposer qualifications and experience, references, implementation schedule and resources.

3) **Scope and integrity of preferred provider network 60 points**

Responses will be carefully evaluated to determine how well each Proposer's preferred provider network matches the geographical distribution of the Authorities' operations and enrolled population.

4) **Account service/account management capabilities 60 points**

Responses will be carefully evaluated with respect to the Proposer's demonstrated commitment to overall account service, at the account level and at the subscriber level. Performance guarantees will be evaluated as part of this component as well.

5) **Plan design adherence 40 points**

Responses will be carefully evaluated with respect to the Proposer's ability to duplicate existing plan designs as well as ability to administer potential plan design changes in the future.

b. Cost Proposal 160 Points

All Proposals will be carefully evaluated based on overall program cost, all elements of which are contained in the worksheets within Section III and Section VII, including, administration fees, projected net claim after guaranteed discounts, guaranteed rebates, dispensing fees, specialty lists and guarantees, and plan design deviations. Proposer is expected to provide the requested information by completing all requested files. In addition, this file may also contain reference information (rate history, enrollment data, etc.) that will assist Proposer in putting together its quote.

5. Cobra

a. Technical Criteria: 240 Points

All Proposals will be carefully evaluated for conformance with the requirements of this RFP. Selection of a carrier will be based on conformance to all of the RFP's requirements and the demonstration of competency and responsibility as presented in the Proposal. Proposers will be awarded a maximum of 200 points upon the following technical criteria:

1) **Response to RFP: Minimum requirements 60 points**

Responses will be evaluated based on Proposer's demonstrated understanding and capability to deliver the full Scope of Services as described in Section III of the RFP and as completed in Section VII.

2) **Response to RFP: Proposer capabilities 60 points**

Responses will be evaluated based on overall Proposer qualifications and experience, references, implementation schedule and resources.

3) **Account service/account management capabilities 100 points**

Responses will be carefully evaluated with respect to the Proposer's demonstrated commitment to overall account service, at the account level and at the subscriber level. Performance guarantees will be evaluated as part of this component as well.

4) **Plan design adherence 20 points**

Responses will be carefully evaluated with respect to the Proposer's ability to duplicate existing plan designs as well as ability to administer potential plan design changes in the future.

b. Cost Proposal 160 Points

All Proposals will be carefully evaluated based on overall program cost, all elements of which are contained in the worksheets within Section III and Section VII, including, administration fees, projected net claim after network discount, Proposer's financial quotation, plan design deviations, provider reimbursement data, if requested. Proposer is expected to provide the requested information by completing all requested files. In addition, this file may also contain reference information (rate history, enrollment data, etc.) that will assist Proposer in putting together its quote.

6. Flexible Spending Account

a. Technical Criteria: 240 Points

All Proposals will be carefully evaluated for conformance with the requirements of this RFP. Selection of a carrier will be based on conformance to all of the RFP's requirements and the demonstration of competency and responsibility as presented in the Proposal. Proposers will be awarded a maximum of 200 points upon the following technical criteria:

1) **Response to RFP: Minimum requirements 60 points**

Responses will be evaluated based on Proposer's demonstrated understanding and capability to deliver the full Scope of Services as described in Section III of the RFP and as completed in Section VII.

2) **Response to RFP: Proposer capabilities 60 points**

Responses will be evaluated based on overall Proposer qualifications and experience, references, implementation schedule and resources.

3) **Account service/account management capabilities 100 points**

Responses will be carefully evaluated with respect to the Proposer's demonstrated commitment to overall account service, at the account level and at the subscriber level. Performance guarantees will be evaluated as part of this component as well.

4) **Plan design adherence 20 points**

Responses will be carefully evaluated with respect to the Proposer's ability to duplicate existing plan designs as well as ability to administer potential plan design changes in the future.

b. Cost Proposal 160 Points

All Proposals will be carefully evaluated based on overall program cost, all elements of which are contained in the worksheets within Section III and Section VII, including, administration fees, projected net claim after network discount, Proposer's financial quotation, plan design deviations, provider reimbursement data, if requested. Proposer is expected to provide the requested information by completing all requested files. In addition, this file may also contain reference information (rate history, enrollment data, etc.) that will assist Proposer in putting together its quote.

7. Health Spending Account

a. Technical Criteria: 240 Points

All Proposals will be carefully evaluated for conformance with the requirements of this RFP. Selection of a carrier will be based on conformance to all of the RFP's requirements and the demonstration of competency and responsibility as presented in the Proposal. Proposers will be awarded a maximum of 200 points upon the following technical criteria:

1) **Response to RFP: Minimum requirements 60 points**

Responses will be evaluated based on Proposer's demonstrated understanding and capability to deliver the full Scope of Services as described in Section III of the RFP and as completed in Section VII.

2) **Response to RFP: Proposer capabilities 60 points**

Responses will be evaluated based on overall Proposer qualifications and experience, references, implementation schedule and resources.

3) **Account service/account management capabilities 100 points**

Responses will be carefully evaluated with respect to the Proposer's demonstrated commitment to overall account service, at the account level and at the subscriber level. Performance guarantees will be evaluated as part of this component as well.

4) **Plan design adherence 20 points**

Responses will be carefully evaluated with respect to the Proposer's ability to duplicate existing plan designs as well as ability to administer potential plan design changes in the future.

b. Cost Proposal 160 Points

All Proposals will be carefully evaluated based on overall program cost, all elements of which are contained in the worksheets within Section III and Section VII, including, administration fees, projected net claim after network discount, Proposer's financial quotation, plan design deviations, provider reimbursement data, if requested. Proposer is expected to provide the requested information by completing all requested files. In addition, this file may also contain reference information (rate history, enrollment data, etc.) that will assist Proposer in putting together its quote.

End of Section IV

SECTION V: INSURANCE AND INDEMNIFICATION

A. Insurance

Prior to the commencement of any activity pursuant to a Contract awarded under this RFP, the Consultant shall procure and maintain at its own expense, throughout the term of any resulting Contract and until acceptance by the Authority of the Services performed under such Contract, or for a duration as otherwise provided herein, from an insurance carrier acceptable to the Authority, the following insurance coverages:

Commercial General Liability Insurance

1. Consultant shall maintain **commercial general liability insurance** (CGL) with a coverage limit of not less than **$2,000,000 each occurrence**. CGL insurance shall be written on the latest ISO occurrence form without any added restrictions or diminution in coverage (or a substitute form providing at least equivalent coverage) and shall cover liability for bodily injury and property damage arising from premises, operations, independent contractors, products-completed operations and for liability arising from personal injury and advertising injury, and liability assumed under Contract. This insurance shall also provide coverage for mental anguish or other mental injury arising from bodily injury. The insurance shall be endorsed to delete the coverage restriction related to work conducted within fifty (50) feet of a railroad, and the XCU exclusions. "The New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers" shall be included as additional insureds on the latest ISO forms providing such status for ongoing operations and products-completed operations without any added restrictions or diminution in coverage (or substitute forms providing at least equivalent coverage). This insurance shall be endorsed to apply as primary insurance and not contribute with any other insurance or self-insurance programs afforded to the Authority. This insurance shall be endorsed to waive the insurance carrier's right of subrogation against The New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers. The required policy limit for this insurance can be provided by a combination of primary and excess coverages, provided that primary coverage shall be not less than **$1,000,000** and that the excess coverage shall be at least as broad as the primary policy. This insurance shall not contain any provision under which claims made by the Authority against the Consultant would not be covered due to the operation of an insured versus insured exclusion. With respect to products and completed operations insurance, Consultant shall maintain such insurance for a period of not less than three (3) years following the termination of this Contract.

Commercial Automobile Liability Insurance

2. Consultant shall maintain **commercial automobile liability insurance** covering all vehicles owned or used by Consultant with a coverage limit of not less than **$2,000,000 each occurrence**. Auto insurance shall be written on the latest ISO form without any added restrictions or diminution in coverage (or a substitute form providing at least equivalent coverage) and shall cover liability for bodily injury and property damage. This insurance shall also provide coverage for mental anguish or other mental injury arising from bodily injury. "The New Jersey Turnpike

Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers" shall be included as additional insureds. This insurance shall apply as primary insurance and not contribute with any other insurance or self-insurance programs afforded to the Authority. Such insurance shall be endorsed to waive the insurance carrier's right of subrogation against The New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers. The required policy limit for this insurance can be provided by a combination of primary and excess coverages, provided that primary coverage shall be not less than **$1,000,000** and that the excess coverage shall be at least as broad as the primary policy. This insurance shall not contain any provision under which claims made by the Authority against the Consultant would not be covered due to the operation of an insured versus insured exclusion.

Should the Services to be provided pursuant to this RFP require the Consultant or any subcontractors, to transport any hazardous materials, hazardous substances, hazardous wastes and contaminated soils, the Consultant shall provide the Authority with evidence of levels of financial responsibility as required by the Motor Carrier Act of 1980 and 49 C.F.R., Part 387. The Consultant and/or subcontractor, as the case may be, shall provide the Authority with an Endorsement for Motor Carrier Policies of Insurance for Liability under Sections 29 and 30 of the Motor Carrier Act of 1980 (Form MCS-90) issued by the insurer.

Workers' Compensation and Employers' Liability Insurance

3. Consultant shall maintain **workers' compensation and employers' liability insurance.** Employers' liability coverage shall be in a limit not less than **$1,000,000 Bodily Injury by Disease Each Employee, $1,000,000 Bodily Injury by Accident- Each Accident, $1,000,000 Bodily Injury by Disease – Policy Limit.** Workers' Compensation Insurance shall be provided in accordance with the requirements of the laws of the State of New Jersey and shall include all-states insurance to extend coverage to any state which may be interpreted to have legal jurisdiction. Such policies shall include endorsements to ensure coverage under the U.S. Longshore's and Harborworkers' Compensation Act and Maritime Act (Death on the High Seas Act) where required. The required policy limit for this employers' liability insurance can be provided by a combination of primary and excess coverages, provided that primary coverage shall be not less than **$1,000,000** and that the excess coverage shall be at least as broad as the primary policy.

Physicians Professional Liability Insurance

4. Where applicable, Consultant shall maintain physicians professional liability insurance with a coverage limit of not less than **$2,000,000 each occurrence**. This insurance shall cover liability arising from any act, error or omission in professional services rendered or that should have been rendered by the medical professional or by any person for whose acts or omissions the medical professional is responsible. This insurance shall include coverage for bodily injury, personal injury and mental anguish or mental injury. "The New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers" shall be included as additional insureds. This insurance shall be endorsed to apply as primary insurance and not contribute with any other insurance or self-insurance programs afforded to the Authority. This insurance shall be endorsed to waive the insurance carrier's right of subrogation against The New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers. This insurance shall not contain any provision under which claims made by the Authority against the Consultant would not be covered due to the operation of an insured versus insured exclusion.

Professional Liability Insurance

5. Consultant shall maintain **Professional Liability Insurance** covering its errors and omissions and liability assumed under Contract with a coverage limit of not less than **$2,000,000 each occurrence**. "The New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers" shall be included as additional insureds. This insurance shall be endorsed to apply as primary insurance and not contribute with any other insurance or self-insurance programs afforded to the Authority. This insurance shall be endorsed to waive the insurance carrier's right of subrogation against The New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers. This insurance shall not contain any provision under which claims made by the Authority against the Consultant would not be covered due to the operation of an insured versus insured exclusion.

Cyber Liability Insurance

6. Consultant shall maintain Privacy and Network Security insurance covering liability arising from (1) hostile action, or a threat of hostile action, with the intent to affect, alter, copy, corrupt, destroy, disrupt, damage, or provide unauthorized access/unauthorized use of a computer system including exposing or publicizing confidential electronic data or causing electronic data to be inaccessible; and (2) computer viruses, Trojan horses, worms and any other type of malicious or damaging code; and (3) dishonest, fraudulent, malicious, or criminal use of a computer system by a person, whether identified or not, and whether acting alone or in collusion with other persons, to affect, alter, copy, corrupt, delete, disrupt, or destroy a computer system or obtain financial benefit for any party or to steal or take electronic data; and (4) denial of service for which the Consultant is responsible that results in the degradation of or loss of access to internet or network activities or normal use of a computer system; and (5) loss of service for which the Consultant is responsible that results in the inability of a third party, who is authorized to do so, to gain access to a computer system and conduct normal internet or network activities; and (6) access to a computer system or computer system resources by an unauthorized person or persons or an authorized person in an unauthorized manner with a limit not less than $5,000,000 per occurrence. This insurance shall provide coverage for personal injury (including emotional distress and mental anguish). This insurance shall not contain any provision under which claims made by the Authority against the Consultant would not be covered due to the operation of an insured versus insured exclusion.

7. Any additional insurance policies necessary to obtain required permits or otherwise comply with applicable law, ordinances or regulations regarding the performance of the Work will be provided upon request of the Authority.

8. All insurance policies shall specify that the territorial limits shall be on a worldwide basis or as otherwise agreed with the Authority. All insurance policies shall provide that not less than 30 days advance written notice of cancellation or material change of any insurance referred to therein shall be given by registered mail to the Law Department, New Jersey Turnpike Authority at P.O. Box 5042, One Turnpike Plaza, Woodbridge, New Jersey 07095. All insurance companies providing coverage shall be authorized to do business in the State of New Jersey and maintain an A.M. Best rating of A-VII or better.

B. Any other insurance carried by Consultant or subcontractors shall be considered to be primary and any insurance carried by or self-insurance programs afforded to the Authority shall be considered excess and non-contributing with such primary insurance.

C. Any other insurance carried by Consultant or subcontractors shall also contain a waiver of subrogation clause in favor of the New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers.

D. Prior to commencing any services under this Contract and thereafter upon the Authority's request, Consultant shall furnish the Authority with a certificate(s) of insurance satisfactory to the Authority and, if requested by the Authority, applicable endorsements and/or a certified duplicate copy of the insurance policy(s) required, executed by a duly authorized representative of each insurer, showing compliance with the insurance requirements set forth herein. The Certificates of Insurance shall state that each of the above-required policies has been amended to include the following endorsements and shall be accompanied by copies of the endorsements:

a. "The New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers" shall be included as additional insureds." This statement is not required for the Consultant's workers' compensation and employers' liability insurance.

b. Thirty (30) days' notice of cancellation or material change in coverage shall be given by registered mail to the New Jersey Turnpike Authority as specified above.

c. All policies shall contain a waiver of subrogation clause in favor of the New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers.

d. With respect to all policies, the other insurance clause under each policy shall be amended to read as follows: "This policy will act as primary insurance and not contribute with policies issued to or self-insurance programs afforded to the New Jersey Turnpike Authority and its members, commissioners, officers, agents, employees, guests, consultants and volunteers"

e. All certificate(s) shall be mailed to: Director of Procurement and Materials Management, New Jersey Turnpike Authority, P.O. Box 5042, Woodbridge, New Jersey 07095.

E. In the event that Consultant subcontracts any portion of its obligations pursuant to this RFP, Consultant shall require such subcontractor to comply with all of the above insurance requirements as if the subcontractor's name were substituted for any reference to Consultant. If any subcontractor cannot comply with this requirement, then such subcontractor shall be added under the Consultant's policies as an additional insured.

It is agreed and understood by the parties that the obligation of the Consultant to obtain and maintain insurance policies required in accordance with this RFP is an essential term of the RFP and that the Authority relies on the Consultant to perform such obligation. The parties further acknowledge and agree that the failure of the Authority to require strict compliance with all the terms and conditions regarding insurance, as set forth in this RFP, and as evidenced by any Certificates of Insurance, Slips and/or Binders, copies of insurance policies, or otherwise, shall not constitute a waiver or amendment

of any of the terms, conditions and requirements of this RFP regarding the provision of insurance coverage by the Consultant.

The Consultant shall ensure that the activities to be performed under this RFP do not violate the terms and conditions of any insurance policy which is or may be provided by the Consultant hereunder, and that it shall take all measures necessary to avoid any actions which may lead to cancellation or voidance of such insurance policies.

F. In the event that the Consultant fails or refuses to maintain or renew any insurance policy required to be maintained herein, or if such policy is cancelled or modified so that the insurance does not meet the requirements contained herein, the Authority may refuse to make payment of monies due under this RFP. The Authority in its sole discretion may use such monies to purchase insurance on behalf of the Consultant or subcontractor. During any period when the required insurance is not in effect, the Authority may suspend performance of the Agreement. If the Agreement is so suspended, no additional compensation or extension of time shall be due on account of such suspension. The Authority may waive or modify any insurance requirement set forth herein.

Due to future changes in economic, financial, risk and/or insurance market conditions the Authority at its discretion may modify the above stated insurance requirements

G. NOTWITHSTANDING THAT MINIMUM AMOUNTS OF INSURANCE COVERAGE CARRIED OR REQUIRED TO BE CARRIED BY THE CONSULTANT ARE SPECIFIED HEREIN, THE LIABILITY OF THE CONSULTANT SHALL NOT BE LIMITED TO THE AMOUNTS SO SPECIFIED AND SHALL EXTEND TO ANY AND ALL LIABILITY IN EXCESS OF THE INSURANCE COVERAGES SO PROVIDED NOR SHALL THESE MINIMUM LIMITS PRECLUDE THE AUTHORITY FROM TAKING ANY ACTION AVAILABLE TO IT UNDER THE PROVISIONS OF THE CONTRACT OR OTHERWISE IN LAW.

H. Terms and Deductibles. The Consultant shall be responsible for any deductible or self-insured retention, exclusions or lack of coverage in the insurance policies described above. Any deductible or self-insured retention greater than $5,000 per occurrence must be disclosed to and approved by the Authority. The Authority reserves the right to require that any deductible or self-insured retention be no greater than $5,000 per occurrence.

End of Section V

SECTION VI: CHECKLIST AND EXHIBITS

CHECKLIST OF ITEMS

THE FOLLOWING ITEMS MUST BE SUBMITTED WITH YOUR PROPOSAL ALONG WITH THIS CHECKLIST ITSELF:

CHECK OFF AS READ, SIGNED & SUBMITTED

	A.	**MANDATORY EQUAL EMPLOYMENT OPPORTUNITY LANGUAGE (Professional Services)**	
	B.	**AFFIRMATIVE ACTION INFORMATION SHEET**	
	C.	**AFFIDAVIT OF MORAL INTEGRITY**	
	D.	**OWNERSHIP DISCLOSURE FORM**	
	E.	**VENDOR FIRM DISCLOSURE FORM – EXECUTIVE ORDER 129**	
	F.	**DISCLOSURE OF INVESTMENT ACTIVITIES IN IRAN**	
	G.	**NOTICE TO ALL PROPOSERS SET-OFF FOR STATE TAX**	
	H.	**NJ ELECTION LAW ENFORCEMENT COMMISSION REQUIREMENT FOR DISCLOSURE OF POLITICAL CONTRIBUTIONS**	
	I.	**AFFIDAVIT OF NON-COLLUSION**	
	J.	**NJ BUSINESS REGISTRATION CERTIFICATE (Recommended with submission, required from Successful Proposer prior to contract award.)**	
	K.	**SMALL BUSINESS ENTERPRISE/DISABLED VETERAN OWNED BUSINESS ENTERPRISE/MINORITY BUSINESS ENTERPRISE/WOMAN BUSINESS ENTERPRISE FORM**	
	L.	**SMALL BUSINESS ENTERPRISE FORM** **SBE FORM -- PROPOSED SCHEDULE OF SMALL BUSINESS ENTERPRISE PARTICIPATION**	
	M.	**INSURANCE (see Section V of RFP) for Insurance Requirements for the Services Agreement) Submit proof of insurance- either certificate of insurance or letter from broker with Proposal.**	
	N.	**FINANCIALS (Provide copies of audited financial statements or federal income tax returns for the past three years.)**	

_____ **_____**

(Firm) **(Title)**

_____ **_____**

(Signature) **(Date)**

_____ **_____**

(Name – please print or type) **(Telephone Number/Fax Number**

EXHIBIT A

MANDATORY EQUAL EMPLOYMENT OPPORTUNITY LANGUAGE
***N.J.S.A.* 10:5-31 *et seq.*, *N.J.A.C.* 17:27**

GOODS, PROFESSIONAL SERVICES AND GENERAL SERVICES AGREEMENTS

During the performance of the Services Agreement, the Contractor agrees as follows:

A. The contractor or subcontractor, where applicable, will not discriminate against any employee or applicant for employment because of age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Except with respect to affectional or sexual orientation and gender identity or expression, the contractor will ensure that equal employment opportunity is afforded to such applicants in recruitment and employment, and that employees are treated during employment, without regard to their age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Such equal employment opportunity shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Public Agency Compliance Officer setting forth provisions of this nondiscrimination clause.

B. The contractor or subcontractor, where applicable, will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity, or expression, disability, nationality or sex.

C. The contractor or subcontractor will send to each labor union, of with which it has a collective bargaining agreement, a notice to be provided by the agency contracting officer, advising the labor union of the contractor's commitments under this chapter and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D. The contractor or subcontractor where applicable agrees to comply with any regulations promulgated by the Treasurer pursuant to ***N.J.S.A*. 10:5-31 *et seq*.,** as amended and supplemented from time to time and the Americans with Disabilities Act.

E. The contractor or subcontractor agrees to make good faith efforts to meet targeted county employment goals established in accordance with ***N.J.A.C.* 17:27-5.2 .**

F. The contractor or subcontractor agrees to inform in writing its appropriate recruitment agencies including, but not limited to, employment agencies, placement bureaus, colleges, universities, labor unions, that it does not discriminate on the basis of age, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity, or expression, disability, nationality or sex, and that it will discontinue the use of any recruitment agency which engages in direct or indirect discriminatory practices.

G. The contractor or subcontractor agrees to revise any of its testing procedures, if necessary, to assure that all personal testing conforms to the principles of job-related testing, as established by the statutes and court decisions of the State of New Jersey and as established by applicable Federal law and applicable Federal court decisions.

H. In conforming with the targeted employment goals, the contractor or subcontractor agrees to review all procedures relating to transfer, upgrading, downgrading and layoff to ensure that all such actions are taken without regard to age, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity, or expression, disability, nationality or sex, consistent with the statutes and court decisions of the State of New Jersey, and applicable Federal law and applicable Federal court decisions.

I. The Contractor shall submit to the public agency, after notification of award but prior to execution of a goods and Services Agreement, one of the following three documents:

i. Letter of Federal Affirmative Action Plan Approval
ii. Certificate of Employee Information Report
iii. Employee Information Report Form AA302 (electronically provided by the Division and distributed to the public agency through the Division's website at www.state.nj.us/treasury/contract_compliance)

The contractor and its subcontractor shall furnish such reports or other documents to the Division of Purchase & Property, CCAU,EEO Monitoring Program as may be requested by the office from time to time in order to carry out the purposes of these regulations, and public agencies shall furnish such information as may be requested by the Division of Purchase & Property, CCAU, EEO Monitoring Program for conducting a compliance investigation pursuant to **Subchapter 10 of the Administrative Code at *N.J.A.C.* 17:27**

The parties to the Services Agreement do hereby agree that the provision of ***N.J.S.A.* 10:5-31 *et seq*.** dealing with discrimination in employment on public contracts, and the rules and regulations promulgated pursuant thereunto, are hereby made a part of the Services Agreement and are binding upon them.

Submitted by:

Firm Name: _____

By: _____

Title: _____

Date: _____

EXHIBIT B

AFFIRMATIVE ACTION INFORMATION SHEET

IN ACCORDANCE WITH THE TERMS OF THE ATTACHED SERVICES AGREEMENT PROPOSERS ARE REQUIRED TO SUBMIT ONE OF THE FOLLOWING FORMS RELATING TO COMPLIANCE WITH AFFIRMATIVE ACTION REGULATIONS. PLEASE COMPLETE AND RETURN THIS FORM WITH THE PROPOSAL.

1. The Proposer has submitted a Federal Affirmative Action Plan Approval which consists of a valid letter from the Office of Federal Contract Compliance Programs (Good for one year of the date of letter).

   YES____ NO_____

   If Yes, a photocopy of the Letter of Approval is to be submitted with the bid.

   (OR)

2. The Proposer has submitted a Certificate of Employee Information Report pursuant to (*N.J.A.C.* 17.27-1.1) and The State Treasurer has approved said report.

   YES____ NO_____

   If Yes, a photocopy of the Certificate is to be submitted with the bid. (Expiration Date on Certificate)

   Certificate of Approval Number _____

   (OR)

3. If Proposer has already submitted the Employee Information Report form to the States' Affirmative Action Office, please return a copy of it with the bid.

   If you are the successful Proposer and have none of the above, please contact the Procurement and Materials Management Department at **(732) 750-5300 ext. 8628** within five (5) days of notification of award for AA-302 Form. This AA-302 Form must be forwarded to the States' Affirmative Action Office with the Authority's copy returned to the Authority's Procurement and Materials Management Department.

The signature below certifies that one of the above forms of Affirmative Action evidence has been submitted, and all information contained above is correct to the best of my knowledge.

Signed_____ Date Signed _____

Print Name and Title _____

Proposers Company Name _____

Address_____

Telephone Number _____ Fax Number_____

EXHIBIT C
AFFIDAVIT OF MORAL INTEGRITY

STATE OF _____

Ss:

COUNTY OF_____

I, _____, the _____(Pres., Vice Pres., Owner/Partner) of

_____ (Proposer), being first duly sworn, deposes and says:

1. That the Proposer wishes to demonstrate moral integrity in accordance with the services to be rendered/goods to be provided in accordance with the Proposer's Proposal.

2. That as of the date of signing this Affidavit, neither Proposer nor any of its Principals, Owners, Officers, or Directors are involved in any Federal, State or other Governmental Investigation concerning criminal or quasi-criminal violations, except as follows: **(If none, so state):_____**

3. Proposer further states that neither the Proposer, nor any of its Principals, Owners, Officers or Directors, has ever engaged in any violation of a Federal or State Criminal Statute; or ever been indicted, convicted, or entered a plea of guilty, *non vult* or *nolo contendere* to any violation of a Federal or State Criminal Statute; or ever engaged in violation of any nature regarding work on the Agreements performed by it, except as follows: **(If none, so state):_____**

4. That Proposer authorizes any depository or other agency to supply the Authority with any information necessary to verify any statement made in this Affidavit of Moral Integrity.

5. That as of the date of signing this Affidavit, outstanding liens filed against this Proposer are as follows: **(If none, so state):_____**

6. That the undersigned, being authorized to act on behalf of Proposer certifies that I am personally acquainted with the operations of said Proposer, have full knowledge of the factual basis comprising the contents of this Affidavit of Moral Integrity and that the same are true to my knowledge.

7. That this Affidavit of Moral Integrity is made to induce the Authority to accept the Proposer as a qualified provider of goods and/or services, knowing that the said New Jersey Turnpike Authority relies upon the truth of the statements herein contained.

Sworn and Subscribed to Before Me This

____Day of _____20__ _____

Signature

_____ _____ (Corporate Seal)

Notary Public Title

EXHIBIT D
OWNERSHIP DISCLOSURE FORM

PART 1

PLEASE COMPLETE THE QUESTIONS BELOW BY CHECKING EITHER THE "YES" OR THE "NO" BOX. ALL PARTIES ENTERING INTO A CONTRACT WITH THE NEW JERSEY TURNPIKE AUTHORITY ARE REQUIRED TO COMPLETE THIS FORM PURSUANT TO N.J.S.A. 52:25-24.2

PLEASE NOTE THAT IF THE PROPOSER IS A NON-PROFIT ENTITY, THIS FORM IS NOT REQUIRED.

1 .Are there any individuals, corporations, partnerships, or limited liability companies owning a **10% or greater** interest in the Proposer? **YES ☐ NO ☐**

IF THE ANSWER TO QUESTION 1 IS "NO", PLEASE SIGN AND DATE THE FORM.
IF THE ANSWER TO QUESTION 1 IS "YES", PLEASE ANSWER QUESTIONS 2 – 4 BELOW.

2. Of those parties owning a 10% or greater interest in the Proposer, are any of those parties individuals?
YES ☐ NO ☐

3. Of those parties owning a 10% or greater interest in the Proposer, are any of those parties **corporations, partnerships, or limited liability companies?**
YES ☐ NO ☐

4. If your answer to Question 3 is "YES", are there any parties owning a **10% or greater** interest in the corporation, partnership, or limited liability company referenced in Question 3?
YES ☐ NO ☐

IF ANY OF THE ANSWERS TO QUESTIONS 2 - 4 ARE "YES", PLEASE PROVDE THE REQUESTED INFORMATION IN PART 2 BELOW.

PART 2

PLEASE PROVIDE FURTHER INFORMATION RELATED TO QUESTIONS 2 – 4 ANSWERED AS "YES".

If you answered "YES" for questions 2, 3, or 4, you must disclose identifying information related to the individuals, corporations, partnerships, and/or limited liability companies owning a 10% or greater interest in the Proposer. Further, if one or more of these entities is itself a corporation, partnership, or limited liability company, you must also disclose all parties that own a 10% or greater interest in that corporation, partnership, or limited liability company. This information is required by statute.

INDIVIDUALS

NAME _____ **DATE OF BIRTH** _____
ADDRESS 1 _____
ADDRESS 2 _____
CITY _____ **STATE** _____ **ZIP** _____

NAME _____ **DATE OF BIRTH** _____
ADDRESS 1 _____
ADDRESS 2 _____
CITY _____ **STATE** _____ **ZIP** _____

NAME _____ **DATE OF BIRTH** _____
ADDRESS 1 _____
ADDRESS 2 _____
CITY _____ **STATE** _____ **ZIP** _____

Attach Additional Sheets If Necessary.

PART 2 continued

PARTNERSHIPS/CORPORATIONS/LIMITED LIABILITY COMPANIES

ENTITY NAME _____

PARTNER NAME _____

ADDRESS 1 _____

ADDRESS 2 _____

CITY _____ **STATE** _____ **ZIP**_____

ENTITY NAME _____

PARTNER NAME _____

ADDRESS 1 _____

ADDRESS 2 _____

CITY _____ **STATE** _____ **ZIP**_____

ENTITY NAME _____

PARTNER NAME _____

ADDRESS 1 _____

ADDRESS 2 _____

CITY _____ **STATE** _____ **ZIP**_____

Attach Additional Sheets If Necessary.

In the alternative, to comply with the ownership disclosure requirement, a Proposer with any direct or indirect parent entity which is publicly traded may submit the name and address of each publicly traded entity and the name and address of each person that holds a 10% or greater beneficial interest in the publicly traded entity as of the last annual filing with the federal Securities and Exchange Commission or the foreign equivalent, and, if there is any person that holds a 10% or greater beneficial interest, also shall submit links to the websites containing the last annual filings with the federal Securities and Exchange Commission or the foreign equivalent and the relevant page numbers of the filings that contain the information on each person that holds a 10 percent or greater beneficial interest. N.J.S.A. 52:25-24.2.

CERTIFICATION

I, the undersigned, certify that I am authorized to execute this certification on behalf of the Proposer, that the foregoing information and any attachments hereto, to the best of my knowledge are true and complete. I acknowledge that the New Jersey Turnpike Authority is relying on the information contained herein, and that the Proposer is under a continuing obligation from the date of this certification through the completion of any contract(s) with the New Jersey Turnpike Authority to notify the New Jersey Turnpike Authority in writing of any changes to the information contained herein; that I am aware that it is a criminal offense to make a false statement or misrepresentation in this certification. If I do so, I will be subject to criminal prosecution under the law, and it will constitute a material breach of my agreement(s) with the New Jersey Turnpike Authority, permitting the New Jersey Turnpike Authority to declare any contract(s) resulting from this certification void and unenforceable.

_____ _____

Signature Date

_____

Print Name and Title

_____

FEIN/SSN

EXHIBIT E

VENDOR DISCLOSURE FORM

Please be advised that, the New Jersey Turnpike Authority (the "Authority") has developed this form under the policy and procedures in accordance with *N.J.S.A.* 52:34-13.2. Under this order, the Authority must consider the requirements of New Jersey's contracting laws, the best interests of the State of New Jersey and its citizens, as well as applicable federal and international requirements.

The Authority shall insure that all Proposers seeking to enter into the Services Agreement in which services are procured on his behalf must disclose:

a. The location by country where the services under the Services Agreement will be performed; and

b. Any subcontracting of services under the Contract and the location by country where the subcontracted services will be performed.

LOCATION BY COUNTRY WHERE SERVICES UNDER THE SERVICES AGREEMENT WILL BE PERFORMED:

The Proposer_____
(Location by Country)

Name: _____

Address: _____

Title: _____

Subcontractor: _____
(Location by Country)

Name: _____

Address: _____

Title: _____

I certify that all information is true and correct to the best of my knowledge.

Proposer: _____ Title: _____

EXHIBIT F

NEW JERSEY TURNPIKE AUTHORITY
NEW - DISCLOSURE OF INVESTMENT ACTIVITIES IN IRAN

NAME OF CONTRACTOR /BIDDER:_____

PART 1: CERTIFICATION

CONTRACTORS/BIDDERS **MUST COMPLETE** PART 1 BY CHECKING **EITHER BOX**.
FAILURE TO CHECK ONE OF THE BOXES SHALL RENDER THE PROPOSAL NON-RESPONSIVE.

Pursuant to Public Law 2012, c. 25, any person or entity that submits a bid or Proposal or otherwise proposes to enter into or renew a Contract must complete the certification below to attest, under penalty of perjury, that neither the person or entity, nor any of its parents, subsidiaries, or affiliates, is identified on the Department of Treasury's Chapter 25 list as a person or entity engaging in investment activities in Iran. The Chapter 25 list follows this certification and can also be found on the State of New Jersey, Department of Treasury, Division of Purchase and Property website at http://www.state.nj.us/treasury/purchase/pdf/Chapter25List.pdf. Contractors/Bidders **must** review this list prior to completing the below certification. **FAILURE TO COMPLETE THE CERTIFICATION WILL RENDER A CONTRACTOR'S/BIDDER'S PROPOSAL NON-RESPONSIVE.** If the Authority finds a person or entity to be in violation of law, it shall take action as may be appropriate and provided by law, rule or Contract, including but not limited to, imposing sanctions, seeking compliance, recovering damages, declaring the party in default and seeking debarment or suspension of the party.

PLEASE CHECK THE APPROPRIATE BOX:

☐ **I certify, pursuant to Public Law 2012, c. 25, that neither the contractor/bidder listed above nor any of the contractor's/bidder's parents, subsidiaries, or affiliates is listed** on the N.J. Department of the Treasury's list of entities determined to be engaged in prohibited activities in Iran pursuant to P.L. 2012, c. 25 ("Chapter 25 List") . I further certify that I am the person listed above, or I am an officer or representative of the entity listed above and I am authorized to make this certification on its behalf. ***I will skip Part 2 and sign and complete the CERTIFICATION below.***

OR

☐ **I am unable to certify as above because the contractor/bidder and/or one or more of its parents, subsidiaries, or affiliates is listed on the Department's Chapter 25 list. I will provide a detailed, accurate and precise description of the activities in Part 2 below and sign and complete the CERTIFICATION below.** Failure to provide such will result in the Proposal being rendered a non-responsive and appropriate penalties, fines and/or sanctions will be assessed as provided by law.

Part 2: PLEASE PROVIDE FURTHER INFORMATION RELATED TO INVESTMENT ACTIVITIES IN IRAN

You must provide a detailed, accurate and precise description of the activities of the bidding person/entity, or one of its parents, subsidiaries or affiliates, engaging in the investment activities in Iran

outlined above by completing the requested information below. Please provide thorough answers to each question. If you need to make additional entries, provide the requested information on a separate sheet

Name_____ Relationship to Contractor/Bidder _____

Description of Activities _____

_____

Duration of Engagement_____ Anticipated Cessation Date_____

Contractor/Bidder Contact Name_____ Contact Phone Number_____

CERTIFICATION

MUST BE SIGNED BY BIDDER

I being duly sworn upon my oath, hereby represent and state that the foregoing information and any attachments thereto to the best of my knowledge are true and complete. I attest that I am authorized to execute this certification on behalf of the above referenced person or entity. I acknowledge that the South Jersey Transportation Authority ("Authority") is relying on the information contained herein and thereby acknowledge that I am under a continuing obligation from the date of this certification through the completion of any contracts with the Authority to notify the Authority in writing of any changes to the answers of information contained herein. I acknowledge that I am aware that it is a criminal offense to make a false statement or misrepresentation in this certification, and if I do so, I recognize that I am subject to criminal prosecution under the law and that it will also constitute a material breach of my agreement(s) with the Authority and that the Authority at its option may declare any Contract(s) resulting from this certification void and unenforceable.

FULL NAME (print)**: _____ SIGNATURE_____**

TITLE:_____DATE:_____

State of New Jersey

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

DEPARTMENT OF THE TREASURY
DIVISION OF PURCHASE AND PROPERTY
OFFICE OF THE DIRECTOR
33 WEST STATE STREET
P. O. BOX 039
TRENTON, NEW JERSEY 08625-0039
https://www.njstart.gov
Telephone (609) 292-4886 / Facsimile (609) 984-2575

ELIZABETH MAHER MUOIO
State Treasurer

MAURICE A. GRIFFIN
Acting Director

The following list represents entities determined, based on credible information available to the public, to be engaged in prohibited activities in Iran pursuant to P.L. 2012, c. 25 ("Chapter 25"):

1. AK Makina Ltd.
2. Amona
3. Bank Markazi Iran (Central Bank of Iran)
4. Bank Mellat
5. Bank Melli Iran
6. Bank Saderat PLC
7. Bank Sepah
8. Bank Tejarat
9. China International United Petroleum & Chemicals Co., Ltd. (Unipec)
10. China National Offshore Oil Corporation (CNOOC)
11. China National Petroleum Corporation (CNPC)
12. China National United Oil Corporation (ChinaOil)
13. China Oilfield Services Limited
14. China Petroleum & Chemical Corporation (Sinopec)
15. China Precision Machinery Import-Export Corp. (CPMIEC)
16. Indian Oil Corporation
17. Kingdream PLC
18. Naftiran Intertrade Company (NICO)
19. National Iranian Tanker Company (NITC)
20. Oil and Natural Gas Corporation (ONGC)
21. Oil India Limited
22. Persia International Bank
23. Petroleos de Venezuela (PDVSA Petróleo, SA)
24. PetroChina Company, Ltd.
25. Sameh Afzar Tajak Co. (SATCO)
26. Shandong Fin Cnc Machine Company, Ltd.
27. Sinohydro Co., Ltd.
28. SK Energy Co. Ltd.
29. SKS Ventures
30. Som Petrol AS
31. Zhuhai Zhenrong Company

List Date: January 4, 2021

EXHIBIT G

NOTICE TO ALL PROPOSERS SET-OFF FOR STATE TAX

Please be advised that 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 the Agreement 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 or construction projects and at the same time the taxpayer, or the 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, partner's or shareholder's share of the payment due to the taxpayer, partnership, or S corporation. The amount of set-off shall not allow for the deduction of any expenses or other deductions which might be attributable to a partner or shareholder subject to set-off under this act. No payment shall be made to the taxpayer, the provider of goods or services, or the contractor or subcontractor of construction projects pending resolution of the indebtedness.

The Director of Division of Taxation shall give notice to the set-off to the taxpayer, the provider of goods or services, or the Contract or subcontractor of construction projects and provide an opportunity for a hearing with thirty (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 shall stay the collection of the indebtedness. Interest that may be payable by the State pursuant to P.L. 1987, c. 184 (c.52:32-32et seq.) to the taxpayer, the provider of goods or services, or the contractor or subcontractor of construction projects shall be stayed.

"I HAVE BEEN ADVISED OF THIS NOTICE."

COMPANY_____

SIGNATURE_____

NAME_____

TITLE_____

DATE_____

EXHIBIT H

NEW JERSEY ELECTION LAW ENFORCEMENT COMMISSION REQUIREMENT FOR DISCLOSURE OF POLITICAL CONTRIBUTIONS

All business entities are advised of their responsibility to file on annual disclosure statement of political contributions with the New Jersey Election Law Enforcement Commission (ELEC) pursuant to N.J.S.A. 19:44A-20.27 if they receive in excess of $50,000.00 from public entities in a calendar year. Business entities are responsible for determining if filing is necessary. Additional information on this requirement is available from ELEC at 888-313-3532 or at www.elec.state.nj.us

DISCLOSURE OF CONTRIBUTIONS TO NEW JERSEY ELECTION LAW ENFORCEMENT COMMISSION IN ACCORDANCE WITH *N.J.S.A.* 19:44A-2027

STATE OF _____

:SS

COUNTY OF _____

I,_____ of the _____ of _____ in the County of

_____ and the State of _____ of full age, being duly sworn according to law on

my oath depose and say that:

I am _____, a _____ in the firm of
(Name) (Title, Position, etc.)

_____, the Proposer making the Proposal in response to the Request for Proposal to Furnish and Provide the Services referenced herein; that I executed said Proposal with full authority to do so; and that the Proposer acknowledges our responsibility to file an annual disclosure statement of political contributions with the New Jersey Election Law Enforcement Commission (ELEC) pursuant to *N.J.S.A.* 19:44A-20.27 if in receipt of in excess of $50,000.00 from public entities in a calendar year. I further acknowledge that business entities are solely responsible for determining if filing is necessary and that all statements contained in said Proposal and in this affidavit are true and correct, and made with full knowledge that the New Jersey Turnpike Authority relies upon the truth of the statements contained in said Proposal and in statements contained in this affidavit in awarding the Services Agreement for the Services.

I further warrant that no person or selling agency has been employed or retained to solicit or secure such Services Agreement upon an agreement or understanding for commission, percentage proposerage, or contingent fee, except bona fide employees of the Proposer, and as may be permitted by law.

_____

Print Name:_____

Subscribed and Sworn to before me this _____day of _____20____

Notary Public of _____ My Commission Expires:_____

EXHIBIT I

AFFIDAVIT OF NON-COLLUSION

STATE OF :
:
COUNTY OF :

The undersigned, being duly sworn according to law, deposes and says:

1. That, as the party submitting the foregoing Proposal, that such Proposal is genuine and not collusive or a sham; that said Proposer has not colluded, conspired, connived, or agreed, directly or indirectly, with any Proposer or person, to put in a sham Proposal or to refrain from participating in this solicitation, and has not, in any manner, directly or indirectly, sought by agreement or collusion, or communication or conference, with any person, to fix the price of affiant or of any other Proposer, or to fix any overhead, profit, or cost element of said price, or of that of any other Proposer, or to secure any advantages against the New Jersey Turnpike Authority ("Authority"), or any person interested in the proposed Services Agreement; and that all statements in said Proposal are true.

2. That he/she has not been convicted or found liable for any act prohibited by state or federal law involving conspiracy or collusion with respect to proposing or bidding on any public Contract within the last three years. Such act or conviction does not automatically disqualify a Proposer, but may be grounds for administrative suspension or grounds for consideration by the Authority as to whether the Authority should decline to award the Services Agreement to such a Proposer on the basis of a lack of responsibility. If Proposer has been convicted of any act prohibited by state or federal law involving collusion with respect to proposing or bidding on any public Contract within the past three years, Proposer should attach an explanation of the circumstances surrounding that conviction.

_____
FIRM NAME

_____
NAME

_____
TITLE

_____
SIGNATURE

Subscribed and sworn to and
before me this day
of , 20___.

_____

EXHIBIT J

NJ DIVISION OF REVENUE BUSINESS REGISTRATION
[Attach]

For information regarding the New Jersey Division of Revenue Business Registration Requirement, Proposers can contact the Bureau of Client Registration at (609) 292-9292.

If you wish to file your application online, you may do so by visiting the following website: http://www.nj.gov/treasury/revenue/forms/njreg.pdf

EXHIBIT K

SMALL BUSINESS ENTERPRISE / DISABLED VETERAN OWNED BUSINESS ENTERPRISE / MINORITY BUSINESS / WOMAN OWNED BUSINESS

SMALL / DISABLED VETERAN OWNED / MINORITY / WOMAN BUSINESS ENTERPRISE FORM

If Proposer is registered with the State of New Jersey as a Small Business Enterprise (SBE) / Disabled Veteran Owned Business Enterprise (DVOB), and/or Certified as a Woman Business Enterprise (WBE) or Minority Business Enterprise (MBE) you must send a copy of the Registration/ Certification Form with your Proposal. Please check off the gross receipt category of your business if registered as an SBE.

- SBE CATEGORY 1 $0- $500,000 _____
- SBE CATEGORY 2 $500,001 thru $5,000,000 _____
- SBE CATEGORY 3 $5,000,001 thru $12,000,000 _____
- NOT APPLICABLE _____

SBE Registration # _____

Please check below if applicable

Woman Business Enterprise _____

Disabled Veteran Owned Business Enterprise _____

Minority Business Enterprise_____

Proposer Name: _____

EXHIBIT L

SMALL BUSINESS ENTERPRISE FORM

SBE FORM -- PROPOSED SCHEDULE OF SMALL BUSINESS ENTERPRISE PARTICIPATION

SMALL BUSINESS ENTERPRISE FORM
SBE FORM -- PROPOSED SCHEDULE OF SMALL BUSINESS ENTERPRISE PARTICIPATION

NAME & ADDRESS OF SBE (SUB)CONSULTANT SUPPLIER	TYPE OF WORK TO BE PERFORMED	ESTIMATED PERCENTAGE OF (SUB)CONSULTANT WORK

(Attach additional sheet if necessary)

_____ _____

Proposer (Print Name) Proposer's SBE Liaison officer (if applicable)

_____

Telephone Number

All Proposers must complete and submit this form with their Proposal (if no subcontracting is involved state so.)

EXHIBIT M

[Attach Certificate of Insurance or Letter from Broker]

EXHIBIT N

[Attach Audited Financial Statements or Federal Income Tax Returns for the Past 3 years]

SECTION VII A – MEDICAL QUESTIONNAIRE

A. GENERAL REQUIREMENTS AND QUESTIONS FOR ALL PROPOSERS

In order for your Proposal to be considered and accepted, your organization must provide answers to the questions presented in this section. All questions must be answered. Reference should not be made to a prior response, or to your Contract, unless the question involved specifically provides such an option. Be sure to refer to the earlier sections of this request for Proposal (RFP) before responding to any of the questions so that you have a complete understanding of all of the Authority's requirements with respect to the Proposal.

If your Proposal is different in any way (whether more or less favorable) from that indicated in this RFP, clearly indicate with appropriate detail. If you do not specify a difference, the submission of your Proposal will be deemed a certification that you will comply in every respect (including, but not limited to, coverage provided, funding method requested, benefit exclusions and limitations, underwriting provisions, etc.) with the requirements set forth in this RFP.

If you are unable to perform any required service clearly indicate: a) what you are currently unable to do; b) what steps will be taken (if any) to meet the requirement; c) the timetable for that process; and d) who will be responsible for the implementation.

B. ADMINISTRATION ISSUES

a. List other group benefit services your organization provides, other than what is being proposed.

b. Designate the individual(s) with the following responsibilities. Include the name, title and address of each individual, along with a brief description of his/her qualifications and experience.

a. The individual(s) representing your company during the Proposal process.	
b. The individual(s) who will be assigned to the overall ongoing account management.	
c. The individual(s) who will be responsible for day-to-day service.	

c. As the Contract will be issued in the state of New Jersey, the Contract must be in full accord with the laws of that jurisdiction. Please confirm that your Proposal and plan design offered is in compliance with all federal and state laws and regulations that pertain to employee benefit programs, relevant state insurance regulations and other related laws.

d. Do you agree to notify the Authority immediately if the network loses any accreditation, licenses or liability insurance coverage or bonding?

e. How will administrative fees be billed?

f. If your organization already provides insurance (e.g., life insurance, EAP, etc.) or a service coverage (e.g., dental administration, etc.) to the Authority, do you coordinate billing procedures so that the Authority receives one comprehensive bill?

g. What on-line services/functions will be made available to the Authority via the Internet? Provide name of the website.

h. References

a. Provide the following for each reference:

1) Client name
2) Address
3) Industry (if not obvious)
4) Contact name, title and phone number
5) Total number of members
6) Total number of covered lives under the health program
7) Length of time as a client of your company

b. Proposer(s) must submit a list of three (3) Public Sector client references, of which:

1) at least two must be New Jersey based;
2) at least two must have participation of between 2,500 and 5,000 employees; and
3) at least one must be a new client (with an Effective Date of 1/1/19 or later) who can attest to their experience with your implementation capabilities.

c. Proposer(s) must provide names, addresses and telephone number of one (1) public sector clients, with between 2,500 and 5,000 employees who terminated their relationship with your company in the last two years.

d. Provide the type of plan administered for each reference.

C. FINANCIAL SECTION

1. **Administrative Fees and Network Access Charges**

a. Complete the following table for ASO Contracts. Fees must be provided in the following formats. Alternatives may be considered. Please include information on all capitated arrangements.

b. The marketplace has shown a move toward unbundling some of the administrative services handled under the ASO Contract. These charges have, for the most part, taken the form of a percentage of the savings. Please clearly specify any additional services that are paid under any form (per employee per month ("PEPM"), percentage of savings, etc). If there are any pieces to the claims administration or payment that are capitated, please clearly indicate. Please provide separate fees for the Actives, Under Age 65 Retirees and Over Age 65 Retirees.

Fees ***PEPM****	**Policy Year**		
	Year 1	**Year 2**	**Year 3**
a. PPO Leasing/Network Access Fees			
b. Wrap Network Fee			

* PEPM represents per employee per month. Provide the estimated annual fees assuming the lives provided on the census. The chart above includes a comprehensive list of all services under the various options requested. Please clearly state the fee that is applicable for a bundled ASO arrangement as well as the alternatives that are proposed specific to the alternates offered by your organization.
If any extra fees will be billed to the Authority, specify the organizations that will perform the functions provided, define fully the functions to be performed and estimate the fees that will be charged and the basis on which the fees will be based (e.g., as a percentage of savings).

Fees *PEPM*[*]	Policy Year		
	Year 1	**Year 2**	**Year 3**
c. Claims Processing Fee			
d. Claims Re-pricing Fee			
e. Utilization Management Fee			
f. Case Management Fee			
g. Disease Management			
h. Diagnostic Review Fee			
i. Behavioral Health			
j. Radiology Fee			
k. Out-of-Network Negotiation Fee (provide fee and carrier utilized)			
l. Quality Management Fee			
m. ID Cards			
n. Provider Directory			
o. Claim Fiduciary			
p. Stop Loss Reporting			
q. SBCs (including ability to integrate external vendor drug)			
r. Booklets/SPDs			
s. Data Reporting			
t. Banking			
u. Runout Claims Processing at Termination (provide term and fee)			
v. Other (Explain)			
w. All Inclusive Fee (PEPM, other)			
x. Total Annual Estimated Fees	$	$	$

Additional Administrative Services	Organization to Perform Service	Fees as a Percentage of Savings
a. Wrap Network Fee		
b. Bill Negotiation Fee		
c. Subrogation		
d. COB		
e. Other		

Notes:

1. All services to be provided for the quoted fee should be listed including quantities and frequencies.
2. Fees must exclude commissions.
3. Individual fee components will be assumed to be self-supporting stand-alone services.
4. Provide estimate of fee for alternative options of services, on requested basis.
5. Fees quoted must be valid for 180 days after receipt of quote & guaranteed for each 12-month period.
6. List services/supplies not covered under the fees quoted above (i.e., custom reports, printing, etc.).
7. Fees quoted are to cover services for claims incurred on or after the Contract Effective Date.

2. Claims Re-pricing

Attached is a detailed claims file containing the Authority's utilization data for the claims for the year ended December 2020. The file contains inpatient hospital, outpatient hospital and professional claims information.

For your proposed network, please provide the actual average discount off eligible charges for each provided TIN for the date of service. Please do not include anticipated deals in the historical figure. Be sure to include a network indicator **(actual status of provider, participating/non-**

participating, regardless of how the claim is paid) for your proposed network as well as a network indicator for any high quality networks available.

In addition, please provide the average projected 2022 discount, which will include any adjustments that are based on finalized future changes to provider discounts.

For both responses, identify in-network non-contracted providers (i.e. non-par hospital-based) as non-participating.

3. **Definition of Terms:**

   a. **Submitted Charges:** All charges submitted by the provider for payment.

   b. **Eligible Billed Charges:** Sometimes referred to as "Covered Charges." Eligible Billed Charges = Submitted Charges less Ineligible Charges, before application of fee schedules or contractual reimbursement provisions.

   c. **Negotiated Savings:** Sometimes referred to as "Provider Discount." Savings resulting from fee schedules or contractual reimbursement provisions. Reductions that result in member balance billing should not be included as Negotiated Savings.

   d. **Contracted Amount:** Sometimes referred to as "Allowed Amount." Contracted Amount = Eligible Billed Charges less Negotiated Savings resulting from fee schedules or contractual reimbursement provisions, prior to member cost sharing. Please identify the re-pricing methodology.

      In order to prepare a discount comparison that is specific to the utilization patterns of the Authority, we request that the average discount be provided for each provider and facility TIN.

      The Authority and Fairview Insurance Agency Associates will treat all information received with utmost confidentiality (i.e., the Proposal shall be viewed only by those individuals within the companies working specifically on this RFP). If your organization wishes the principals of the consulting firm to sign a document to affirm this statement, please advise.

D. MEMBER SERVICE (I.E., CUSTOMER SERVICE, INTERNET ACCESS, ETC.)

1. Will a toll-free number be made available to the Authority and members to handle service issues?
    a. What hours will the lines be staffed?
    b. Who will staff the lines during normal business hours and after hours?
    c. Where is your call center located?
2. Does your organization offer Spanish language member services? What, if any, additional languages are services offered in?
3. Indicate your average telephone wait time to speak to a live customer service representative (not just an operator).
4. Average wait time for year ended December 2020 (if available):
5. Indicate the ways in which your organization is able to accommodate the special needs of enrollees. Check all that apply.
    a. ☐ No special accommodations.
    b. ☐ Have a TDD (Telecommunications Device for the Deaf) or other voice capability for the hearing impaired.
    c. ☐ We accommodate non-English speaking enrollees by contracting with an independent translation service.
    d. ☐ We maintain customer service staff with the ability to translate the following languages:
    e. ☐ Other
6. Do you offer a Nurse Triage (nurse advice/demand management) telephone program for enrollees? Check one only.
    a. ☐ Yes, staffed by live health professionals, 24 hours/day, 7 days/week.
    b. ☐ Yes, staffed by live health professionals, ___ hours/day, ___ days/week
    c. ☐ No, enrollees are to seek information/guidance from their physician
    d. ☐ Other: _____
7. Do you have a telephone system that allows enrollees to dial in to hear Health Care Information on certain health topics? Check one only.
    a. ☐ Yes, this system is available _____hrs/day, _____days/week.
    b. ☐ No, not yet.
    c. ☐ Other (specify) _____
8. Indicate how your organization typically responds to an enrollee who calls to complain that a network provider is balance billing them for an amount of money above and beyond the patient's required copay or coinsurance? Check one only.

a. ☐ We ask that the patient communicate to their doctor that a network provider does not permit balance billing.

b. ☐ Our organization contacts the provider directly to discuss the issue and have the provider stop balance billing.

c. ☐ Other (specify) _____

d. ☐ Not an issue, as none of our network providers ever balance bill an enrollee.

e. ☐ Unknown.

9. What support do you provide for selecting and/or locating network physicians and for answering provider credential questions that members may have? What other member services are provided with regard to provider selection assistance?

10. Do you provide on-line access to network provider listings and locations to assist members with provider selection? Do you specify the languages providers speak?

11. In the following grid, indicate the average percentage of complaints/calls received by your customer/member service department, by the type of the call.

Type of Calls (Last 12 months available))	Average % of Complaints/Calls	
a. New Enrollment Issues (e.g., ID cards, directory received, how to use plan, etc.)	☐ Unknown	_____%
b. Service Issues (e.g., access, referral problems, etc.)	☐ Unknown	_____%
c. General Information	☐ Unknown	_____%
d. Other (specify) _____	☐ Unknown	_____%
e. TOTAL (sum of a – d should =100%)		**100%**

12. Describe the grievance and appeals protocols in place for Members.

13. The Authority processes the member appeals received per ERISA guidelines. Please describe how you will coordinate with the Authority when a member appeal is received.

14. Do you have a response time goal for which to respond to other questions and complaints?

15. Do you participate in CAHPS or other member satisfaction surveys? If so, for calendar year 2020, indicate the enrollees who responded they were at least "satisfied" with your organization. Check one only.

a. ☐ A total of _____ enrollees were at least "satisfied" which represents _____% of those surveyed. Response valid only if a copy of your survey is attached.

b. ☐ Unknown.

c. ☐ Enrollee satisfaction surveys not currently conducted.

E. COMMUNICATIONS

1. How often are provider directories updated for Members?

2. Please submit a sample of all forms that would be used in the administration of this plan (e.g., ID cards).

3. Are there any forms required for plan administration, the cost of which are not included in your fees? If so, please describe the forms and specify additional cost.
4. Describe how you will communicate the network features and rules to members.
    a. Please attach sample communication materials you have produced for your clients, in the appendix.
    b. Is the cost of these communication materials included in your regular fee for the use of the network? If not, what is the additional cost?
5. Will your organization offer bi/multi-lingual communication materials?
6. Are the communication materials available electronically?
7. What Literacy level are your communications? Are you capable at producing communications between the 4th to 6th grade level if requested?
8. Provide sample patient/member education materials sent to enrollees in the last 12 months.

F. IMPLEMENTATION

1. Will you agree to guarantee complete implementation within one of the following timeframes, after being awarded the Contract?
    a. Within 60 days of receiving eligibility
    b. Within 90 days of receiving eligibility
    c. Within 120 days of receiving eligibility
    d. Cannot provide a guarantee on implementation timing
2. Provide a detailed proposed implementation plan and timetable, assuming an Effective Date of no later than January 1, 2022. Begin with the award of business to Effective Date of coverage, including:
    a. Steps required to implement the program.
    b. Role played by the client/vendor.
    c. Contacts and personnel assigned to each step of the implementation process.
    d. Production and distribution of ID cards, directories, and enrollment materials.
3. Please describe the implementation process that you will follow (and expect the Authority to follow) for implementing claims exchange procedures. Please include a sample implementation work plan that identifies expected activities, roles and responsibilities and timing.
4. Will you allow the Authority to conduct implementation testing prior to the plan going live?
    a. ☐ Yes
    b. ☐ No
5. In addition to testing, what other assistance do you offer internal staff, at no cost to the Authority, to familiarize them with the new system?

6. Please identify and describe any technical and networking requirements (i.e., file transfer protocol, workstation requirements, connectivity, and transmission software) that must be implemented to facilitate the electronic exchange of claims information.

   a. Will you provide an implementation allowance? If so, please quantify.

   b. Will you provide a pre- and post-implementation audit allowance? If so, please quantify.

G. NETWORK MANAGEMENT AND ACCESS

Upon receipt of the Intent to Propose Form, additional information will be provided via excel exhibits. Please complete the tables found in the attached excel document relating to your provider network, including network access, number of providers, average travel distance. NETWORK TURNOVER

1. Do you notify the Authority and/or members if a network physician terminates his/her Contract during the plan year?

   a. How and when are members notified?

   b. What happens to patients that are receiving ongoing treatment from that network physician?

2. Can the Authority or Member nominate providers to be considered for inclusion in the network panel? If so, what is the procedure for the Authority and/or member? What is the average length of time for review of these nominations?

3. For all service areas applicable to the Authority, provide the number of Network Providers that have terminated their Contract:

Provider Type	Unknown	Total # of Terminations in the Past 12 Months	Terminations Equate to What % of Your Contracted Providers?	Most Common Reasons For Termination (e.g. fraud, fees, quality)
a. Hospital Facilities	☐			
b. Physicians	☐			

   a. List any counties in the service areas that impact this Plan Sponsor that have had 5% or more physician turnover in the last 12 months. If so, please list each county and explain.

County	% of Physicians No Longer in Network	Reason for Physician Turnover

   b. With respect to network contracted outpatient hospital facilities, do all individual physicians within a group practice participate in your network? If not, please explain.

   c. Please list all hospitals, within those counties where members reside, that your organization does not have a negotiated hospital rate for all outpatient services.

H. ACCREDITATION

Complete the following grid with respect to your organization's accreditation status. Be sure to answer all three columns regarding the current levels of accreditation and the duration of each type of continuous accreditation, certifications and recognitions.

Type of Accreditation, Certification, Recognition	Current Level of Accreditation, Certification, Recognition	Duration of Continuous Accreditation, Certification, Recognition (# of years)
a. None		
b. American Accreditation Health Care Commission Inc. (AAHCC), formerly known as URAC	Check one: ☐Full accreditation ☐Denied/non-accredited ☐Pending (initial certification requested but not yet finalized). ☐Not yet requested	☐Less than 1 year ☐1 year ☐More than 1 year, but less than 2 years ☐2 years ☐More than 2 years, but less than 3 years ☐3 years or greater
c. JCAHO	Check one: ☐Accreditation with commendation ☐Accreditation ☐Accreditation with recommendation or improvement ☐Conditional accreditation ☐Provisional accreditation ☐Preliminary non-accreditation ☐Denied/non-accredited ☐Pending (initial visit requested but not yet visited) ☐Not yet requested	☐Less than 1 year ☐1 year ☐More than 1 year, but less than 2 years ☐2 years ☐More than 2 years, but less than 3 years ☐3 years or greater
d. NCQA	Check one: ☐Excellent (full 3 yrs) ☐Commendable (full 3 yrs) ☐Accredited (1 year) ☐Provisional ☐Denied/non-accredited ☐Pending (initial visit requested but not yet visited) ☐Not yet requested	☐Less than 1 year ☐1 year ☐More than 1 year, but less than 2 years ☐2 years ☐More than 2 years, but less than 3 years ☐3 years or greater

I. PROVIDER CREDENTIALS

1. Complete the following table regarding your organization's hospital credentialing requirements. [Copy chart and complete all columns of the following table separately if rural hospital credentialing differs]

Hospital Criteria	Check if the criteria is included in standard credentialing	Percent of Your Network Hospitals that Satisfy Criteria	Check if the criteria is included in standard recredentialing
a. Require State Licensure	☐		☐
b. Review Malpractice Coverage and History	☐		☐
c. Require full disclosure of current litigation & other disciplinary activity	☐		☐
d. Review CMS/Medicare certification status	☐		☐
e. Require JCAHO Accreditation	☐		☐
f. Review state health department citations	☐		☐
g. Review CMS/Medicare citations/problems	☐		☐
h. Patient Safety	☐		☐

2. When are contracted hospitals re-credentialed? (Check only one)

   a. ☐ Every year

   b. ☐ Every two years

   c. ☐ Every three years

   d. ☐ Less frequently than every three years

   e. ☐ Other timeframe (specify)

3. Please complete the following table regarding your monitoring of network hospitals for CMS "never events":

CMS Never Event	Do you monitor network hospitals for CMS "never events"?		If yes, what is the total percent of hospital infringement over the last 12 months?
	Yes	No	
a. Unintentional retention of a foreign object after surgery.	☐	☐	
b. Air embolism	☐	☐	
c. Blood incompatibility	☐	☐	
d. Pressure ulcers (Stages III and IV)	☐	☐	
e. Hospital-acquired injuries from falls and certain traumas (fracture, dislocation, intracranial injury, crushing injury, burns and/or electric shocks)	☐	☐	
f. Manifestations of poor glycemic control	☐	☐	

CMS Never Event	Do you monitor network hospitals for CMS "never events"?		If yes, what is the total percent of hospital infringement over the last 12 months?
	Yes	No	
g. Catheter-associated urinary tract infections (UTI)	☐	☐	
h. Vascular catheter-associated infection	☐	☐	
i. Deep vein thrombosis (DVT) or pulmonary embolism following total knee replacement and hip replacement procedures	☐	☐	
j. Surgical-site infections following certain orthopedic procedures, mediastinitis following coronary artery bypass graft (CABG) and/or following bariatric surgery for obesity	☐	☐	
k. Surgery on the wrong body part	☐	☐	
l. Surgery on the wrong patient	☐	☐	
m. Wrong surgery performed on a patient	☐	☐	

4. What percentage of your network providers in the following specialties are Board Certified? (Complete all)

Specialty	Percent Board Certified
a. Pediatricians	
b. Primary Care Physicians (e.g., include all general and family practitioners, and internists	
c. OB/GYNs	

5. Which of the following criteria does your organization use for credentialing physicians in your network? Check one in each credentialing criteria.

Requirement	Physician Credentialing Criteria
a. Medical license requirements:	☐ Currently not restricted or revoked, but past history exists. ☐ Never been restricted or revoked.
b. Board certification requirements:	☐ Require Board certification in specialty practice area. ☐ Board eligibility or certification not required. ☐ Must be Board eligible or Board certified.
c. Residency training requirements:	☐ Completed residency training with any institution/program. ☐ Residency must have been completed in a LCGME or AOA accredited institution/program. ☐ Residency training not required.
d. Drug Enforcement Administration (DEA) requirements:	☐ Current valid certificate with no history of revocation or limitation. ☐ Valid certificate not required. ☐ Current valid certificate with prior history.
e. Hospital privileges:	☐ Has admitting privileges to at least one community or teaching hospital and privileges have never been revoked or restricted. ☐ Hospital privileges not required. ☐ Has admitting privileges to at least one community or teaching hospital and privileges are currently not revoked or restricted.

Requirement	Physician Credentialing Criteria
f. References	☐ Not required. ☐ Requested but not always investigated. ☐ Requested and references are contacted and queried.
g. Proof of malpractice insurance.	☐ Not required. ☐ Required.
h. Onsite assessment of the physician's office by your staff, prior to Contract finalization.	☐ Not required. ☐ Required.
i. Full disclosure of current litigation and other disciplinary activity.	☐ Not required. ☐ Required.
j. Practice patterns and utilization results.	☐ Not required. ☐ Required.
k. Primary source verification.	☐ Not required. ☐ Required.

6. What is the minimum amount of malpractice coverage you require?

Malpractice Coverage	Minimum Amount
a. Per Hospital Occurrence	
b. Per Physician Occurrence	

7. Will your firm make information regarding provider sanctions and complaints available to the Authority and its members? If no, please explain.

   a. Yes

   b. No

J. MEDICAL CLAIMS ADMINISTRATION

1. Please confirm your ability to administer 1) 90th percentile of Fair Health for out-of-network claims reimbursement, 2) 225% of Medicare reimbursement rate, and 3) any other out-of-network reimbursement levels.

2. Please describe any preferred laboratory vendor arrangements you have and/or ability to interface with the existing vendors.

3. Please describe your subrogation process and corresponding fees.

4. Please confirm you will provide large claim reports with specific detail to the Authority's stop loss carrier. Please identify the frequency and the associated fee. You must also be able to accept a RX file for Stop Loss reporting requirements.

5. Please confirm you will communicate with a member in the process of submitting medical evidence for those procedures requiring pre-authorization.

6. How do you monitor and measure claims administration performance to assure quality, timeliness, and accuracy of services? Define your measurement and internal goals for each of the following: Financial Dollar Value, Number of claims without any error, number of claims without coding error, and number of claims without financial error.

7. Is your recordkeeping system flexible enough to capture and track the following data elements?
    a. Basic employee census data, such as employee name, address, social security number, e-mail address, and alternate ID number
    b. Data for each eligible dependent including, date of birth, sex, social security number, relationship to member (spouse, domestic partner, child, etc.), student/disability status and verification dates, other employment/coverage (COB), Medicare coverage, alternate mailing address, etc.
    c. Effective date by plan
    d. Termination date
    e. Eligibility rules and benefit design by plan
    f. Eligibility accounting by plan group and subgroup
    g. Subgroup accounting
    h. Appeals process (intake and first response)
    i. Status (Employee, LTD Claimant, Retiree, COBRA, etc.)
    j. HIC Numbers
8. Please describe your claims processing system. What other software is utilized (e.g., unbundling)?
9. Describe how you will track and capture eligibility information, claim payments, etc. for the Plans. Explain your retroactive eligibility procedures: are overpayments automatically recovered or previously denied claims reprocessed?
10. Identify the electronic processes in place for transfer of eligibility, claims payment, etc. Provide specific information for each task – for example, (1) are claims received direct from the provider for a clearinghouse? (2) Indicate the percentage of claims submitted electronically for your book of business.
11. Describe your system's auto adjudication capabilities. What percentage of claims are you typically able to auto adjudicate (please specify hospital, medical, etc.)? Estimate the percent you anticipate will auto adjudicate for the described benefits; list the type of Authority benefits that would not auto adjudicate.
12. Do you provide RDS cost reporting, payment assistant, and reconciliation services? Please include any applicable fees in Table 1 of the Fee Section, under "Other Fees." Please describe the RDS services your company can provide.
13. What processes or programs do you have in place (other than PPO discounts) that identify and result in claims cost savings? (e.g. unbundling, passive/silent network, OON claims negotiations, DME special pricing etc.)
14. Please describe your claims system capabilities in terms of reasonable and customary (R&C) profiles maintained. How do you develop and maintain your R&C profiles? How often are they updated? Can you capture CPT-4 codes plus modifiers? RBRVS? Custom R&C schedules?
15. Describe your internal procedures to monitor turnaround time and payment accuracy.

16. Describe your internal procedures and methodology for claims audits and quality control. Identify any criteria for examiner audits (i.e. high dollar limits, percent of claims, etc.) Are client specific reports available?

17. Please provide your most recent claims processing performance statistics for the claims office/staff that you are proposing for the Health Plans:

	Statistic
a. Claims processing turnaround time for clean claims (in working days)	days
b. Financial accuracy	%
c. Coding accuracy	%
d. Overall processing accuracy	%
e. Auto adjudication ratio	%

18. How do you handle backlogs or emergencies that affect claims processing and member service (e.g., overtime, switch to another office)?

19. Describe process for monitoring, recording and retrieving member service calls and correspondence.

20. What is your procedure for identifying sources of other coverage and for calculating COB savings?

21. Please describe what managed care services (i.e., UR, concurrent review, SSO, large case management, etc.) your organization can provide directly or through vendor partnerships. Identify each subcontractor arrangement by type of service and associated fee charged to the Authority (i.e. % of findings, hourly rate, etc.)

22. Describe the utilization review procedures. Include the primary care physicians and specialists role in the utilization review process.

    Your answer should address:

    a. Pre-service/Pre-certification

    b. Concurrent and Retroactive Review of on-going treatment

    c. Ability to provide utilization statistics and savings report

    d. UR staff credentials and qualifications

    e. UR staff training programs and monitoring

    f. Appeals process

    g. Third Party Review Policy and Associated Fees

    h. Systems edits and on-line access to supporting information

    For each component noted above be sure to provide:

    i. The qualifications of personnel performing the stated task.

    j. The timing requirements of each task

    k. How standards where developed

23. Please provide the names of Independent Review Organizations for which you have contracted. Is investigation coordinated in-house or subcontracted? Will a client-specific log

demonstrating the investigation efforts, refunds, and outstanding amounts be made available to the Authority?

24. Please describe how you identify and handle subrogation claims. Do you pay then pursue? Is investigation handled in-house or subcontracted? What is your fee for obtaining third party reimbursements? Will a client-specific log demonstrating the investigation efforts, refunds, and outstanding amounts be made available to the Authority?

25. What types of programs do you have in place to investigate potential health care fraud and abuse? How do you identify cases for investigation? What procedures are followed once a case is identified?

26. Explain how unusual claims and/or charges are handled. Do you retain medical consultants for the review of any unusual claims or charges? If yes, explain the method in which such medical consultants are used and their qualifications. Also, indicate the savings in claim costs that are attributable to the use of these medical consultants and how that amount of savings is calculated. Does this outside organization or person have any other kind of business or personal relationship with your organization or any member of your organization? If so, what is the relationship?

27. Are your systems and processes compliant with the DOL requirements for Claims and Appeals procedures?

28. How do you define medical necessity and appropriateness of medical treatment? What medical procedures/treatments are currently considered experimental by your organization? How do you determine whether a medical procedure/treatment is considered experimental?

29. Please describe your procedures and capabilities for handling a mid-benefit year transition. How do you obtain and incorporate file accumulators for deductibles, out-of-pocket accumulations, account balances, etc. from the current administrator for application to individual files? Do you accept electronic file transfers, printed explanation of benefit statements, etc.? Identify any limitations that apply.

K. PROVIDER AUDITS

1. Please provide latest statistics regarding on-site clinical quality audits of your contracted providers.

Provider Audits	On-Site	Electronic/Paper
a. Percent of Physicians Audited Annually		
b. Percent of Random Audits Performed		

2. Please describe fraud and abuse policies and procedures including how you identify and investigate abusive practice patterns.

3. What items do you audit electronically? (Check all that apply)
   a. Claims payment accuracy
   b. Claims coding accuracy
   c. Provider credentials
   d. Abusive provider practice patterns
   e. Provider sanctions

f. None of the above or unknown

g. Other

4. As a result of onsite electronic audits, what percentage of providers were terminated or removed from the network in the last 12 months?

Percent terminated as a result of audit		
	On-Site	**Electronic/Paper**
a. Network Hospitals		
b. Network Providers		

L. PROVIDER PROFILING AND CONTRACTING

1. Do you compare individual network provider practice patterns against best practices or averages on any of the following: (Check all that apply)

   a. ☐ Referral rates to specialists

   b. ☐ Frequency and quality of prescription drug dispensing

   c. ☐ Rates of Diagnostic Procedures ordered (Lab/Imaging)

   d. ☐ Rates of surgical procedures relative to peers

   e. ☐ Repeat Procedures within given timeframes

   f. ☐ Hospital Readmission Rates

   g. ☐ Emergency Room Admission Rates

   h. ☐ Other (please describe) _____

   i. ☐ Do Not Track

   For all that apply, please provide sample information.

2. What training or outreach do you offer network providers that are not performing well against benchmarks?

3. How do you ensure that someone using a network hospital will not get balance billed or charged an out-of-network benefit level due to the hospital using independent non-network provider (e.g., anesthesiologist)? Do you address in your provider Contracts? If so, please provide Contract language.

4. Does your provider Contract specify the minimum amount of fidelity and surety insurance or bond coverage each provider must maintain? If so, what are those minimums?

5. Are referrals restricted to contracted facilities only? (Check only one)

   a. ☐ Yes

   b. ☐ No

   c. ☐ Yes, unless we do not have a needed facility in our network

6. Does the Authority have the ability to pay certain providers (same type of physicians) at a different coinsurance or have a different copay structure? Can the Authority "bonus" providers?

7. Does the Authority have the ability to Contract directly with a network provider or a center of excellence to arrange special rates for certain services?

8. Which of the following provisions are contained in your standard provider contracts? (Check one in each provision)

   a. Penalty if patient is referred to non-network provider/facility?
      1) ☐ Yes
      2) ☐ No
      3) ☐ Unknown

   b. Reciprocity of discounts for enrollees from another state/plan.
      1) ☐ Yes
      2) ☐ No
      3) ☐ Unknown

   c. Require network provider to submit detailed encounter data.
      1) ☐ Yes
      2) ☐ No
      3) ☐ Unknown

   d. Prohibit network providers from balance billing above network discount amount. [except for any member required copay or coinsurance]
      1) ☐ Yes
      2) ☐ No
      3) ☐ Unknown

   e. Performance guarantees between the network and the provider.
      1) ☐ Yes
      2) ☐ No
      3) ☐ Unknown

   f. Provision that discount does not have to be honored if claim not paid within a certain timeframe, such as 90 days.
      1) ☐ Yes
      2) ☐ No
      3) ☐ Unknown

9. Is there a timeframe in which the negotiated discount would apply if a claim is paid?

   a. ☐ Yes

   b. ☐ No

   c. If yes, what is the time frame?
      1) ☐ Beyond 6 months
      2) ☐ Beyond 9 months
      3) ☐ Beyond 12 months

4) ☐ Other, specify _____

10. Does your Contract have a prompt pay provision?

    a. ☐ Yes

    b. ☐ No

    c. If yes, what is the percentage savings that would apply?

11. Does your Contract have a pay-for-performance feature?

    a. ☐ Yes

    b. ☐ No

    c. If yes, please explain: _____

12. Provide at least three samples of current physician, hospital, specialist and diagnostic network provider contracts.

    a. Would you allow the Authority to audit network provider contracts?

        1. Yes

        2. No

13. What additional tertiary network agreements are set up for non-network providers that belong to a rented network?

M. NETWORK PROVIDER OUTCOMES & QUALITY MANAGEMENT

The following two sections concern provider quality and outcomes. The Authority is interested in providing enhanced support to improve the overall health of members. This may include the implementation of programs that guide members to high-quality, high-performance providers.

1. The envisioned network will be created with the objective of population health management tied to quality and outcomes. Please indicate your willingness to partner with the Authority to create such a network, if one is not currently in place.

2. Describe any networks that you may currently have in place for other clients driven by quality, cost-effectiveness and evidence-based outcomes (e.g. tiered networks).

    a. Please provide any plan design restrictions in place to utilize these networks.

    b. What other incentives are used to drive member utilization at the preferred providers?

3. Describe the programs and the technology that your organization has in place to measure performance and quality variations between medical providers (hospitals and physicians).

4. Provide a description of the source of that information.

5. Explain how the information is used to develop high-quality/high-performance networks for clients.

6. Explain how your organization obtains provider outcomes and how it uses that information to establish group criteria and performance standards.

7. Explain any mechanisms in place to communicate quality and performance information to members, such as health advocates, nurse advice lines, members directly, etc.

8. Explain how this information is currently used to measure physician/hospital performance and drive quality improvements of under-performing providers.
9. Does the Authority have the ability to make decisions about the structure of the network (create a high performance network versus a broad EPO network, etc.)? If yes, please explain how you would envision this process including limitations.
10. What are the readmission rates of patients that are released within 30 days of discharge?
11. Please provide a copy of your most recent Quality Management Program Description and Evaluation. If not available, please describe in detail your program.

N. HIGH PERFORMANCE NETWORK

1. Provide a brief overview of your high-quality or high-performance network capabilities.
2. Does your high quality network have any Accreditations, Certifications, or Recognitions? If so, please provide detail on the current level of each and the duration of continuous accreditations, certifications or recognitions.
3. Provide a listing of the markets where the network is currently available, including plans for future expansion.
4. What types of medical providers/facilities are in your high performance network?
5. Provide a detailed list of physician subspecialties that are included in your high performance network.
6. Explain any programs in place to help navigate or guide members to high- performance/high-quality providers and to avoid care from under-performing providers.
7. How do you coordinate care with established patient centered medical homes?
8. Provide a list of client references that have implemented any of the aforementioned program strategies as described above.
9. What percentage of your network providers in the top member regions are currently contracted via a risk-share formula? Please provide the percentage separately for inpatient facilities, outpatient facilities and physicians. The percentage should represent the number of unique providers divided by the total number of unique network providers for each provider type. No providers should be counted more than once, and you must list the numerator and the denominator used to calculate the percentage inserted in each box.

Provider Type	"Accountable Care Organization"	Capitations or Shared Savings Contract
a. Inpatient		
b. Outpatient		
c. Physician		

10. Please indicate how you are defining "Accountable Care Organization".

11. How many Accountable Care Organizations (ACOs) do you currently Contract in each of the areas of the Authority's membership? Please provide details. Again, please indicate how you are defining "ACO".

12. Provide the number of ACO's contracted with by the end of 2019 as well as the number estimated for 2020. Would you include the Authority's population in the risk-share target negotiated with an ACO, or will the Authority have its own risk-share target set up with that particular ACO?

13. Explain in detail the nature of your relationship with all contracted ACO's in terms of the expectations you have for your model and the specific set of metrics that will be used to measure performance.

14. How are you going to be measuring repeat imaging and duplicative services?

15. What is your strategy for provider contracting beginning in 2022? 2023?

16. What impact do you expect the ACO contracting will have on trend in 2020? In 2021?

17. The Authority is interested in securing a trend guarantee that places a portion of the fee at risk for meeting overall cost increases. Please provide a guarantee for the following three years.

	01/01/2022-12/31/2022	**01/01/2023-12/31/2023**	**01/01/2024-12/31/2024**
a. Guaranteed Trend*			
b. Amount at Risk (as a % of Administration Fee)			

O. MEDICAL MANAGEMENT

The Authority is interested in medical management programs that address the entire continuum of care including: Health Promotion, Acute Care, Chronic Care, and End of Life. The following sections provide the Authority a brief overview of the services your organization can offer in this regard.

1. Health Promotion

For the purpose of the following questions, assume that the definition of health promotion refers to an organized program or approach to assist members in (a) identifying health risks, (b) receiving education to lower risk, (c) monitoring health status, and (d) changing behavior toward a healthy, more productive lifestyle.

* Trend guarantee will be based on the following methodology:
- The trend guarantee will apply to all claims incurred through all medical plans administered by the selected carrier for all non-Medicare members.
- The actual year one incurred claims number will be measured using medical claims that were incurred during the May 2021 to April 2022 policy year and paid during that policy year and a six month run-out period through October 2022, removing claims in excess of $250,000. This total will be divided by the actual enrollment during the policy year. (Same methodology applies for each year)
  - Claims will include the amounts that are the responsibility of both the member and the employer to mitigate distortions created by plan design changes. The actual year trend will be calculated by dividing the adjusted 2020 incurred claims per employee per month (calculated as described above) by the adjusted 2020 incurred claims per employee per month (calculated as described above) less 1. (Same methodology applies for CY 2020 over CY 2021 and CY 2023 over 2022.)
  - A member continuously enrolled 12 months would count as 12 member months.

a. Please describe your Health Promotion programs and initiatives to include:
    1) Targeted Population identification
    2) Communication Modes
    3) Program Components (i.e., education, screenings, etc.)
    4) Follow Up
    5) Initiatives in place (i.e., smoking cessation, key screenings, immunizations, weight loss, etc.)

b. Do you currently, or would you be willing to sponsor member Health Fairs?

c. Do you conduct Health Risk Assessments? If so, please provide sample tool and describe process and follow up.

d. Are bio-medical screenings included in your HRA?

e. Do you have a 24/7 Nurse Advice line?

f. The Plan is interested in robust, integrated wellness programs. Please provide specifics of programs available that would be of interest to the Plan, for example, smoking cessation, weight loss, etc.

2. Acute Care

    This section should address acute events, which require prompt diagnosis and treatment, such as, but not limited to Emergency Room visits, inpatient admissions, subacute/rehab/SNF stay, Home Health/DME.

3. Utilization Management: please describe the following UM components/programs

    1. Inpatient Concurrent Review
    2. Retrospective Reviews
    3. Prior Authorizations/Pre-certification
    4. Discharge Planning
    5. Transitional Care Management
    6. Inappropriate/Non-emergent ER visits
    7. ER Overutilization (i.e., frequent fliers)
    8. Readmission Reduction
    9. Home Health/DME Utilization
    10. SNF/Subacute/Rehab Utilization
    11. Potentially Avoidable Admissions
    12. Outpatient Facility Treatment and Diagnostic Utilization

    Please provide your most recent Utilization Management program description and evaluation documents.

4. Care Management

    For the purpose of the following questions, “care management” will refer to a program or initiative designed to improve the health, outcomes and quality of life of enrollees, as well as

lower costs through a systematic approach to actively manage a population of members with a specific disease or complex condition(s) and/or catastrophic events.

a. Complete the following grid regarding your organization's Care Management programs. Check all that apply.

Check the programs currently in place.	# of years program in place?	# members currently participating in program?	In-House Staff or Outsourced	What data or results are you currently tracking to demonstrate the effectiveness of each Disease Management Program? (Attach added documentation as needed)
1) Diabetes				
2) High Risk Pregnancy				
3) Hypertension				
4) HIV/AIDS				
5) Oncology				
6) Chronic obstructive pulmonary (COPD)				
7) Congestive Heart Failure (CHF)				
8) Adult asthma				
9) Pediatric asthma				
10) Pain Management				
11) Chronic renal failure				
12) End Stage Renal Disease (ESRD)				
13) Depression				
14) Transplants				
15) Coronary Artery Disease (CAD)				
16) Back Pain				
17) Complex Care (i.e.; Multiple Diagnoses)				
18) Behavioral Health/Substance Abuse				
19) Other:				

b. Indicate the elements that your organization incorporates into each care management program that you administer. Check all that apply.

1) Protocol to assist physician in making efficient diagnosis.
2) Periodic calls to discuss enrollee's compliance and health status.
3) Practice guidelines to develop consistency and effectiveness in treatment planning.
4) Provider survey on satisfaction with the disease management protocol.
5) Recommended drug therapy regimens.

6) Enrollee satisfaction with your disease management program.
7) Enrollee educational material (e.g., brochure, cards, video).
8) Patient's return demonstration of techniques or equipment taught to them.
9) Outcome measures indicating the CLINICAL effectiveness of program.
10) Outcome measures indicating the COST effectiveness of program.
11) Other:

c. How are potential candidates for the program(s) identified? Check all that apply.

1) A referral from the member's physician.
2) Evidence of at least one bill (claim/encounter) for a pertinent diagnosis.
3) Identified via a health risk assessment survey.
4) Members who have had at least one hospital admission for a pertinent diagnosis.
5) Prescription Drug usage.
6) ER visit(s) for a pertinent diagnosis.
7) Self-Referral
8) Predictive Modeling
9) Other (Please describe):

d. Please provide copies of your most recent Care Management program description and evaluation.

5. End of Life Care

a. Please describe any end of life programs/initiatives including:
1) Hospice
2) Palliative Care

6. Behavioral Health and Substance Abuse

a. Please describe the processes in place to manage mental health claims
b. Is this coverage outsourced? If so, please provide the name of your partner.

P. RISK IDENTIFICATION

1. Describe programs and technology that your organization has in place to do health risk stratification of plan populations.

2. Explain the current uses of claims data analysis to develop risk profiles of members and how that information is used to engage the member through medical management, disease management and other programs.

3. Describe the programs in place to do predictive modeling for a client population and how that information is used to manage care. In particular, describe the capability to do the

modeling before medical utilization. Include a review of the sources (data groupers—ETG, DRG, software, etc.) in the development of your predictive modeling system.

4. Behavioral Health/Substance Abuse

5. How are mental health and substance abuse services delivered? Check only one.

   1) We do not provide or offer mental health or substance abuse services.
      a. We Contract directly with mental health facilities and/or professionals.
      b. We subcontract with an independent organization to provide mental health and substance abuse services for our enrollees.
         Indicate name of Organization:

      c. We **subcontract with a division of our parent organization** to provide mental health and substance abuse services for our enrollees.

6. How does Behavioral Health/Substance Abuse services and providers integrate with your medical care management programs?

7. Please complete the following table for each three-digit zip location, as identified in the census file:

Provider	Total number of providers	Percentage of members with access to	
		2 providers within 5 miles	1 provider within 8 miles
a. Psychiatrist[1]			
b. PhD Psychologist[2]			
c. Other Psychologist[2]			
d. Social Worker[3]			
e. Substance Abuse Expert[4]			
f. Acute Care Hospitals			
g. Tertiary/Specialty Hospitals (e.g., Rehab facility, Intermediate care facility)			

8. During what hours of the day and/or night are your counseling staff and/or your network of local mental health professionals required to be available to see members?

[1] Psychiatrists are defined as physicians who deal with mental, emotional, behavioral disorders or substance abuse.
[2] Psychologists are defined as someone who has studied the science of mind and behavior, but does not have a medical degree.
[3] Certified Social Workers.
[4] A Substance Abuse Expert has at least one of the following credentials: a licensed physician, a licensed or certified social worker, a licensed or certified psychologist, a licensed or certified employee assistance professional, or an alcohol and drug abuse counselor certified by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission or by the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse.

9. Do you currently have an adequate number of staff to provide counseling services to the client in each region? If not, do you propose expanding your staff so that all regions are covered adequately? How long will this take? Can you have it done by January 1, 2022?

10. What programs do you offer Plan Sponsors? Complete the following table:

Services Offered	Yes or No	Comments
a. 24 hour 1 800 Telephone Access		
b. Face to Face Assessment and Referral (Indicate visit options 1 – 3,5,8)		
c. Are telephonic therapy visits a part of your program? Explain.		
d. Function as Gatekeeper to Inpatient and Outpatient facilities		
e. Telephone Crisis Intervention		
f. On site Crisis Intervention		
g. Management/Supervisor Training		
h. Provide Educational Material to all Enrollees		
i. Provide Wellness/Behavioral Health Seminars as requested by Client		
j. Offer and administer inpatient and outpatient network of providers (carve out of medical plan)		
k. Offer Insured Inpatient and Outpatient PPO/POS network of providers (carve out of medical plan)		
l. Pre-certification		

11. Are you able to provide TeleHealth services? If so, do you utilize case conferences? What is that process?

12. What processes do you have in place to avoid hospital admissions and emergency room usage?

Q. ORGANIZATIONAL STABILITY & EXPERIENCE

1. Network Ownership & Background

Complete the following information, for the benefits that are being proposed:

a) Describe company ownership including Parent Company name or other majority owners.

b) How long have you been providing your network arrangements to group health Plan Sponsors? Please provide response for all networks, PPO, EPO, POS and HMO.

c) Complete the following table indicating the proportion of networks provider contracts owned or leased.

Provider Type	100% Owned	% of Network Contracts Leased	Name of Sub-Contractor
1) Physicians	☐ Yes ☐ No		
2) Hospitals	☐ Yes ☐ No		

d) In the past 12 months, has your organization: (Check all that apply).

1) Closed any network services areas. If yes, please list the areas:
2) Combined/consolidated member service or claims service centers. If yes, please list the centers:
    1) Closed/consolidated or relocated any claims offices. If yes, please list the offices:
    2) Conducting a reduction in work force of more than 2% of total employees?
    3) Does not apply

e) Has your organization acquired, been acquired by, or merged with another organization in the past 24 months?
    1) Yes, please explain
    2) No

2) Financial Condition of Organization

a. Complete the following for your entire book of business.

	Most Current 12-Month Period	Previous Year
1) Admitted Reserves as a Percent of Premium	%	%
2) Current Ratio (Cash to Current Liability) *(For example, if 100%, indicate 1.0)*		
3) Days in Unpaid Claims	Days	Days
4) Medical Claims Loss Ratio		
5) Present Net Worth (Assets less Liabilities) as a percentage of total annual premium revenue	%	%

b. Indicate your most current claims-paying abilities as rated by:

Independent Rating Agency	Rating	Date
1) AM Best		
2) Standard & Poor		
3) Moody's		
4) Other/Not Rated (circle one and explain)		

c. Has there been any downgrade in your ratings in the last 2 years?

1) Yes, please explain the nature and reason(s) for the change
2) No

d. Indicate any reinsurance policies presently purchased OR special cash reserves set aside, to continue paying claims on existing policies in the event your organization ceases to operate due to bankruptcy, liquidation or other factors. (Check only one)

1) None

2) Reinsurance is in effect or separate reserves are held to cover contractual services for the following number of days: _____
(Response valid only if # of days provided)

3) Reserves as a percent of premium are _____%
(Response valid only if % provided)

4) Other (specify)

3. Staffing (Experience, Turnover)

a. Indicate your overall staff turnover rate for the past 12 months, period ended December 2020.

Position	Turnover
1) All Staff	%
2) Account Management Staff Only	%

b. Provide the number of years of experience in network management for the following executives. Please provide separately for each network, PPO, POS, EPO and HMO, if applicable:

Position	Number of Years of Industry Experience	Number of Years In Your Organization
1) Chief Executive Officer		
2) Chief Actuary/Chief Underwriter		
3) Medical Director		
4) Account Executive assigned to Plan Sponsor		
5) Claims Manager assigned to Plan Sponsor		

4. Membership Profile/Client Base (client retention, disenrollment, etc.)

a. Please complete the following for all lines of business:

Membership	January 2021	January 2022	January 2023	January 2024
1) Annual PPO Membership				
2) Annual HMO Membership				
3) Annual EPO Membership				
4) Annual POS Membership				
5) Annual Medicare / Medicaid Membership				
6) Annual Self Administrative Membership				

b. Please complete the following table on client retention rates (Group Accounts Only):

	1 Year	2 Years	3 Years
a. Client Retention Rates	%	%	%
b. Termination Rates	%	%	%

c. Indicate your organization's commercial membership (number of employees and dependents) disenrollment rate for the most recent one-year period. (Check only one)

1) Unknown
2) %

5. Liability Insurance/Pending Legal Action
   a. Are there any outstanding legal actions pending against your organization?
      1) Yes. Please explain the nature and current status of the action(s) to the extent possible.
      2) No

      If yes, can you assure the Authority these actions will not disrupt business operation?
      1) Yes
      2) No
   2. What fidelity and surety insurance or bond coverage do you carry to protect your clients? Specifically describe the type and amount of the fidelity bond insuring your employees that would protect this plan in the event of a loss. [Please provide copies of such policies].
   3. Indicate your firm's liability INSURANCE LIMIT with regard to errors, omission, negligence, malpractice.

Annual dollar limit per occurrence	%
Name of insurer	%

   d. What legal support do you provide in the event there is litigation regarding a claim payment?

R. COVERAGE AND PLAN CONTRACT ISSUES

1. How are Usual & Customary (U&C) fees determined for out of network claims? Please indicate the basis for both facility and professional. Does it vary by geography within the Authority's service area? How often is U&C updated? Can the Authority establish its own U&C fee schedule?

2. Please confirm your ability to administer the active and legacy programs on an "equal to or better than" basis.

3. Please confirm your ability to administer 1) 90th percentile of Fair Health for out-of-network claims reimbursement, 2) 225% of Medicare reimbursement rate, and 3) any other out-of-network reimbursement levels.

4. Please describe your processes for the transition of care for members currently receiving treatment.

5. Please confirm that your Proposal provides a mirroring of the Plan provisions currently inforce and note if there are any obstacles within your system programming. Are the provision for coverage and exclusion contained in the Plan inconsistent with any requirements of your claims management systems?

6. Please identify how your organization identifies non-covered services for reasons of acts of war, felony, skydiving terrorism, acts of misrepresentation, etc.

7. How is medical necessity defined by your plan? Would you suggest any changes to the provisions of Authority's definition?

8. How are experimental procedures defined by your plan? Would you suggest any changes to the provisions of Authority's definition?

9. How is Emergent care vs. Non-emergent care defined as per utilization of an Emergency Room for services, which may or may not be appropriate?

10. At the outset of a new client Contract, how is treatment in progress covered? (Check only one)

    a. Will offer network discounts only if patient's provider is in-network.

    b. No network benefits apply if treatment is in progress on first day of eligibility.

    c. There will be no balance billing for out of network (network management section)

11. At the end of the client's Contract and treatment in progress, network discounts will apply to inpatient stays through discharge date.

    a. Yes

    b. No

12. How long will you process claims incurred within the Contract period but submitted after the Contract was terminated? Provide the results separately for claims sent from the provider and from the patient. In addition, specify the additional charge for this service, if applicable.

13. Submit the most recent copy of all contracts/agreements that you would use if you were selected as the provider of services for the Authority.

14. Does your Contract allow for the assignment of any portion of the Contract to any other third-party? If yes, describe the conditions under which such assignment may be made.

15. Will your organization be able to provide an SSAE 16 (formally, SAS70) report on an annual basis? If not, please provide details on what measures your company takes in lieu of the SSAE 16 report.

16. Will your Contract include notification requirements that the Authority will be notified within 30 days if the network loses any accreditation, licenses, or liability insurance coverage, security or bonding?

17. Does your organization agree that the Authority will always pay the lesser of the negotiated fee or the billed charge? If no, please detail the types of services that "case over-charges" might occur (e.g., inpatient hospital, lab work, DME, etc.).

18. Will you accept the role of Claims Fiduciary, as that term is defined in ERISA, for the Authority's Medical and Behavioral Health benefits for the duration of your Contract to provide services under the Authority Plan?

19. Will your Contract provide that the Authority will be provided with a list of each separate vender that you use to fulfill your duties as Claims Fiduciary to the Plan? That list must be complete on the inception of the Contract and it must be updated with 30 days of any change in the venders listed or in the duties performed by a vender.

S. PERFORMANCE GUARANTEES

1. Would you agree to include the following service performance guarantees in your Contract? Check all that apply. Supporting documentation may be required for independent validation through an external audit. Check all that apply and provide your recommended definition for measurement.

a. **Timely delivery of initial ID cards**: 99% mailed within 10 business days after eligibility data has been provided by the Authority Office. This includes all initial ID cards for new enrollees.

b. **Timely delivery of provider directories:** 99% mailed at the same time as initial ID cards.

c. **Account Service Resolution:** Authority's calls returned within 1 business day.

d. **Timely delivery of updated provider directories:** All provider directories are to be updated at least annually.

e. **Accuracy of new and replacement ID cards:** 100% of all ID cards will contain accurate information compared to the enrollment information furnished by the Authority.

f. **Telephone call availability and answering speed:** 100% of all calls are answered within 45 seconds between 8:00 am and 8:00 p.m. EST on business days.

g. **Telephone call abandonment rate:** An abandonment rate of less than 5% is maintained during standard business hours.

h. **Initial implementation and enrollment process.** Based on the overall satisfaction of the Authority.

i. **Eligibility updates**: Less than or equal to 2 business days measured from the date of receipt to date the system is updated; receipts after 4:00 pm are recorded as the following business day.

j. **Eligibility error reports**: Less than or equal to 48 hours

k. **Written inquiry**: Response Less than or equal to 10 business days

l. **Customer Satisfaction**: Greater than or equal to 85 % reported annually

m. **First Call resolution**: Greater than or equal to 90 %

n. On-time delivery of periodic and annual experience/utilization reports and delivery of information or notifications to the Trust.

o. A subjective service measurement that will be solely determined by the Trust's benefits management.

2. Would you agree to include the following access performance guarantees in your Contract? Check all that apply.

   a. **Appointment access time:** Appointments for routine physicals within three weeks of initial request; for non-urgent care within five days of initial request; for urgent care within same day as request.
   b. **PCPs with closed practices:** Less than 4% of PCPs with a closed practice.
   c. **Timely notice of network charges:** Authority Office is to be notified of every addition or deletion of providers by mail within 2 business days.

3. Indicate the amount of fees, as a percentage of total fees that you are willing to put at risk.

4. Are you willing to take up-side and/or down-side risk for performance guarantees for specific metrics agreed upon by both parties?

   Please note, we have provided standard guarantee parameters. The Authority will work with finalists to refine the guarantees that are deemed necessary to meet their specific needs.

U. CERTIFICATION LETTER FOR MEDICAL

As an officer of the following corporation, I certify that all of the information included in this Proposal is true and accurate.

As an officer of the following corporation, I certify that all of the information included in this Proposal is true and accurate.

Signature _____

Name _____

Title _____

Date _____

V. ACKNOWLEDGMENT AND STATEMENT OF EXCEPTIONS FORM FOR THE MEDICAL PROGRAM

Re: New Jersey Turnpike Authority

We have reviewed the Proposal specifications contained in this RFP and are in agreement with those requirements except as stated or referenced below (or on the attached sheet(s)):

Company Name	**Signature**
Date	**Title**

SECTION VII B – DENTAL QUESTIONNAIRE

A. GENERAL REQUIREMENTS AND QUESTIONS FOR ALL PROPOSERS

In order for your Proposal to be considered and accepted, your organization must provide answers to the questions presented in this section. Each question must be answered specifically and in detail. Reference should not be made to a prior response, or to your Contract, unless the question involved specifically provides such an option. Be sure to refer to the earlier sections of this RFP before responding to any of the questions, so that you have a complete understanding of all of the Authority requirements with respect to the Proposal.

If your Proposal is different in any way (whether more or less favorable) from that indicated in this RFP, clearly indicate where. If you do not, the submission of your Proposal will be deemed a certification that you will comply in every respect (including, but not limited to, coverage provided, funding method requested, benefit exclusions and limitations, underwriting provisions, etc.) with the requirements set forth in this RFP.

If you are unable to perform any required service indicate clearly: a) what you are currently unable to do, b) what steps will be taken (if any) to meet the requirement, c) the timetable for that process, and d) who will be responsible for the implementation.

The Authority is requesting several plan alternatives on an ASO basis. For each of the proposed networks, indicate within the question if response varies based upon the product offered, otherwise it will be assumed to be for all proposed options. For the funding arrangements, under the fully insured clearly indicate if the arrangement is retrospective or prospective. If both are offered, respond to those questions that apply and clearly indicate which arrangement the response applies to.

B. FINANCIAL SECTION

1. Administrative Fees and Network Access Charges

   Complete the following table for ASO contracts. Fees must be provided in the following formats.

   The marketplace has shown a move toward unbundling some of the administrative services handled under the ASO Contract. These charges have, for the most part, taken the form of a percentage of the savings. Please clearly specify any additional services that are paid under any form, per employee per month, percentage of savings, etc.

Fees PEPM	Policy Year		
	Year 1	**Year 2**	**Year 3**
a. PPO Network Access Fees			
b. Utilization Management Fees			
c. ID Cards			
d. Dental Claim Processing			
e. Incentive Coinsurance Administration			
f. Provider Directory			
g. Data Reporting			
h. Out of Network Negotiation Fee (provide fee and carrier utilized)			
i. Claim Fiduciary			
j. SPD's/Benefit Booklets			
k. Other			

l. All Inclusive Fee (PEPM)			

Fees (Per Member Per Year)	Year 1	Year 2	Year 3
a. Estimated claims PEPY			

Based on the census, estimate the total network fees in years one, two and three.

The chart above includes a comprehensive list of all services under the various options requested. Please clearly state the fee that is applicable for a bundled ASO arrangement as well as the alternatives that are proposed specific to the alternates offered by your organization.

If any extra fees will be billed to the Authority, specify the organizations that will perform the functions provided, define fully the functions to be performed and estimate the fees that will be charged and the basis on which the fees will be based (e.g., as a percentage of savings).

Notes:

1) All services to be provided for the quoted fee should be listed including quantities and frequencies.
2) Fees must exclude commissions.
3) Individual fee components will be assumed to be self-supporting stand-alone services.
4) Provide estimate of fee for alternative options of services, on requested basis.
5) Fees quoted must be valid for 180 days after receipt of quote & guaranteed for each 12-month period.
6) List services/supplies not covered under the fees quoted above (i.e., custom reports, printing, etc.).
7) Fees quoted are to cover services for claims incurred on or after the Contract Effective Date.

2. Provider Reimbursement & Access
   a. Dentist Reimbursement
      a. Describe how network dentists are reimbursed. Your answer should be consistent with the fees provided in the financial section of this Proposal specification. Include any incentive-based bonuses, withholds, retroactive capitations, etc.
      b. Describe how network specialists are reimbursed. Your answer should be consistent with the fees provided in the financial section of this Proposal specification. Include any incentive-based bonuses, withholds, retroactive capitations, etc.
      c. How often are network fees updated?
      d. Are there financial incentives to network providers that are tied to utilization goals, specialty referrals, quality of care outcomes or other performance results? If so, please explain.
      e. Can a Plan Sponsor provide its own set of allowances or "freeze" the existing level of reimbursement? If so, is there any limitation on, or is there any extra charge for doing so? If so, what are the limitations/charges?
      f. Will R&C data and claim payment data be made available by ADA/CPT-2 code and zip code?
      g. Do you reimburse assistant oral surgeons? If so, how do you determine the allowance for the specific surgery performed? What percentage do you use? If you use another method of reimbursement, please explain.
      h. Do you prohibit network dentists from being direct owners, or having any financial involvement, of outpatient facilities such as labs, and surgical centers? If not, is there any monitoring of self-referrals to provider owned outpatient facilities?

i. What steps are taken if the network provider charges in excess of the maximum allowable charge? How are the Plan Sponsor and the members supported in their resistance to charges in excess of maximum allowable charge?

j. Can a claimant be privy to the payment schedule in advance of treatment? If so, how?

k. What are your average R&C savings and how are they calculated?

l. Are any arrangements made with dental suppliers and labs? Do you limit reimbursement for supplies [i.e., crowns, bridges] and equipment, or help network providers to purchase supplies at wholesale prices?

3. Discount Evaluation

Discount Evaluation Exhibits – Please provide responses for PPO network proposed.

Complete the following exhibits for your network and/or non-network providers where appropriate. The exhibits list common procedures by ADA codes. Please provide contractual fees for these services for your network providers for the following three-digit zip codes: 070, 087, 077, 088, 080, 071, 085, 082, 076 and 074. If one network allowance applies for a multitude of areas, please indicate so.

The amounts listed should be what is currently the average or contractual amount reimbursed for the given procedures for the program being requested as of December 2020. Fees should represent any maximum allowance, contractual discounted fee schedule, lesser of provisions or any other factors that will influence the average charge that the Plan Sponsor can expect to pay.

For the following procedures, please list the fee for service contractual network amount. The amounts shown should be based on what will be in place for the projected plan Effective Date and for the current period for location noted below. Please provide separate charges for each product offered. For plans with out of network charges, indicate the out of network separately. Clearly label all charts.

*Chart should be filled out separately for the following zip codes: 070, 087, 077, 088, 080, 071, 085, 082, 076 and 074.

Location: ZIP *		**Allowable Network Charge**	
ADA Codes	**Procedure**	**Current**	**Effective Date**
D1110	Prophylaxis –Adult		
D0120	Periodic Oral Examination		
D2750	Crwn Porcn Fus/Hgh NBL Met		
D4341	Periodontal Scaling & Root		
D3330	Endodontic Therapy, Molar		
D8670	Periodic Orthodontic Treat Visit		
D2392	Resin Based Composte – 2SU		
D2393	Resin Based Composite – 3 SU		
D2391	Resin Based Composite – 1SU		
D0274	Dental Btewings Four Radiog		
D6750	Crown Porcln High Noble		
D3320	Endodontic Therapy, Bicuspidl		
D4260	Osseous Surgery		
D2752	Crown Prcln Fus Noble Met		

Location: ZIP *		Allowable Network Charge	
ADA Codes	**Procedure**	**Current**	**Effective Date**
D0230	Intraoral Periapial – ea add		
D0330	Endodontic therapy – anterior		
D2332	Resin 3 surface – anterior		
D7210	Removal of tooth, erupted		
D2740	Crown Prcln, ceramic sub		
D2335	Resin 4+surface with incs ant		
D0220	Intraoral periapical first		
D2751	Crown Prcln Fuse Met		
D6240	Bridge Prcln High noble		
D2954	Prefab post core and crown		
D1120	Prophylaxis – Chile		

4. Network Access

a. Complete the geographic matching specifications using the Plan's census information (census information will be provided upon receipt of the Intent to Propose Form). Please provide the charts separately each three-digit zip 070, 087, 077, 088, 080, 071, 085, 082, 076 and 074. Also, please provide reporting on all employees who do not have desired access and how far they will have to travel to see an in-network dentist.

Provider	Total number of providers	Percentage of 2 providers within 5 miles	Percentage of 2 providers within 8 miles
a) Primary			
b) Specialists			
c) Orthodontists			

b. Complete the following exhibit for each network.

Access Criteria	Primary Care Dentists	Specialists
a) Average number of office hours available to members per week		
b) Percent of Providers with evening or weekend office hours		
c) Average number of days between request for appointment and actual visit		

C. REFERENCES

1. Provide the following for each reference:

a. Client name
b. Address
c. Industry (if not obvious)
d. Contact name, title and phone number

e. Total number of active members

f. Total number of retirees and survivors. Total number of covered lives under the health program.

g. Length of time as a client of your company.

2. Proposer(s) must submit a list of three (3) client Public Sector references, of which:
   a. at least two must be New Jersey based;
   b. at least two have participation between 2,500 and 5,000 employees; and
   c. at least one must be a new client (with an Effective Date of 1/1/19 or later) who can attest to their experience with your implementation capabilities.
3. Proposer(s) must provide names, addresses and telephone numbers of one (1) Public Sector clients, with between 2,500 and 5,000 employees) who terminated their relationship with your company in the last two years.
4. Please submit a national labor client list.
5. Provide the type of plan administered for each reference.

D. GENERAL ISSUES (EXPERIENCE, SOLVENCY, MEMBERSHIP)

1. Complete the following information, for the benefits that are being proposed:

   Parent Company, if any: _____

   Year Network Established: _____

   Number of Group Plans terminated in past 24 months: _____

2. Provide the name, address, and telephone numbers of at least three current clients that are similar with respect to coverage, group size, industry and/or location.
3. Are there any outstanding legal actions pending against your organization? If so, please explain the nature and current status of the action(s). What fidelity and surety insurance or bond coverage do you carry to protect your clients? Specifically describe the type and amount of the fidelity bond insuring your employees, which would protect this plan in the event of a loss. Do you agree to furnish a copy of all such policies for review by legal counsel if requested?
4. List other group benefit services your organization provides, other than what is being proposed.
5. Designate the individual(s) with the following responsibilities. Include the name, title, and address of each individual, along with a brief description of qualifications and experience.
   a. The individual(s) representing your company during the Proposal process.
   b. The individual(s), who will be assigned to the overall ongoing management.
   c. The individual(s) responsible for day-to-day service.
6. As the Contract will be issued in the state of New Jersey, the Contract must be in full accord with the laws of that jurisdiction. Please confirm that your Proposal and plan design offered is in compliance with all federal and state laws and regulations that pertain to employee benefit programs, relevant state insurance regulations and other related laws.
7. If the plan design requested does not comply with any state or federal laws, please indicate which provisions in the Proposal specifications are in conflict with specific laws and propose alternatives.
8. Is your firm anticipating expansion or reorganization in the next year? Please explain.

9. Have you eliminated any network service areas in the last 12 months? If yes, please explain.
10. In the past 12 months, has your organization combined/consolidated member service or claims service centers?
11. Has your organization acquired, been acquired by, or merged with another organization in the past 24 months? If yes, please explain.
12. Please supply a copy of your latest annual report that includes all financial exhibits. If your report does not contain a balance sheet, an income statement and a statement of cash flows with all required footnotes, please supply the supplemental materials that contain this information.
13. Please indicate your current ratio, days cash on hand and debt to equity ratio.
14. If your network is inadequate to meet the Authority's requirements in a geographic area, would you agree to recruit additional providers or Contract with another network of providers in order to improve access? If an outside network were contracted, would you agree to pass through to the Authority all discounts and/or charges? What is your fee in contracting with additional networks? What services do you perform for this fee?

E. COVERAGE ISSUES

1. Please confirm your ability to administer the five (5) programs on an "equal to or better than" basis.
2. Please confirm your ability to follow the Plan's exclusions and limitations as set forth in the current program. Are there any concerns for your ability to program this plan into your system?
3. How is medical/dental necessity defined? What procedures are currently considered experimental by your organization?
4. Describe your pre-existing condition exclusion? Will you waive the pre-existing condition for all actively at work members, who are currently covered under an existing dental plan?
5. Describe how work in progress (at the time of plan transition) will be treated. How will orthodontics claims be adjudicated? What portions of claim expenses will be honored?
6. Describe how treatment in progress will be covered if your plan is terminated during an episode of treatment. What services (i.e., root canal, crowns, etc.) are covered and for what amounts?
7. Indicate whether any of the services currently offered cannot be provided to any of the members?

F. FEES AND AGREEMENTS

1. List all services and supplies that are covered by the fees provided in the financial section.
2. If your organization makes any charges of any kind for services or supplies that are not included in the fees quoted on the basis indicated above (e.g., start-up costs, booklet drafting or printing) please describe clearly in your Proposal such services and/or supplies and the charges that will be made for them. Otherwise, we will assume that the fees that you quote include all services and supplies that could reasonably be expected to be provided to the Plan during the course of your administration of the plan.
3. Will there be any additional charges if the plan of benefits is restructured or new classes are added? If so, what is that charge?
4. The Plan Sponsor asks that any fees you propose in response to these specifications be guaranteed until the Effective Date of January 1, 2022. Will you agree to guarantee your quoted fee until the proposed Effective Date?

5. Please list any additional or optional services that you offer that have not been requested. Provide charges and fees for these additional services.
6. If you are selected as the insurance carrier, what are your rules regarding pre-existing conditions, your actively-at-work rules or any other provisions that might limit or eliminate benefits to certain employees on the Effective Date of the policy? Do you have a thirty-one day non-confinement rule or any other restrictions on coverage for dependents on the Effective Date of the policy?
7. Will you guarantee that all insureds (including COBRA continuers), who would have continued to be covered on the plan Effective Date if there had been no change in carriers, will be covered by your policy on the plan Effective Date?
8. Please indicate any minimum requirements for employee and dependent participation in the plan. Also, indicate whether rates can be affected by participation. If so, how?
9. Please indicate what procedure your company requires when an employee desires to elect coverage after the period during which he was originally eligible (i.e., how is a late entrant treated)?
10. Describe your preferred funding arrangement for self-funded claims.

G. ACCOUNT CASE, MEMBER SERVICES & NETWORK STRUCTURE

1. What sales office would handle the general servicing of this account? Provide a brief biography of the senior officials responsible for the overall service of the account and for the day-to-day operations. What are the standard office hours for the sales and service office?
2. How will fees be billed and collected? If more than one coverage is provided by your organization, do you coordinate billing procedures so that the Plan Sponsor receives one comprehensive bill? Is there any discounts offered for multi-line business?
3. Will dedicated customer service representatives be assigned to this account?
4. Is a toll free number available to the Plan Sponsor and members to handle service issues? If not, would you agree to establish toll free 800 telephone lines for this group? How many telephone lines do you expect to use? What hours will the telephone lines be manned?
5. Does your organization offer simultaneous language interpretation via AT&T or other communications vendors? This service would allow the Authority's members to receive responses to questions about their benefits in the language in which they are most comfortable.
6. Describe any special programs you can provide to members who speak a foreign language as their primary language. Be sure to indicate any additional costs for these special programs.
7. Provide a sample of communications material available to Plan Sponsors and members with regard to network enrollment, network utilization, ID cards, etc.
8. Are the communication materials available electronically?
9. What geographic areas constitute the service areas of the network? How do you define whether an employee is within a service area (e.g., three-digit zip, county)?
10. For the DPPO list any current federal, state, and independent qualifications or accreditation.
11. In the selection of network providers and members:
    a. Please submit a copy of the application form.
    b. Please submit a copy of site visitation/analysis form.
    c. Are site visits performed prior to network acceptance? If not, why?

d. Besides the application and site visit, what other criteria are used to select a network provider?

e. Who performs the site visits?

12. Do general dentists act as gatekeepers for specialists' service? Describe the referral process. Does this vary by option proposed? Please clearly indicate which options proposed have the gatekeeper approach.

13. Describe how members select network providers. Do you provide member support services for selecting and/or locating network physicians and for answering provider credential questions that members may have? Do you have on-line access to network provider listings and locations to assist members with provider selection? What other member services are provided with regard to provider selection assistance.

14. What assistance do you provide members if a network dentist terminates their Contract during the plan year? How and when are the Plan Sponsor and/or members notified? What happens to patients who are receiving on-going treatment from that network provider?

15. Can the Plan Sponsor or member nominate providers to be considered for inclusion in the network panel? If so, what steps would be required to be made by the Plan Sponsor and/or member? Would you allow all current participating providers to be included in your network? If yes, how quickly would they be added to your provider directories/on-line listings?

16. Do you monitor waiting times for patients for appointments and once the patient is in the facility of the provider?

17. Are any health education programs available through your organization? If so, please describe in detail.

18. Are there any dental services or specialties that are not available in your network in any of the areas in which there are members? If so, what are they? What provisions are made for patients requiring these services?

19. Will you agree to notify the Contract holder immediately if the network loses any accreditation, licenses or liability insurance coverage, security or bonding?

20. Please complete the following profile for your Dental PPO network.

Network Name:	**Location**
a. Operational date of DPPO	
b. List the service area counties	
Enrollment in the DPPO for:	
1) 2018	
2) 2019	
3) 2020	
d. Information on Primary Dentists	
1) Total Number (December 2020)	
2) Number by Type of Practice:	
a) Sole practitioner	
b) Clinic	
3) Number with open practices	
4) Percentage reimbursed by:	
a) Capitation	
b) Discounted FFS	
c) Fee schedule	
e. Information on Specialty Dentists	

Network Name:	Location
1) Number by specialty (December 2020)	
d) Orthodontics	
e) Endodontics	
f) Periodontics	
g) Oral Surgery	
h) Pedodontics	
i) Prosthodontics	
j) Other (describe)	
2) Percentage reimbursed by:	
a) Capitation	
b) Discounted FFS	
c) Fee schedule	

H. NETWORK QUALITY ASSESSMENT

1. Complete the following table. Check off those elements that are included in the provider selection process and provide the percentage of network providers that satisfy the following selection criteria elements.

Criteria	Standard Selection Criteria (check if *yes*)	Percentage of Providers that Satisfy Criteria	Comments
a. Require Unrestricted State Licensure	☐		
b. Review Malpractice Coverage and History	☐		
c. Require full disclosure of current litigation & other disciplinary activity	☐		
d. Require Signed Application/Agreement	☐		
e. Require Hepatitis B (3) series of shots	☐		
f. Require dated examination of radiograph equipment	☐		
g. Require Current DEA Registration	☐		
h. Review adherence to state and community practice standards	☐		
i. On-site review of office location, appearance, and ease of access	☐		
j. Review hours of operation and capacity	☐		
k. Review Practice Patterns & Utilization Results	☐		

2. Describe the general credentialing process and minimum criteria for a dentist to be selected as a network provider. If the process differs by type of provider (i.e., primary care vs. specialists), please indicate and describe separately.
3. Is malpractice coverage required per dentist? List minimum amounts of coverage.
4. Describe the re-credentialing process, include timing and percentage of providers that are re-credentialed each year. Provide the number of years that a provider's Contract is in effect.

5. Are visit summaries given to the network providers? How often and under what circumstances are these site reports followed up on?
6. Are you willing to have random site visitations for some of the providers of the network by the client's dental consultant? If not, why not?
7. Termination Rates

For the service areas that will service the proposed group, provide the number of participating dentists that were terminated in past 24 months (or two complete years):

	Number of Dentists	Percentage of Dentists	Reason for Terminations
a. By Your Organization:			
b. .By Provider:			

8. Describe your organization's objectives/efforts with regard to provider relations. Is there an oversight committee that addresses provider relations issues? If so, what are the credentials of the staff members that serve on the committee? How do you address "Any Willing Provider" laws? What procedures are in place to monitor network provider grievances?
9. What quality improvement programs are in place or have been implemented in the last 24 months? Describe how providers are educated about any quality improvement programs related to the delivery of care.
10. Do you currently perform membership satisfaction surveys? If so, provide a copy of the latest results of the survey. Does an outside organization perform the survey? The survey should provide the percent of members who indicated that they were "satisfied with the plan."
11. Describe what aspects of care are being monitored and evaluated on an ongoing basis. Include any established treatment benchmark and any review of adverse outcomes for specific conditions. Summarize any practice guidelines implemented by network providers that are employed as a network standard for delivery of care. If available, provide statistical results supporting the effective application of these guidelines.
12. Describe specific examples of how your Quality Assurance program has led to improved dental care.
13. Please describe your review procedures for the frequency of periodontal evaluations
14. Are network providers required to take continuing education courses?
15. For plans that require members to select a primary care dentist, do you allow/encourage "disease based" specialists to serve as the primary care dentists for patients with chronic specialized illnesses such as periodontal disease?
16. Provider Audits

Describe the procedures in place to audit the quality of care being rendered by network providers. Include the following information:

	On-Site	Total
a. Percent of Dentists Audited Annually	%	
b. Percent of Random Audits Performed	%	
c. Percent of audits performed or reviewed by independent agents. Provide name, credentials, and role of independent auditors. _____ _____ _____		%

	On-Site	Total
d. Is the right to audit included in your standard provider contracts?		☐ Yes ☐ No
e. Percent of contracts terminated due to result of audit		%

17. Are your networks accredited by any nationally recognized quality assessment organization? If so, explain.
18. Please provide copies of your network provider Contract and provider office procedural manuals.
19. Is there a formal committee that sets quality assurance policy and reviews outcomes on a regular basis?
20. Describe in detail the claims auditing procedures established by your company (frequency, extent, etc.). Will you supply a copy of all such reports to the policyholder?
21. Describe the quality assurance program that you have in place. Include a description of the nature of the program, the frequency with which the controls are applied, who conducts the program, where it is conducted, what standards are applied, what percentage of claims are reviewed and the means of selecting the claims to be reviewed. Are analyses done pre or post payment?
22. Do you maintain statistics with respect to telephone response time? Abandonment? Inquiries made? If so, provide results for the last calendar year.
23. Please indicate your ability to provide prevention-oriented services to members to enhance dental health and control long-term costs. Please be specific. In particular, describe any programs oriented to dependent children.
24. Do you have outreach programs that could be developed and/or supported to enhance member and neighborhood dental health? If so please describe.

I. UTILIZATION MANAGEMENT

1. Describe the utilization review procedures for in-network claims.

   Your answer should address:

   a. Pre-service/Pre-certification
   b. Concurrent and Retroactive Review of on-going treatment
   c. Ability to provide utilization statistics and savings report
   d. UR staff credentials and qualifications
   e. UR staff training programs and monitoring
   f. Appeals process
   g. Systems edits and on-line access to supporting information

2. For each component noted above be sure to provide:

   a. The qualifications of personnel performing the stated task.
   b. The timing requirements of each task
   c. How standards where developed

3. How information is captured and results are monitored?

4. What is the process for assigning pre-certification and appeals to dentists for review? What percent of cases typically require a dentist's involvement? At what point is dentist involvement initiated?
5. Provide the percentage of in-take telephone calls handled directly by clinically trained personnel? Are there telephone numbers specially set aside for members and providers? If not, why not?
6. In what form and how quickly is notification of utilization review provided to the attending provider and patient?
7. What is your typical turnaround time for your pre-certification service (from the time a call is initiated by the member or provider to the time a phone determination is given and written confirmation is released)?
8. Describe the specialist referral process. Include an explanation of how self-referrals are handled (where network specialists are available, and where there is no available network specialist).
9. Are specialists being added to fill voids that exist and/or occur? What is normal replacement time?
10. Briefly explain any financial incentives established for providers to comply with utilization management protocols or treatment benchmarks. Include withholds, bonuses or other arrangements that are tied directly to provider utilization results and/or outcomes.
11. What utilization/encounter information do you require your network providers to report? Describe the process of how this information is provided.
12. Explain any contractual relationships with outpatient facilities such as surgical centers and laboratories. Are referrals restricted to contractual facilities only? What utilization controls are in place with these facilities to reduce the number of unnecessary services being performed?
13. Does your system verify the appropriateness of the billed charge? Please describe in detail.
14. Do you track and collect data on provider reimbursement by provider? What data is captured and tracked? Are providers terminated for abusive or excessive billing practices?
15. How do you prevent over and under treatment? Give examples.
16. Do you have established procedures for review determination, including qualified staff (e.g., primary reviewer is a practicing dentist), and dentists review all program denials and patient appeals procedure?
17. Do you have an authorization procedure for referral to non-plan providers? Do you monitor dentist referral patterns?
18. Describe any other unique utilization review programs that you provide.

J. INFORMATION SERVICES DATA REPORTING

1. The Plan Sponsor may require a number of regular monthly, quarterly, and annual claim reports. Samples are listed below. Please indicate for each: a) whether or not you can provide such a report and, b) if you can provide the requested report, please indicate the price or if the cost is included in your fees. The timing and number of reports actually required will be determined at a later date. The required reports are noted below (provide samples):
    a. A monthly paid claims summary for all benefit payments made during the month. The summary should show separately for employees and dependents, the amount paid during the month, and the number of claims paid. How soon after the end of any given month would such a report be available?
    b. Claims paid by type of service category (e.g., Preventive, Basic, Major) showing total number of claims, and claim payments for each category.

2. Describe any other claim/management reports you would be able to supply to the Plan Sponsor regularly at no additional charge and the frequency with which they could be provided. Which of these reports would be available online via the internet or other access medium?
3. Describe any other kinds of management information reports (content and frequency) that are available for an additional charge and their cost. Which of these reports would be available online via the internet or other access medium?
4. Describe the management information computer systems used to manage data. Specifically:
    a. How long are records maintained in the system? How far back can the Plan Sponsor go to obtain historical information on its dental plan?
    b. Do you record all procedures using the ADA code?
5. What percentage of your contracted providers currently have electronic interface capabilities i.e., the ability to exchange eligibility, fee and treatment data electronically with your offices? With the client's Authority Office? What are your plans to require this capability from all contracted providers in the future?

K. DENTAL CLAIMS ADMINISTRATION

1. Which claim office(s) will you assign to the Authority?
2. What is the average number of years of experience of your claim adjuster?
3. If your firm is selected, do you anticipate hiring additional claim adjusters? If so, how many?
4. What was the percentage of all claims that have been submitted electronically by network providers in 2020?
5. What was your rate of auto-adjudicated (no human intervention after data entry) in 2020?
6. Do claims adjusters and member service personnel have online access to plan designs, your payment policies, eligibility & payment histories at their primary workstations?
7. For the claim office(s) proposed, what is the average turnaround time for clean and complex in-network, out-of-network, and out-of-area dental claims?
8. For the claim office(s) proposed, please provide the following for the last two calendar years:
    a) Financial accuracy as a percent of total claims dollars paid (include over and underpayments)
    b) Coding accuracy as a percent of total claims submitted
9. Please describe your procedures and capabilities for handling a mid-benefit year transition. How do you obtain and incorporate file accumulators for deductibles, annual and lifetime maximums, etc. from the current administrator for application to individual files? Do you accept electronic file transfers, printed explanation of benefit statements, etc.? Identify any limitations that apply.

L. CONTRACTUAL ISSUES

1. Will your Contract have a hold harmless provision that indemnifies the Plan Sponsor against liability that arises as the result of negligent acts, errors, omissions, fraud and other criminal acts committed by your network providers, officers, employees and agents of the organization? Will you agree to such a provision?
2. The Plan Sponsor wishes to include in the Contract the right to cancel the Contract at any time for any reason provided that it would provide 60 days prior written notice. In addition, it wants

the right to terminate the Contract immediately for cause. Do you agree to include this provision in your Contract?

3. Does the Contract provide the Plan Sponsor the right to audit the performance of the plan and services provided? Indicate what services, records and access will be made available to the Plan Sponsor at no additional charge. If additional audit rights are available subject to a charge, describe those additional rights and the manner in which the additional charge would be calculated. Also, indicate frequency and notice requirements that are part of the right to audit provision.
4. Do you have a contractual relationship with third party administrators/organizations in which you pay service fees or other fees that the Authority is charged? If so, identify these outside organizations that receive these service fees and explain the nature of the relationship.
5. Do you agree that the fees, rates, performance guarantees, provider credentialing, provider access, quality assessment and monitoring responses you provided in this Proposal are legally binding? For what period of time are these responses valid?
6. Do you agree during the duration of any Contract, and for 12 months after termination, that any direct contact, direct marketing, educational material, and other communication made to members, other than responses to individual member inquiries regarding individual dental claim or member services issues, are strictly prohibited without the authorization and approval of the Plan Sponsor?
7. Do you agree that all books, records, lists or names, plates, seals, passbooks, journals and ledgers and all data specific to this Plan shall be the property of and shall be used exclusively for this Plan at the direction of the Plan Sponsor? Your Proposal must specifically answer this question.
8. Do your provider contracts prohibit providers from balance billing patients for amounts over any negotiated charges or capitation rates? If so, provide additional wording.
9. Describe the type of contractual relationship proposed between the network and the Plan Sponsor and provide a specimen copy of the Contract you propose to offer for our client's review.
10. Please provide a signature ready copy of the Contract(s) the Authority would be required to sign.

M. PERFORMANCE GUARANTEES

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

1. Membership Satisfaction
    a. Telephone Response Time
    b. Problem Resolution
    c. General Member Survey Results
2. Implementation
    a. Deliver ID cards/forms prior to the plan Effective Date.
    b. Complete enrollment prior to the plan Effective Date.
3. Data Reporting
    a. Deliver standard reports within 45 days of end of reporting period.
    b. Deliver annual reports, regulatory documentation within 90 days of policy year end

4. Will you guarantee provider discounts as quoted? If so, how will you measure discounts? What penalty will be imposed for not achieving the stated discount?
5. Provide other guarantees that you are willing to include in the Contract. List standards, measures and range of penalties and incentives you are willing to agree to with respect to the following categories? Additional criteria can be offered and are encouraged. (See below.)
    a. Network Access
        1) Minimum Access
        2) Average Wait Time
        3) Minimum Provider Turnover

N. IMPLEMENTATION

1. Provide a proposed implementation plan and timetable, beginning with the award of business to Effective Date of coverage, include:
    a. Steps required to implement the program.
    b. Role played by the Plan Sponsor.
    c. Production and distribution of ID cards, directories, and enrollment materials.
    d. Contacts and personnel assigned to each step of the implementation process.
    e. Establishment of bank accounts, check stock, on-line plan information.
2. Please attach sample communication materials you have produced for your clients, in the appendix. Are the costs of these communication materials included in your regular fee for the use of the network? If not, what is the additional cost? Are customized communications available? What is the cost?
3. Identify separately any start-up costs and how you proposed to recover them. Describe any other charges not included in proposed fees (e.g., 800 lines, printing). Can they be amortized over several years of the Contract? Be sure to address:
    a. Initial set-up charges _____
    b. Development of communications materials _____
    c. Participation at employee education meetings _____
    d. Review of transition cases _____
    e. Other charges (please specify) _____
    f. Total first year start-up fees _____
4. What is the minimum amount of time recommended to ensure a clean transition into the proposed program?
5. Would you transfer enrollment cards, claim information and other administrative records at no charge to another organization?
6. Will you provide an implementation allowance? If so, please quantify.
7. Will you provide a pre- and post-implementation audit allowance? If so, please quantify.

O. CERTIFICATION LETTER FOR DENTAL

As an officer of the following corporation, I certify that all of the information included in this Proposal is true and accurate.

Signature _____

Name _____

Title _____

Date _____

Attachment 1B. - Acknowledgment and Statement of Exceptions Form for the Dental Program

Re: New Jersey Turnpike Authority

We have reviewed the Proposal specifications contained in this RFP and are in agreement with those requirements except as stated or referenced below (or on the attached sheet(s)):

Company Name	**Signature**
Date	**Title**

SECTION VII C – VISION QUESTIONNAIRE

A. GENERAL REQUIREMENTS AND QUESTIONS FOR ALL PROPOSERS

In order for your Proposal to be considered and accepted, your organization must provide answers to the questions presented in this section. Each question must be answered specifically and in detail. Reference should not be made to a prior response, or to your Contract, unless the question involved specifically provides such an option. Be sure to refer to the earlier sections of this request for Proposals (RFP) before responding to any of the questions, so that you have a complete understanding of all of this client's requirements with respect to the Proposal.

If your Proposal is different in any way (whether more or less favorable) from that indicated in this request for Proposals, clearly indicate where. If you do not, the submission of your Proposal will be deemed a certification that you will comply in every respect (including, but not limited to, coverage provided, funding method requested, benefit exclusions and limitations, underwriting provisions, etc.) with the requirements set forth in this RFP.

If you are unable to perform any required service indicate clearly: a) what you are currently unable to do, b) what steps will be taken (if any) to meet the requirement, c) the timetable for that process, and d) who will be responsible for the implementation.

B. FINANCIAL SECTION

1. Administrative Fees
   a. Please provide rates under a fee-for-service arrangement on the following chart.

Fees	Year 1	Year 2	Year 3
1) PEPM			

   b. Specify whether the Plan Sponsor would be assessed any additional fees, including administrative and provider access fees, which are not included in those listed in the table. If the fee for service charges is all-inclusive, (*i.e.,* includes administrative and provider access costs) please clearly indicate this.
   c. Based on the census data, please indicate your expected annual total claims paid for the Plan Sponsor in years 1, 2 and 3.
   d. Complete the following table. The benefit designs and census information will be provided upon receipt of the Intent to Propose Form. Copayments will vary by option selected. Complete the table assuming what the network price should be based on the average contractual network price for the item before co-pays, coinsurance, or deductibles. Provide the costs for the following zip codes provided in the Plan's census information.

Item	Average Cost Per Service (as defined above)
1) Exams	
2) Frames	
3) Single Vision Lenses	
4) Bifocal Lenses	
5) Trifocal Lenses	
6) Progression Lenses	
7) Transition Lenses	
8) Ultra-violet Coating	

Item	Average Cost Per Service (as defined above)
9) Premier Frames	
10) Progressive Additional Lenses	
11) Polycarbonate Lenses	
12) Blended Invisible Bifocals	
13) Reflection Free Coating	
14) Scratch Resistant Coating	
15) Polaroid Lenses	
16) High Index Lenses	
17) Photosensitivity Lenses	
18) Daily Wear Contact Lenses	
19) Extended Wear Contact Lenses	
20) Permeable Contact Lenses	
21) Toric, Soft Contact Lenses	
22) Disposable (24 hour) Contact lenses	

Complete the geographic matching specifications using the enclosed census information.

Provider	Total number of providers	Percentage of 1 provider within 10 miles	Percentage of 2 providers within 15 miles
1) Optometrists			
2) Other			

C. QUESTIONNAIRE FOR VISION

1. Complete the following:
   a. Parent Company, if any _____
   b. Year Operations Began _____
   c. Number of Group Plans _____
   d. Terminated in the past 24 months _____
   e. Annual Statistics **Volume of Services**
      1) 2018 _____
      2) 2019 _____
      3) 2020 _____
2. Provide the name, address, and telephone numbers of at least three current clients that are similar with respect to coverage, group size, industry, and/or location. Please include Public Sector clients.
3. Are there any outstanding legal actions pending against your organization? If so, please explain the nature and current status of the action(s). What fidelity and surety insurance or bond coverage do you carry to protect your clients? Specifically, describe the type and amount of the fidelity bond insuring your employees, which would protect this plan in the event of a loss.
4. List other group benefit services your organization provides, other than what is being proposed.
5. Designate the individual(s) with the following responsibilities. Include the name, title, and address of each individual, along with a brief description of his/her qualifications and experience.

a) The individual(s) representing your company during the Proposal process.	
b) The individual(s) who will be assigned to the overall ongoing account management.	
c) The individual(s) who will be responsible for day-to-day service.	

6. As the Contract will be issued in the state of New Jersey, the Contract must be in full accord with the laws of that jurisdiction. Please confirm that your Proposal and plan design offered complies with all federal and state laws and regulations that pertain to employee benefit programs, relevant state insurance regulations and other related laws.
7. If the plan design requested does not comply with any state or federal laws, please indicate which provisions in the Proposal specifications are in conflict with specific laws, and propose alternatives.
8. Describe the steps taken by your organization to become fully HIPAA compliant.
9. Please indicate if the HIPAA regulations have been addressed in client contracts. If so, please provide sample Contract language.

10. Please indicate whether your organization has identified any gaps in the data content requirements of HIPAA. If so, how will they be addressed? Please specify how your organization will integrate any additional data requirement into your claims adjudication system and your claims information management system.
11. Will you provide an implementation allowance? If so, please quantify.
12. Will you provide a pre- and post-implementation audit allowance? If so, please quantify.

D. ACCOUNT AND MEMBER SERVICES

1. Which sales office would handle the general servicing of this account? Provide a brief biography of the senior officials responsible for the overall service of the account and for the day-to-day operations. What are the standard office hours for the sales and service office?
2. How will service fees be billed and collected?
3. Provide a sample of communications material available to Plan Sponsors and members with regard to network enrollment, network utilization, ID cards, etc.
4. Please submit a sample of all forms that would be used in the administration of this plan (e.g. claim form, completed EOB, ID cards) that are included in your standard fees. Are there any options that you offer with respect to forms that the Plan Sponsor may use for an additional cost (e.g., name imprints, special SPDs)? If so, please describe and indicate the cost. Please enclose samples.
5. How are member grievances resolved? Will there be a toll-free number to call? If so, what hours will the line be staffed?
6. Does your organization offer simultaneous language interpretation via AT&T or another communications vendor? This service would allow the Plan's members to receive responses to questions about their benefits in the language in which they are most comfortable.
7. Does your organization have any web-based communications and provider or beneficiary interactivity capabilities?
8. Are the communication materials available electronically?
9. What percentage of your contracted providers currently has electronic interface capabilities, i.e., the ability to exchange eligibility, fee, and treatment data electronically with the vendor? What are your plans to require this capability from all contracted providers in the future?
10. What management reports will be made available to the Plan Sponsor? Indicate the frequency and cost for any reports. What standard reports are included in the fee quoted?
11. Can ad-hoc reports be requested? Will there be additional costs for any ad-hoc report requests?
12. Outline your abilities to provide on-line access to data and reports by computerized means. Are there any additional charges for this access?
13. Will you provide the Plan Sponsor with access to your database for statistical analysis and benchmarking?
14. Do you have the ability to provide data electronically into an electronic medical record system?
15. What system checks are in place to prevent fraud? What recovery procedures can you offer a Plan Sponsor for recovering benefits paid to terminated employees?

E. NETWORK SERVICES

1. List the services included with an eye exam. Check which services are covered in an exam:

Exam Includes	Check if Yes
a. Case History	
b. Recording corrected and uncorrected visual acuity	
c. Internal exam	
d. External exam	
e. Pupillary Reflexes	
f. Binocular vision	
g. Objective refraction	
h. Subjective refraction	
i. Test for Glaucoma	
j. Slit Lamp Exam (Biomicroscopy)	
k. Dilation (as indicated and permitted)	
l. Color Vision	
m. Depth Perception	
n. Contact lens fitting	
o. Other	

2. What services are covered with respect to the dispensing of frames and lenses? Are frames ordered or fitted on site? Are checks made for accuracy and fit? Are any follow-up adjustments covered? If, so for how long a period after frames are dispensed?
3. How long are the frames and lenses guaranteed? What is your replacement policy for frames and lenses?
4. Indicate if frames and lenses are provided on-site. If frames and lenses are ordered, what is the average waiting period between placement of order and delivery of frames? Do members have the option to either pick up finished orders or have orders delivered to their residence?
5. Please confirm your ability to administer “Safety Glasses” for the Authority.
6. What services are covered with respect to the dispensing of contact lenses? Are lenses ordered or fitted on site? What test and checks are made at time of fitting? Are any follow up tests covered? If so, for how long a period after the frames are dispensed?
7. Are instructions provided regarding adequate care, handling, insertion, and wearing time of contact lenses? Who is authorized to provide instructions?
8. How long are the contact lenses guaranteed? What is your replacement policy for contact lenses?
9. Indicate if contact lenses are provided on-site. If lenses are ordered, what is the average waiting period between placement of order and delivery of lenses? Do members have the option to either pick up finished orders or have orders delivered to their residence?
10. Provide the types of frames, lenses, and contact lenses you will make available to members. Include type of tints, frame materials, custom grinding, scratch resistance lenses, oversized lenses, and any custom finishes or material used.
11. Are the labs that manufacture the materials owned by your organization? If not, list the labs and manufacturers that will be providing materials.
12. What other benefits are you providing that are included in your quoted fees?
13. List the limitations and exclusions that would be part of your standard Contract. Are there any pre-existing condition exclusions?
14. Please provide a sample of your standard provider contracts and service agreement you will offer the Plan Sponsor.

F. NETWORK PROVIDER CREDENTIALS & PROVIDER RELATIONS

1. Complete the following table for network optometrists. Check off those elements included in the optometrist selection process and provide the percentage of optometrists who satisfy the following selection criteria elements.

Criteria	Standard Selection Criterion (check if yes)	Percentage of Providers that Satisfy Criterion	Comments
a. Require unrestricted licensure	☐		
b. Review malpractice coverage and history	☐		
c. Require full disclosure of current litigation & other disciplinary activity	☐		
d. Require signed application/agreement	☐		
e. Require current DEA registration	☐		
f. Review adherence to community practice standards	☐		
g. On-site review of office location and appearance	☐		
h. Review hours of operation and capacity	☐		
i. Review practice patterns & utilization results	☐		

2. Describe the general credentialing process and minimum criteria for an optometrist to be selected as a network provider. Include the minimum required malpractice coverage per individual practitioner, per occurrence. If the process differs by type of provider, please indicate and describe separately.
3. Describe the re-credentialing process, including timing and percentage of optometrists who are re-credentialed each year. Provide the number of years that an optometrist's Contract has been in effect.
4. Based on the Plan's census information (census information will be provided upon receipt of the Intent to Propose Form). Provide the number of participating optometrists who were terminated in the past 36 months:

	# of Optometrists	% of Optometrists	Reason for Termination
a. By your organization			
b. By Provider			

G. CONTRACT/LIABILITY ISSUES

1. Describe the type of contractual relationship to be proposed between your organization and the Plan Sponsor. Provide a sample of your Contract.
2. Does your provider Contract have "hold harmless" language that protects the Plan Sponsor from any acts arising out of the Contract, such as omissions, fraud, misconduct or negligence of your officers, staff clinicians, technicians, and other employees?
3. Are you willing to include language in your Contract that stipulates that members will not be liable for any unpaid bills for all eligible services performed?
4. Will you agree to notify the Contract holder immediately if you lose any accreditation, licensure, liability and malpractice insurance coverage, security or bonding?
5. Please indicate current liability and malpractice insurance policies, specify coverage and limits.

6. Will you provide 60-day advance notice of significant changes in policies, practices, affiliations, or staffing?
7. Are any exclusions or limitations required in conjunction with your organization's services? If so, please explain and include sample wording?
8. How do you ensure and maintain the confidentiality of patient records and medical information? Does your Contract include language protecting the confidentiality of patient information?
9. What is the term the Contract is effective and what is the termination provision you propose to include in your Contract? Be specific with regard to dates, advanced notice and responsibilities placed on the Plan Sponsor.

H. QUALITY ASSURANCE

1. Do you currently perform membership satisfaction surveys? If so, provide a copy of the latest results of the survey. Does an outside organization perform the survey? The survey should provide the percent of members who indicated that they were "satisfied with the health plan."
2. Describe what aspects of care are being monitored and evaluated on an ongoing basis. Include any established treatment benchmarks and any review of adverse outcomes for specific conditions. Summarize any practice guidelines implemented by network providers that are employed as a network standard for delivery of care. If available, provide statistical results supporting the effective application of these guidelines.
3. Summarize the quality assessment studies your organization completed in the past three years. Describe the most important actions your plan has taken in the past year, based on these studies, to improve performance.
4. Describe the procedures in place to audit the quality of care being rendered by network providers. Is the right to audit included in your standard provider contracts?

I. CERTIFICATION LETTER FOR VISION

As an officer of the following corporation, I certify that all of the information included in this Proposal is true and accurate.

Signature _____

Name _____

Title _____

Date _____

Attachment 1C. - Acknowledgment and Statement of Exceptions Form for the Vision Program

Re: New Jersey Turnpike Authority

We have reviewed the Proposal specifications contained in this RFP and are in agreement with those requirements except as stated or referenced below (or on the attached sheet(s)):

Company Name	**Signature**
Date	**Title**

SECTION VII D – PRESCRIPTION DRUG QUESTIONNAIRE

A. MINIMUM CONTRACTUAL REQUIREMENTS

The following are the Plan's core requirements. Proposer(s)' responses to this section will be heavily weighted in the selection process. Please include your responses within this form. Indicate "yes" or "no" as to your organization's ability to comply.

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
1. The Plan will have the right to terminate the PBM with or without cause given a 60-day notice period after the initial 12-month period elapse, without penalty to the Plan.	☐	☐
2. Definitions (You agree to following Contract definition)		
a. "Transparent Retail Pharmacy Contract"- The PBM agrees to pay participating pharmacies at the PBM's contracted rate. The PBM warrants that no pricing spread is retained at any participating network pharmacy under Contract ALTERNATIVE LANGUAGE TO CONSIDER - a."Pass Through" and "Transparent" - PBM agrees to pass-through 100% of negotiated discounts with network pharmacies at the point-of-service and to provide auditing protocol, enabling tracking of individual claims back to original pharmacy network Contract documents. The PBM agrees to disclose details of all programs and services generating financial remuneration from outside entities.	☐	☐
b. "Rebates" – The PBM agree to pay 100% of drug manufacturer **formulary rebates earned** on the NJ Turnpike claims experience.	☐	☐
c. Compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons, including, but not limited to, incentive rebates categorized as mail order purchase discounts; credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees paid by manufacturers will be disclosed and pass through to the client. This includes any payments made to fully owned subsidiaries that receive payments on NJ Turnpike pharmacy claim experience.	☐	☐
d. AWP (Average Wholesale Price) is based on date sensitive, 11-digit NDC as supplied by a nationally recognized pricing source (e.g., Medi-Span) for retail, mail order, and specialty adjudicated claims (Subject to outstanding litigation).	☐	☐
e. Member Copay - Members will pay the lowest of the following: plan copay/coinsurance, plan-negotiated discounted price plus dispensing fee, usual and customary (U&C), or retail cash price.	☐	☐
f. The Plan's eligibility and claim data - All eligibility and claims records are the sole property of the Plan and must be made available upon request to the Plan and its representatives. Selling or providing of the Plan's data to ANY outside entities must be approved in advance, reported on a monthly basis and all income derived must be disclosed and shared per agreement with the Plan. Even if PBM has not "sold" the data, it is NOT free to use the data for analyses that they publish or provide to outside industries.	☐	☐
g. Paid Claims - Defined as all transactions made on eligible members that result in a payment to pharmacies or members from the Plan or the Member copays. (Does not include reversals and adjustments.) Each unique prescription that results in payment shall be calculated separately as a paid claim.	☐	☐
h. Members - All eligible employees and their eligible dependents enrolled under the Plan prescription benefit program.	☐	☐

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
3. The PBM agrees to a three-year Contract term effective no later than January 1, 2022.	☐	☐
4. The PBM Contract will provide 180-days advance notice of renewal rates (after initial three-year term), which shall then be subject to negotiation and written agreement between the parties. The Authority reserves the right to renew the Contract. No automatic renewal language will appear in the Contract.	☐	☐
5. PBM agrees to allow the Authority a minimum of two (2) mid-Contract-term market checks in the first three-year contract, and one (1) mid-Contract-term market check in the two one-year optional years. Each of these mid-Contract-term market checks will be conducted by an independent third party to ensure the Plan is receiving appropriate current pricing terms competitive with the industry based on its volume and membership, and will improve pricing in the event that the Plan's Contract terms are less than current. The Plan will have the right to terminate without penalty if the pricing terms are not industry competitive.	☐	☐
6. The Plan or its designee will have the right to audit, with an auditor of its choice (for both claims and rebate audits), with full cooperation of the selected PBM, the claims, services and pricing and/or rebates to verify compliance with all program requirements and contractual guarantees.	☐	☐
7. The audit provision shall survive the termination of the agreement between the parties for a period of three (3) years.	☐	☐
8. The Plan or its designee will have the right to conduct an audit at any time during the year, at any point during the Contract term, and the selected PBM will provide all documentation necessary to perform the audit.	☐	☐
9. The Plan or its designee will have the right to audit up to 36 months of data.	☐	☐
10. All pricing submitted will NOT be contingent on participation in any proposed clinical management programs, group medical or behavioral health programs proposed by you or any other vendor other than programs that are requested by the Plan. Further, the pricing guaranteed in the Financial Section of this RFP reflects a) the PBM's broadest national network and b) the PBM's broadest formulary or preferred drug listing, without any drug coverage exclusions unless otherwise authorized or requested by the Plan.	☐	☐
11. All rebate revenue earned by the Plan will be paid to the Plan regardless of their termination status as a client. Lag rebates will continue to be paid to the Plan after termination until 100% of earned rebates are paid.	☐	☐
12. The PBM agrees to load all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for current members from the existing PBM at NO charge to the Plan (with no charges being deducted from the implementation allowance for file loading or IT).	☐	☐
13. The PBM agrees to send all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the Members to the next PBM at NO charge if the Plan terminates the Contract with or without cause.	☐	☐
14. Brand and Minimum Generic Discount Guarantees for both mail and retail shall be defined as follows: (Aggregate Ingredient Cost/Aggregate AWP)		
a. Aggregate Ingredient Cost prior to application of member cost share will be the basis of the calculation.	☐	☐
b. Aggregate AWP will be from a single, nationally recognized price source for all claims. Please indicate source of AWP.	☐	☐
c. Dispensing Fees are not included in the Aggregate Ingredient Cost.	☐	☐
d. Both the Aggregate Ingredient Cost and Aggregate AWP from the actual date of claim adjudication will be used.	☐	☐

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
e. Aggregate AWP will be the date sensitive, 11-digit NDC of the actual product dispensed.	☐	☐
f. Both non-MAC, MAC, single-source and multiple source generic products are to be included in the generic discount guarantee measurement.	☐	☐
g. Compounds, OTC claims, and claims with ancillary charges will be excluded from the guarantee measurements for retail and mail order components. The current prior-authorization rules for compound prescriptions must be duplicated. Other cost containment options may be proposed.	☐	☐
h. The guarantee measurement must exclude the savings impact from DUR programs, formulary programs, utilization management programs, and/or other therapeutic interventions.	☐	☐
i. Any shortfall between the actual result and the guarantee will be paid, dollar-for-dollar, to the Plan within 60 days of the end of the measurement period.	☐	☐
j. Measurement will be performed annually by the PBM subject to independent audit utilizing date-sensitive AWP derived from a single, nationally recognized price source for all claims.	☐	☐
15. The PBM agrees to provide upon request any proprietary algorithms, hierarchy or other logic employed to define a prescription drug as generic or brand.	☐	☐
16. The PBM agrees to base all guarantees on the actual package size from which the prescriptions are dispensed.	☐	☐
17. The Plan will be notified of any switch to the source of the aggregate AWP with at least a 180-day notice. In the event that a switch is made that is not price neutral, the Plan will have the right to terminate the Contract with no penalty.	☐	☐
18. Each distinct pricing guarantee (including rebates) will be measured and reconciled annually on a stand-alone basis (e.g. retail brand, retail generic, mail order brand, mail order generic, and specialty) and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by the Plan. Surpluses in one component may not be utilized to offset deficits in another component.	☐	☐
19. Guaranteed rebates per prescription will be based on all brand prescriptions dispensed.	☐	☐
20. Rebates guarantees are minimums (i.e., not fixed) and all excess amounts above the minimums will be passed through to the Plan Sponsor.	☐	☐
21. Rebates are guaranteed for the life of the Contract as well as any extension of the underlying agreement.	☐	☐
22. Rebates will not be withheld for execution of annual Contract amendments. PBM agrees to pay rebates earned so long as invoices are paid by the client and claims are being processed by the PBM. The Plan is entering into a multi-year agreement and needs no annual renewals/amendments signatures for payments of rebates.	☐	☐
23. The PBM agrees to provide Retail/Mail Order unit cost equalization to the Plan, meaning that Mail Order unit costs prior to member cost sharing, dispensing fees, and sales taxes charged to the Plan will be no greater than those at Retail. The PBM agrees to produce a date sensitive comparison report showing unit costs charged to the Plan at a GCN level, and reimburse the Plan on a dollar-for-dollar basis for all instances where mail order unit costs exceed retail unit's costs. Report and reconciliation will be provided on a quarterly basis.	☐	☐
24. The PBM agrees to obtain the Plan's approval for all member communication materials before distribution to members. The PBM will not automatically enroll the Plan in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from the Plan.	☐	☐

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
25. The PBM agrees to hold the Plan harmless for any HIPAA Violations made by the PBM or its Network Pharmacies.	☐	☐
26. The PBM will agree to be claims fiduciary for clinical based determinations.	☐	☐
27. The PBM will agree to defend claims litigation based on its decisions to deny coverage for clinical reasons.	☐	☐
28. The PBM will be responsible for collecting any outstanding member cost shares for prescriptions dispensed through the mail order facility. The PBM will not invoice the Plan for any uncollected member cost shares.	☐	☐
29. The PBM will not withhold any financial recoveries from audits performed on the contracted pharmacy network including mail order and specialty pharmacies. Any recoveries will be disclosed and credited to the Plan.	☐	☐
30. The PBM agrees not to remove any drug products, brand or generic, from the Plan's formulary or preferred drug listing without notification and prior approval from the Plan. No alterations to financial guarantees provided for the initial three-year term will be made on formulary drug exclusions.	☐	☐
31. The PBM agrees to notify the Plan or its designee in advance of 180 days when a formulary drug is targeted to be moved to or from the preferred drug list. The PBM must notify all affected members in advance with out of pocket expense impact and alternatives. PBM shall provide a detailed disruption and financial impact analysis at the same time.	☐	☐
32. The PBM shall indemnify, defend and hold harmless the Plan, its officers, directors, employees and agents from and against any and all claims, actions, demands, costs and expenses, including reasonable attorney fees and disbursements, as a result of a breach by the PBM of any of its obligations under this Agreement or arising out of the negligent act or omission or willful misconduct of the PBM or its employees or agents.	☐	☐
33. The PBM agrees it will not remove any participating network pharmacies that impact greater than 2% of the Plan's prescriptions without communicating to the Plan at least sixty (60) days in advance of the scheduled change. The current guarantees will be honored if the Plan opts out of the network changes.	☐	☐
34. The PBM agrees to offer improved pricing to the Plan if greater than 2% of members are impacted by proposed changes to the participating pharmacy network.	☐	☐
35. The PBM agrees to provide weekly and/or monthly data transmissions to chosen vendors at no charge and two full, annual electronic claims files, in NCPDP format, at no charge as needed. PBM will also interact/exchange data with all vendors as needed at no additional charge.	☐	☐
36. The PBM acknowledges that is compliant with the electronic Data Interchange ("EDI"), Privacy and Security Rules of the Health Insurance Portability and Accountability Act ("HIPAA"), and will execute the appropriate Business Associate Addendum ("BAA") as provided by the Plan (copy attached in the Reference Documents). PBM also agrees that in the event of a privacy violation or data breach, that the PBM will notify the Plan and the impacted members to a breach and provide any required remedies.	☐	☐
37. Claims Funding and Reporting:		
a. Claims to be funded by weekly wire.	☐	☐
b. Proposer shall maintain separate Accounts and Banking Agreements for the Authority with all reporting broken out accordingly.	☐	☐
c. Proposer must be willing to replicate the existing account structure	☐	☐

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
d. Proposer must be willing to include the following requirements into the service agreement: Initial imprest fund, and future requests for increases to the imprest fund, shall be subject to mutual agreement, however- under no circumstances - shall be an amount exceeding the average weekly (seven consecutive calendar days') claims cost.	☐	☐
e. Proposer must support weekly claims invoices with detail claim back-up reports in an editable format the sums of which must reconcile to the totals of the previous/associated wire fund requests. **See Appendix 6 for minimum required detail needed to support weekly claims invoices.** The Invoices and supporting detail will begin on the first of the month and end on the last day of the month.	☐	☐
f. All wires and reports must be itemized – with subtotals – by account structure. Monthly report can be aggregate or by account structure (account structure preferred.)	☐	☐
g. Proposer must be able to provide Authority access to claim and utilization reports electronically.	☐	☐
h. Standard reports must be archived indefinitely or available to be downloaded electronically from your site.	☐	☐
38. Enrollment Materials. Proposer shall be responsible for initial direct mailing of ID cards to all members, along with a copy of the applicable Summary Plan Document as part of the implementation process. Thereafter, and for the duration of the Agreement between the Proposer and the Authorities, the Proposer shall maintain responsibility for direct mailing of ID cards and applicable Summary Plan Documents to all newly enrolled members and to all members who, pursuant to benefit actions, are moved into a different plan design and/or group/sub-group.	☐	☐
39. Staffing. Employ sufficient and appropriately trained dedicated staff, familiar with administering your proposed plan of benefits, to meet the service specifications outlined herein and subsequently detailed in a performance standards agreement that would be executed between the Authority and your company.	☐	☐
a. Benefit Staff needs a dedicated Account Management staff that is always available during normal business hours. This Account Management team will meet with the Authority once a week to discuss the status of the program. It will be required for the Account Management team to make on-site visits at least once a month.	☐	☐
b. Benefit Staff needs a dedicated Claims Account Manager that will handle claim issues as designated by the Authority.	☐	☐
c. Benefit Staff needs a dedicated enrollment representative for processing electronic enrollment reports and work with Authority staff to address errors.	☐	☐
d. Staffing. Employ sufficient and appropriately trained dedicated staff, familiar with administering your proposed plan of benefits, to meet the service specifications outlined herein and subsequently detailed in a performance standards agreement that would be executed between the Authority and your company.	☐	☐

B. CONTRACTUAL EXPECTATIONS

The following are the Plan's Sponsor expectations of how the topics below will be addressed in the final, executed contracts with the Plan Sponsor.

Please complete this form and include it within your response. Indicate "yes" or "no" as to your organization's ability to comply.

Explanation of your "yes" or "no" response may be requested during the Proposal evaluation process.

CONTRACTUAL EXPECTATIONS	YES	NO
1. The PBM will provide a signature ready Contract incorporating all agreed upon provisions within this RFP. Contract document will be submitted along with Proposal response.	☐	☐
2. The Plan will not be held responsible for time or miscellaneous costs incurred by the PBM in association with any audit process including, all costs associated with provision of data, audit finding response reports, or systems access, provided to the Plan or its designee by the PBM during the life of the Contract. Note: This includes any data required to transfer the business to another vendor and money collected from lawsuits and internal audits.	☐	☐
3. The PBM agrees to a 21-day turnaround time to provide its response to claims audit findings.	☐	☐
4. The PBM will NOT implement, administer or allow any program that results in the conversion from lower discounted ingredient cost drug products to higher ingredient cost drug products or increases member's cost share without the prior written consent of the Plan or its designee.	☐	☐
5. PBM agrees to notify the Plan and its members at least 60 days prior to the addition of a drug to specialty drug list and at least 90 days prior to a deletion of a drug from the specialty drug list. The Plan reserves the right to approve any addition to the specialty drug list.	☐	☐
6. The Plan will have the ability to annually renegotiate and/or "carve-out" specialty drug pricing and service terms without penalty or changes to the financial guarantees.	☐	☐
7. All pricing will be effective and guaranteed for the term of the agreement (excluding the renegotiated specialty pricing) and will not include adjustments for claims volume shifts amongst the various provider channels (e.g., mail utilization rates decline).	☐	☐
8. The PBM agrees to provide online, real time, claim system access to the Plan or its designee, including access to historical claims data for up to three (3) years following termination of the agreement.	☐	☐
9. The PBM agrees that all future edits required because of plan design changes implemented by the Plan shall be completed, after testing, by the PBM within 45 days of request/advisory by the Plan.	☐	☐
10. All applicable administrative fees will be on a per paid claim basis as defined in 2.d. definitions.	☐	☐
11. All applicable fees include the cost of claims incurred/filled during the Effective Dates of this Contract regardless of when they are actually processed and paid (run-out).	☐	☐
12. All customer service call recordings and notes between the PBM and the Plan's members will be the Plan's property.	☐	☐
13. The PBM agrees to document 100% of the Plan's customer service calls through call recordings and call notes. PBM will forward written transcripts of calls at the Plan request within two business days of the request being made.	☐	☐
14. The Plan reserves the right to access all call recordings or call notes from customer service calls with its members. PBM agrees to allow the Plan the right to request call recordings and/or notes at any time.	☐	☐
15. The PBM agrees to allow the Plan with access to its member website with a dummy login prior to the go-live date.	☐	☐
16. The PBM will provide the Plan with a virtual tour of its CSR system and any custom messaging system.	☐	☐

CONTRACTUAL EXPECTATIONS	YES	NO
17. The PBM agrees to, at minimum, quarterly calls to review customer service issues. The PBM agrees to allow the Plan to review customer service quality issues to the resolution endpoint.	☐	☐
18. The PBM agrees to a minimum of one annual meeting with call center executives to discuss services regarding enrollment and member issues.	☐	☐
19. The PBM agrees to grandfather the Plan's current formulary for up to 90 days following the Contract Effective Date.	☐	☐
20. The PBM will provide electronic access to monthly claims information to the Plan and/or its designee(s).	☐	☐
21. There are NO additional fees (beyond those outlined in the Financial Section) required to administer the services outlined in this RFP. Any mandatory fees, including clinical and formulary programs fees, must be clearly outlined in the Financial Section.	☐	☐
22. The PBM agrees to a review and negotiate the pricing applied to newly introduced generics drugs annually.	☐	☐
23. The PBM will respond to and incorporate future Health Care Reform changes in full compliance with the law and at no additional cost to the Plan.	☐	☐
24. The PBM agrees to no additional charges for any retroactive claims reprocessing and member reimbursements due to retroactive plan design adjustments	☐	☐
25. Mail order pricing applies to all prescriptions dispensed through mail order facilities.	☐	☐
26. The PBM agrees to offer MAC pricing on claims for OTC products (e.g., Proton Pump Inhibitors (PPIs), Non-Sedating Antihistamines (NSAs), smoking cessation agents, allergy/decongestion agents, and ophthalmic agents).	☐	☐
27. The PBM agrees to adjudicate prescription claims for compound medications with the same dispensing fees and logic associated with traditional claims.	☐	☐
28. The PBM agrees that this Agreement or any of the functions to be performed hereunder shall not be assigned by either party to another party, absent advance notice to the other party, and written consent to said assignment, which consent shall not be unreasonably withheld. In the event either party shall not agree to an assignment by the other party, then this agreement shall terminate upon the Effective Date of said assignment.	☐	☐
29. The PBM must agree that in the event of a dispute between the parties, about the payment or entitlement to receive payment, or any administrative fees hereunder, the PBM and the Plan shall endeavor to meet and negotiate a reasonable outcome of said dispute. In NO event shall PBM undertake unilateral offset against any monies due and owed the Plan, whether from manufacturer rebates, credit adjustment or otherwise.	☐	☐

C. FINANCIAL SECTION

Proposer(s) are required to complete all financial forms as instructed. Proposer(s) should provide proposed fees and guarantees separately for each year of the three-year Contract, so that the Plan's pricing terms keep pace with expected market trends. We ask all Proposer(s) to provide a hybrid transparent pricing Proposal as described in this RFP. The services provided should include, but should not be limited to, the services referred to in the "PBM Services to be Provided" section. Per Paid Claim fees must be based on prescriptions dispensed (not adjustments, errors, or redo's)

1. Administrative Fees

a. Complete the following Administrative Fee Tables:

TRANSPARENT PROPOSAL ADMINISTRATIVE FEES	01/01/2022-12/31/2022		01/01/2023-13/31/2023		01/01/2024-12/31/2024	
Retail/Mail Administrative Fee	$	per paid claim	$	per paid claim	$	per paid claim
Services to be included in fees above:						
1) Toll Free Phone Lines	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
2) Monthly Data Feeds to the Plan or Designee(s)	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
3) Prospective /Concurrent/Retro DUR	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
4) Standard Reports (including claim summaries for stop loss insurer reporting purposes)	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
5) Ad Hoc Reports	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
6) COB Program	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
7) Mandatory Mail Program	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
8) Dose Optimization Program	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
9) Prior Authorization Program	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
10) Step Therapy Program	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
11) Quantity Limitations	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
12) Custom System Overrides	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
13) Annual EOB Statements	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
14) Retro Termination Letters	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
15) Group Coding	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
16) Drug Notification Letters	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
17) Formulary Administration/Management	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
18) ID Cards	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
19) Pharmacy Directories and other member materials	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
20) SPD or Benefit Booklets	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
21) Claim Fiduciary	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
22) Standard 1st level appeals processing	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
23) Standard 2nd level appeals processing	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
24) Urgent appeals processing	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
25) Overrides	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
26) Audit Recovery Fees						
Services <u>not</u> included in fees above (i.e., services marked "N" above) (show fees separately):						
27) Detail all services and supplies to be provided under your basic fees that are not included in your response to question one.						
28) Will there be any additional charges if plans/benefits are restructured or new classes of eligible members are added? If so, how are these charges determined and state amount of charges?						
29) Confirm that postage is included in all mail order						

TRANSPARENT PROPOSAL ADMINISTRATIVE FEES	01/01/2022-12/31/2022	01/01/2023-13/31/2023	01/01/2024-12/31/2024
prescriptions and any mailings.			
30) Confirm that quoted fees include postage paid mail order envelopes for member prescription submission.			
31) Confirm that mail order and specialty drug dispensing fees will remain constant throughout the Contract term and will not be increased for any increases in postage charges.			
32) Detail all data related services included under the base administrative fees including ad hoc reporting, electronic claims files, plan design options, custom mailings, etc.			
33) In addition, detail any data-related service fees not included in the base administrative fees.			
34) Confirm that multi-language communication phone line support is included in the base administrative fee. List the languages available to the Members speaking to your customer service representatives.			
35) Are there separate fees for assuming Fiduciary responsibilities			
36) Should the Authority request your PBM produce the Summary Plan Document or Benefit Booklet please list proposed fees for this service			

The Authority is also interested in alternative fee structure formats other than per transaction fee based arrangements. If you will consider PMPM, PEPM or flat monthly fee based arrangements if proposed.

2. Prescription Drug Pricing

AWP Reimbursement Basis: Complete the following tables using the drug reimbursement that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the Contract. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. All guarantees must be based on the AWP unit cost dispensed at the point of sale, and post January 1, 2022 AWP rollback.

a. Transparent Proposal

1) Year 1 (01/01/2022-12/31/2022)

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply			
	Up to 30 days		1 – 90 days	
Brand Drugs[1]				
a. Discount from AWP[2] for all brands	%		%	
b. Dispensing Fee Per Prescription	$	per Rx	$	per Rx
Generic Drugs[3]				
a. Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	%		%	
b. Dispensing Fee Per Prescription	$	per Rx	$	per Rx
Rebates				

[1] Including both single source and multi-source brands.
[2] Post January 1, 2022 AWP rollback.
[3] Including single-source generics.

a. Per Brand Prescription Dispensed	$	per Rx	$	per Rx
b. Per Specialty Brand Prescription Dispensed	$	per Rx	$	per Rx

2) Year 2 (01/01/2023-12/31/2023)

Broadest Retail Network (List any Major Retail Chains Excluded)	**AWP Discount Retail Supply Up to 30 days**		**AWP Discount Mail Supply 1 – 90 days**	
Brand Drugs[1]				
a. Discount from AWP[2] for all brands	%		%	
b. Dispensing Fee Per Rx	$	per Rx	$	per Rx
Generic Drugs[3]				
a. Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	%		%	
b. Dispensing Fee Per Rx	$	per Rx	$	per Rx
Rebates				
a. Per Brand Prescription Dispensed	$	per Rx	$	per Rx
b. Per Specialty Brand Prescription Dispensed	$	per Rx	$	per Rx

3) Year 3 (01/01/2024-12/31-2024)

Broadest Retail Network (List any Major Retail Chains Excluded)	**AWP Discount Retail Supply Up to 30 days**		**AWP Discount Mail Supply 1-90 days**	
Brand Drugs[1]				
a. Discount from AWP[2] for all brands	%		%	
b. Dispensing Fee Per Rx	$	per Rx	$	per Rx
Generic Drugs[3]				
a. Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	%		%	
b. Dispensing Fee Per Rx	$	per Rx	$	per Rx
Rebates				
a. Per Brand Prescription Dispensed				
b. Per Specialty Brand Prescription Dispensed				

3. Assumptions

a. Confirm the pricing above reflects:

Assumptions	**YES**	**NO**
1) The PBM will provide a signature ready Contract incorporating all agreed upon provisions within this RFP. Contract document will be submitted along with Proposal response.	☐	☐
2) All-in generic guarantee inclusive of single-source generics	☐	☐
3) Drugs with an "Insufficient Supply" are included in the guarantees	☐	☐
4) Member Cost Share at the point-of-sale (for retail and mail) is based on the lowest of the plan copay/coinsurance, usual and customary charges, negotiated discounted ingredient cost plus dispensing fee or retail cash price	☐	☐
5) All guarantees are calculated before the application of member cost share	☐	☐

[1] Including both single source and multi-source brands.
[2] Post January 1, 2022 AWP rollback.
[3] Including single-source generics.

Assumptions	YES	NO
6) All guarantees (including Rebates) are stand-alone with no offsetting (within or across channels)	☐	☐
7) Any guarantee shortfalls are paid on a dollar-for-dollar basis	☐	☐

b. Please confirm your proposed drug type designation or classification (e.g. brand, generic) source (i.e., Medi-Span, Redbook, Other). If other, please specify.

c. We also seek prospective generic drug MAC list pricing as an alternative to discount percentage off of AWP. Will you be willing to quote a retail and mail prospective MAC ceiling price schedule for retail and mail order generic drugs for generic drugs covered by the plan? If so explain how you will create the prospective MAC list and if you would be willing to guarantee 100% reimbursement for any cost exceeded the ceiling prices for the generic drug price list?

d. Utilizing the claims file provided and based on the broadest preferred drug list (with no exclusions or clinical programs), complete the table below based on the proposed calendar year 2021 pricing:

Type	Total AWP/WAC* Cost ($)	As a Percentage (%) of Total AWP/WAC* Cost
Retail		
1) Total Brand Drugs (AWP)	*Decimal.*	*Decimal.*
2) Total Generic Drugs (AWP)	*Decimal.*	*Decimal.*
3) Projected Rebate Revenue (WAC)	*Decimal.*	*Decimal.*
Mail		
1) Total Brand Drugs (AWP)	*Decimal.*	*Decimal.*
2) Total Generic Drugs (AWP)	*Decimal.*	*Decimal.*
3) Projected Rebate Revenue (WAC)	*Decimal.*	*Decimal.*
Specialty		
1) Total Brand Drugs (AWP)	*Decimal.*	*Decimal.*
2) Total Generic Drugs (AWP)	*Decimal.*	*Decimal.*
3) Projected Rebate Revenue (WAC)	*Decimal.*	*Decimal.*

4. Allowances

Allowance	Description	Response
a. Implementation	Place the $ (dollar) Per-Member amount or the flat dollar ($) amount you are offering the Plan.	
b. Pre-Implementation Audit	Place the flat dollar ($) amount you are offering the Plan to be used to conduct a pre-implementation audit.	
c. Audit	Place the dollar ($) Per-Member amount or the flat dollar ($) amount you are offering the Plan to be used annually to verify the Plan is receiving discounted costs and major services as contracted as well as 100% of rebates.	

Any allowance will be applied against future Plan Sponsor invoices as a credit subject to receipt of qualified expenses incurred for auditing.

* AWP should be based on the actual date of service of the claims provided.

5. Generic Drugs - Dispensing Rates
    a. Complete the table below for Contract Years 1, 2, and 3. Note that generic dispensing rate (GDR) includes only true instances of generic dispensing (i.e., exclude multi-source brand drugs dispensed under member-pay-difference plan designs)

Guaranteed GDR	Retail ≤ 30 days	Retail >30 days	Mail Order
1) 01/01/2022-12/31/2022	%	%	%
2) 01/01/2023-12/31/2023	%	%	%
3) 01/01/2024-12/31/2024	%	%	%

What dollar amount are you prepared to put at risk for failure to meet your GDR guarantee?

D. SPECIALTY PHARMACY PROGRAM PRICING

1. Please provide your organization's definition and qualification criteria of a "specialty drug product."
2. Provide an AWP-based pricing list of all specialty pharmaceuticals that your company dispenses and distributes to providers and patients. Your pricing must include adequate supplies of ancillaries such as needles, swabs, syringes, and containers. The following items must be included in your list:
    a. NDC-11
    b. Product Name
    c. Therapeutic Group/Therapeutic Category
    d. Guaranteed Minimum AWP Discount for all specialty pharmacy program prescriptions for both Open and Exclusive specialty arrangements
3. Complete the following tables:

Open Specialty Pharmacy Program	01/01/2022-12/31/2022		01/01/2023-12/31/2023		01/01/2024-12/31/2024	
a. Guaranteed Ingredient cost discount from AWP	$	per Rx	$	per Rx	$	per Rx
b. Dispensing Fee - Per Prescription	$	per Rx	$	per Rx	$	per Rx
c. Administrative Fee - Per Prescription	$	per Rx	$	per Rx	$	per Rx
d. Minimum Rebate Guaranteed Rebate - per specialty Prescription	$	per Rx	$	per Rx	$	per Rx

4. Discounted quoted must be based on weighted average specialty discount achieved.

Exclusive Specialty Pharmacy Program	01/01/2022-12/31/2022		01/01/2023-12/31/2023		01/01/2024-12/31/2024	
a. Guaranteed Ingredient Cost discount from AWP	$	per Rx	$	per Rx	$	per Rx
b. Dispensing Fee - Per Prescription	$	per Rx	$	per Rx	$	per Rx
c. Administrative Fee - Per Prescription	$	per Rx	$	per Rx	$	per Rx
d. Minimum Rebate Guaranteed Rebate - per specialty Prescription	$	per Rx	$	per Rx	$	per Rx
e. Guaranteed Ingredient Cost discount from AWP	$	per Rx	$	per Rx	$	per Rx

5. Please provide the guaranteed mode specialty pharmacy program (open and exclusive) discount guarantees (i.e., the discount appearing most often on your specialty drug list).
6. Confirm your proposed guarantees for non-specialty drugs at retail/mail program are **NOT** contingent upon the Plan's purchase of your specialty drug management program?
7. Based on the Plan's prescription drug claims information provided, indicate the percent retail and mail specialty prescriptions and specialty AWP under your Proposal on the following table:

a. Specialty Prescriptions at Retail as a Percent of all Retail Prescriptions	%
b. Specialty AWP at Retail as a Percent of all Retail AWP	%
c. Specialty Prescriptions at Mail as a Percent of all Mail Prescriptions	%
d. Specialty AWP at Mail as a Percent of all Mail AWP	%

8. Based on the Plan's prescription drug claims information provided, alternatively we seek prospective ceiling pricing by specialty drug.
9. Can you provide a prospective schedule of maximum allowable pricing for specialty drugs dispensed to Plan Sponsors?
10. For the plan year beginning no later than January 1, 2022, provide a list of ceiling prices per day of therapy (claim cost before member copay applying discounts, rebates, dispensing fees, taxes, etc.) you would be willing to offer to the Plan Sponsor. In lieu of discounts and rebates, an annual reconciliation would be performed applying the actual days of therapy incurred times the ceiling price for the drugs where ceiling pricing guarantees are provided. The PBM will reimburse the Plan Sponsor 100% of excess costs above the ceiling price.
11. Please indicate any requirements you would impose to secure this alternative pricing guarantees and the methodology you would propose.

E. PERFORMANCE GUARANTEES

The Plan will require specific performance guarantees. All guarantees shall be set and measured annually, and must have the ability to measure performance separately based on its experiences with the chosen PBM. Measurement of performance guarantees may be based on internal self-reporting, subject to independent audit.

1. The Plan is looking for flat dollar ($) performance guarantee amounts. Indicate the amount you are willing to place at risk for each item listed in the table below

	Standard	Measurement Criteria (BOB or Client specific)	Penalty Dollars at Risk	Timing of Payments
Implementation				
a. Clean Implementation	No systems errors, ID card delays, and Plan online access to all tools prior to Effective Date			
b. Implementation Timeline	All Key dates of Implementation timeline will be met			
c. Implementation Satisfaction Scorecard	Assigned Account Executive will work with the Plan prior to the start of implementation to agree on terms of a satisfaction scorecard to be issued to the Plan after Effective Date for completion			
Payment Accuracy & System Performance				
d. Protected Health Information	PBM guarantees no incidents in violation of HIPAA Security Rules which results in a transmission of electronic PHI for the Plan's covered members			
e. Plan Administration Accuracy	Implementation of all plan design changes will be 100% accurate			
f. Pricing Change Accuracy	Implementation of all pricing changes will be 100% accurate			
g. Financial accuracy (electronic and paper claims)	Percentage of claim payments made without error relative to the total dollars paid will be at least 99%			
h. Mail Service Non-Financial Accuracy	The mail service pharmacy shall guarantee dispensing accuracy of at least 99.995% (correct member name, correct member address, correct drug, correct dosage form, and correct strength)			
i. System Downtime	At least 99.5% access to its systems by all the retail pharmacies in PBM's network 24 hours a day, 7 days a week, 365 days a year			
j. Invoicing Errors	All invoicing errors will be credits back to the Plan by next billing cycle or PBM will pay interest			
k. Claims Eligibility Data	Eligibility loads not to exceed 24-hours after receipt			
l. Eligibility Data Error Reporting	Eligibility file error reporting on all eligibility file updates will be provided to the Plan within 2 business days			
m. Eligibility Error Rate Audits	Error rate identified through quarterly audits shall not exceed, on an average basis, 2%			

	Standard	Measurement Criteria (BOB or Client specific)	Penalty Dollars at Risk	Timing of Payments
n. Retail Pharmacy Audit	PBM will perform an on-site audit of 3% or more of their retail pharmacies which dispense greater than 500 claims a year			
o. Retail Pharmacy Turnover	Less than 5% of retail pharmacies will leave the retail network			
p. Claims Detail File	All claims detail files sent to external vendors will be provided within 8 days of request or scheduled delivery date			
Account Management				
a. The Plan Approval of Member Communications	100% of all member communications will be approved by the Plan - exceptions for drug recalls and urgent patient safety communications			
b. Delivery of Standard Reports	Within 30 days of end of reporting quarter			
c. Accuracy of Standard Reports	All standard reports provided will be 100% accurate			
d. Pharmacy Audit Resolution	Response to audit findings within 21 days after receipt of audit results or claims			
e. Account Management Turnover	Account team members will remain constant for at least the first 18 months of the Contract period, unless a change in account management staff is requested by the Plan			
Member Services				
a. Mail Turnaround – Prescriptions not requiring intervention	95% of prescriptions dispensed within average of 2 business days and 100% within average of 3 business days			
b. Mail Turnaround – Prescriptions requiring intervention	95% of prescriptions dispensed within average of 4 business days and 100% within average of 5 business days			
c. Paper Claims Turnaround	95% of prescriptions reimbursed within average of 10 business days and 100% within average of 14 business days			
d. ID Cards Mailing	98% of all ID cards are sent within 5 business days of receipt of eligibility. 100% mailed within 10 business days.			
e. Mailing Member Materials	All applicable member materials (for example, mail order forms) will be mailed at least 10 days prior to the Effective Date and will be 100% accurate (provided that eligibility file was received at least 30 days prior to the Effective Date).			
f. Phone Average Speed of Answer	100% of calls to the Plan-specific toll free line shall be answered within 20 seconds (excluding IVR)			
g. Phone Abandonment Rate	100% of calls to the Plan-specific toll free line shall be answered with an abandonment rate of 3% of less			

	Standard	Measurement Criteria (BOB or Client specific)	Penalty Dollars at Risk	Timing of Payments
h. Written Inquiry Answer Time	95% of inquiries responded to in 5 business days - 100% in 20 business days			
i. Member Satisfaction Survey	The PBM agrees to conduct a Member Satisfaction Survey for each Contract year and that the Satisfaction Rate will be 90% or greater. A penalty may be assessed against the PBM for failure to meet this standard. "Member Satisfaction Rate" means (i) the number of Eligible Persons responding to PBM annual standard Patient Satisfaction Survey as being satisfied with the overall performance under the Integrated Program divided by (ii) the number of Eligible Persons responding to such annual Patient Satisfaction Survey; the Plan must provide timely approvals and responses, and a minimum of 20% of surveys must be returned for the Performance standard to be applicable.			
j. Issue Resolution: Verbal Inquiries	PBM will resolve 99% of all telephone issues at the first point of contact (the number of telephone inquiries completely resolved at the time of initial contact divided by the total number of calls)			
k. Issue Resolution: Written Inquiries	PBM will resolve 98% of all written inquiries within 10 business days of receipt of inquiry			
l. Issue Resolution: The Plan Staff Involvement / Escalation	PBM will resolve member issues within 48 business hours for any case that required the involvement of the Plan's staff due to incorrect or incomplete information being provided by the PBM. If not resolved within 48 hours, a penalty will be applied per case, up to an annual maximum.			

In addition, you may provide other guarantees designed to differentiate your program.

m. Medicare RDS				
n. Medicare RDS	Monthly Claims file must be submitted to CMS by the last day of the following month (subject to the following penalties).			
o. Medicare RDS	All claims must be submitted in accordance with both CMS guidelines and the Plan's strategy			

F. QUESTIONNAIRE

Complete the following tables as per the Proposal Instructions:

CONTACT INFORMATION

a. Organization Name:	
b. Date Founded	
c. Contact Person's Name	
d. Title	
e. Address	
f. City/State	
g. Phone Number	
h. E-mail Address	
i. Fax Number	

REFERENCES

1. Current References (Preferably public sector clients with similar characteristics such as CBAs)

CURRENT REFERENCES				
Name	**Contact Name**	**Phone Number and Client Location**	**Number of Members**	**Contract Start Date**

2. Recently Terminated Client References (at least 2 in the last 24 months)

RECENTLY TERMINATED CLIENT REFERENCES				
Name	**Contact Name**	**Phone Number**	**Termination Reason**	**Termination Date**

Authorized Signature

G. ORGANIZATIONAL STABILITY & EXPERIENCE

1. Provide the following most recent result for your parent organization: Credit Rating (S&P, Moody's, Fitch) Latest SSAE-16 Latest annual report (if public)

2. Complete the following table:

ORGANIZATIONAL STABILITY & EXPERIENCE	RESPONSE
a. Parent Company	
a. Year PBM Established	
b. Current # of PBM employees and # that will directly support this account	
c. Membership count (total covered lives)	
b. Current (2020)	
c. 1 year prior (2019)	
d. 2 years prior (2018)	
e. % from MCO/HMO plans (current)	
d. Number of Group Plans (current)	
f. Total	
g. Group Contracts with 5,000 or more covered lives	
h. Group Contracts with Collectively Bargained employees	
i. # of Public Sector Group Contracts	
e. AWP dollars processed (latest year available)	
j. Retail	
k. Mail Order	
f. Number of Group Plans Added:	
l. Past 12 months	
m. Past 24 months	
g. Number of Group Plans Terminated:	
n. Past 12 months	
o. Past 24 months	
h. Have you acquired or sold any organizations in the last 24 months? If so, explain	
i. Have you relocated staff, changed computer or telephone systems in the last 12 months?	
j. Detail any major changes to your organization or structure that are expected in the next 12 months?	
k. Indicate the number of any outstanding legal actions pending against your organization and/or owners. Explain the nature and status of action if permitted. Can you assure the Plan these actions will not disrupt business operations?	
l. What general and professional liability coverage do you currently have in place for the entity that is proposing the service? Include per occurrence $ limits and insurance company rating.	
m. Does your organization comply with all HIPAA regulations?	

H. OUTSIDE SERVICE ORGANIZATIONS

1. List all functions you currently outsource to any third party and name sub-contractor for the following functions:

OUTSIDE SERVICE ORGANIZATIONS PROVIDING FUNCTIONS	YES	NO	NAME AND ADDRESS OF THE SUB-CONTRACTOR
a. Claim processing system	☐	☐	
b. Formulary Management	☐	☐	
c. Appeals	☐	☐	
d. Clinical programs	☐	☐	
e. P and T	☐	☐	
f. Customer service	☐	☐	
g. Rebate contracting	☐	☐	
h. Network contracting	☐	☐	
i. Mail order	☐	☐	
j. Specialty Pharmacy	☐	☐	
k. Data Reporting	☐	☐	

2. Describe what portion of the Plan's business with your organization will be serviced by a subcontractor or through leased services/networks.

3. List the years experience in the PBM industry and with your organization for the following individuals assigned to this account:
   a. Lead Account Manager
   b. Lead Clinical representative
   c. Implementation manager
   d. Customer Services/Member Services manager
   e. Lead underwriter

I. DRUG UTILIZATION REVIEW

It is expected that all pharmacies will have real-time online edits. If this is not the case, indicate the deviation. For the following section, please indicate in your response if there are discrepancies between the retail pharmacy network and mail order capabilities.

DRUG UTILIZATION REVIEW	RESPONSE			
	Real Time Edit Criterion	**% of Pharmacies that Satisfy Criterion**	**% of Pharmacies with real time, Online edits**	**Percent of Total Rxs Denied (Last Calendar Year)**
1. It is expected that all pharmacies will have real-time online edits. If this is not the case, indicate the deviation. For the following section, please indicate in your response if there are discrepancies between the retail pharmacy network and mail order capabilities.				
a. Eligible Member/Dependent				
b. Eligible Drug				
c. Contract Price of Drug				
d. Drug Interactions				
e. Duplicate Prescription				
f. Refill too Soon				
g. Proper Dosage				
h. Proper Days' Supply				
i. Generic Availability				
j. Patient Copayments				
k. Other (List)				
2. What edits occur prospectively at point of sale (POS)?				
a. Concurrently?				
b. Retroactively?				
3. What Drug Utilization Review features, capabilities, and/or processes differentiate your organization from your competitors?				
4. Provide most recent quarterly book of business savings for the following programs:				
a. Concurrent DUR _____% of Total Ingredient Costs				
b. Retrospective DUR _____% of Total Ingredient Costs				
c. Prior Authorization _____% of Total Ingredient Costs				
5. Are reported savings based on the Plan specific claim-by-claim analysis? If no, describe the savings calculation process in detail for each of the claims edit services you offer.				
a. If no, describe the savings calculation process in detail for each of the claim edit services you offer.				

DRUG UTILIZATION REVIEW	RESPONSE			
	Real Time Edit Criterion	**% of Pharmacies that Satisfy Criterion**	**% of Pharmacies with real time, Online edits**	**Percent of Total Rxs Denied (Last Calendar Year)**
6. Do you have edits or programs in place designed to detect and address potential drug fraud and/or abuse?				
a. If yes, explain and include a listing of the specific drugs targeted by this program.				
b. If yes, please describe the member outreach after fraud and/or abuse is identified.				
c. If yes, please detail the controls put into place after fraud and/or abuse is identified.				
7. Are there charges associated with your organization's fraud and/or abuse programs or edits?				
8. Provide a sample of DUR reports you produce and monitor. Are these reports made available to the Plan at no additional cost?				
9. What criteria and methodologies are used to identify and monitor high cost claimants?				
10. Describe your pre-authorization protocols available to the Plan. Include information on step therapies and other clinical management programs along with any additional costs for such services and credentials of the staff performing pre-authorization. What drugs or class of drugs do you recommend be pre-authorized?				
11. How will you communicate innovative programs such as genetic testing or therapy-specific management centers to the Plan?				
12. Explain any financial incentives established for providers to comply with utilization management protocols or treatment benchmarks. (Include withholds, bonuses, or other arrangements.)				
13. How do you guard against the filling of separate prescriptions for the same or similar drugs at different pharmacies on the same day?				
14. Do you evaluate the appropriateness of the prescribing physician/practitioner credentials?				
15. What clinical programs do you offer that incentivize adherence? Do you have the system capabilities to offer lower cost shares for more adherent members? (e.g., if prescription is consistently filled when 75% to 100% of the prescription has been depleted, the copay is cut in half or a lower co-insurance is applied.)				

DRUG UTILIZATION REVIEW	RESPONSE			
	Real Time Edit Criterion	**% of Pharmacies that Satisfy Criterion**	**% of Pharmacies with real time, Online edits**	**Percent of Total Rxs Denied (Last Calendar Year)**
16. Do you have the system capabilities for a "starter dose" program where the first few weeks of therapy do not incur a member cost share?				
17. Identify which of the following edits are performed at the point-of-sale:	**Performed at the Point of Sale** ☐ Yes or ☐ No			
a. Ineligible member				
b. Pre-existing condition				
c. COB				
d. Benefit maximums for certain drug types				
e. Drug is inappropriate for the patient due to age				
f. Drug is inappropriate for the patient due to gender				
g. Quantity versus Time				
h. Allergy				
i. Incorrect AWP or formula price				
j. UCR input				
k. Duplicate Rx				
l. Refill too soon				
m. Incorrect dosage				
n. Rx splitting				
o. Drug interactions				
p. Over utilization				
q. Under utilization				
r. Aggregate Benefit Maximums				
s. Possible Narcotic Abuse				
t. Other POS Edits (provide list)				

J. ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES

ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES	RESPONSE
1. Which office would handle the general member servicing of the Plan?	
a. What are the standard office hours for the sales and service office?	
2. Will you agree to weekly conference calls and one monthly face-to-face meeting with the Plan to discuss plan performance, present financial results, etc.?	
a. What information would be shared at these meetings?	
3. Will dedicated customer service representatives be assigned to this account?	
4. Do customer service reps have online access to real time claim processing information?	
5. For the customer service center proposed for the Plan provide the following for 2019:	
a. Percent of calls abandoned	
b. Percent of calls handled by live representative	
c. Number of seconds to reach a live customer service representative	
d. Inquiries made	
6. Where is your call center located?	
7. Will you record 100% of customer service calls? If not, what percentage of customer service calls will be recorded?	
8. Do you offer the Plan online access to information and services via the Internet or through CRT interface? Are there quantity access limits? If yes, what information is accessible and at what additional cost, if any.	
9. Will the Plan be able to produce ID cards and/or temporary proof of benefit letters in "real time"?	
10. Are communication materials available electronically?	
11. Can your organization send recovery letters to members who continue to use their drug card after their termination? If yes, at what cost?	
12. Will you survey the Members annually regarding program administration satisfaction?	
a. If yes, provide an example.	
13. Will one toll-free number handle coverage for the retail, mail order, and specialty program?	
14. What hours will the telephone lines be staffed?	
15. Are automated services available 24/7?	

ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES	RESPONSE
16. How do you service members travelling internationally? What if international stay is for an extended period (visiting semester, etc.)?	
17. Can you provide early refills for traveling members?	
18. Describe service available to the Deaf, Hard of Hearing, and Blind?	
19. How do you track member complaints?	
20. List the top five member complaints related to retail, mail order, and the specialty pharmacy program.	
21. Do you currently perform membership satisfaction surveys? What percent of members indicated that they were "satisfied or very satisfied" with the overall program?	
22. Do you provide member support services for selecting and/or locating network pharmacies and formulary look-ups?	
23. How are members notified of the following events? (Indicate for each below: Phone, Written Document, or Other (specify)).	
a. Plan Change	
b. New Drug Additions/Formulary Changes	
c. Change in Pharmacy Network Panel	
d. Ineligible, Banned, or Recalled Drug	
e. Generic Substitution	
f. Change in medical/clinical management rules	
24. How do you remind members regarding refills and adherence? Indicate methods and frequency of interventions.	
a. At mail	
g. At retail	
25. How often are network pharmacy directories updated and distributed to members?	
a. Monthly	
h. Quarterly	
i. Semi-annually	
j. Annually	
k. Other	
26. What services are available to members via the Internet? Do you have a website for members? Provide details regarding capabilities (e.g., clinical resources, drug cost estimators, etc.).	
27. Does your member website include network pharmacies' usual and customary (U&C) and/or contracted discounted pricing information? If so, please indicate if the pricing is real-time or how often it is updated?	
28. Describe security systems and protocols in place to protect confidential patient records in storage and in transit.	
a. Is the site VIPPS certified and licensed in every state?	

ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES	RESPONSE
29. Do you have programs specifically designed for members, which will increase formulary compliance? Explain and include any sample member materials.	
30. Can your organization produce "EOB" type statements for the members? (should include YTD payments, deductible balances, total paid by plan costs, total paid by member, etc.)	
31. Describe what reporting you will provide to the Plan regarding formulary use and member satisfaction.	
32. How many sub-group levels can be captured in your claims and billing systems? PBM must replicate current account structure	
33. Do you administer medical necessity appeals? Please describe the process in detail for your self-insured ERISA plans and the Plan.	
34. How are out-of-network claims processed?	
35. Does your system have the ability to identify claims for which a manufacturer copay coupon was used? If so, can your system restrict these coupons from being used?	
36. Describe any reports either clinical or financial in nature that would be provided to the Plan in order to help manage benefit costs.	
37. How many days does the Plan have to pay once an invoice is received? What methods of payment are available (e.g., ACH, Direct Deposit, SurePay, Checks)? What exceptions are there to the standard payment terms?	
38. Please confirm and describe your organization's ability to implement and report outcomes for its core clinical programs and non-core (buy-up) programs. Please confirm and describe this reporting availability for the Plan's account hierarchy structure.	
39. Please confirm that the Plan will have the ability to access your internal and external national benchmark data (e.g. IMS) and support inquiries from the Plan regarding benchmark information (e.g. quarterly IMS market shares for select drug classes, IMS generic dispensing rates, etc.).	

ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES	RESPONSE
40. Please confirm your organization can provide comprehensive Plan Sponsor benefit description set-up documents upon request or on an ongoing basis to the Plan. Please provide the guaranteed turn-around time for providing such requested documents.	
41. What one-time implementation audit rights and allowance will you provide the Authority should you be awarded the Contract?	
42. Vendor agrees to notify member of any prescription drug adjustment(s) with any formulary change, in advance of 60 days, if cost negatively impacts members. A list of these members, along with the specific changes, will be sent to the Authority in Excel format.	

K. REPORTING CAPABILITIES

Please indicate for each report noted below whether you can provide such a report. If you can provide the requested report, please indicate the price or if the cost is included in the basic fee.

Report Type	Yes	No	Cost	Frequency	Available by Unique Account Structure or Sub-Group	Available in total
1. Eligibility Report which shows accuracy of updates and changes	☐	☐				
2. Paid Claims Summary (Ingredient cost, day supply, dispensing fees, taxes, copay totals by month)	☐	☐				
3. Paid Claims Summary by AHFS therapeutic category showing total number of claims, eligible charges and claim payments for each category	☐	☐				
4. Detail Claim Listing (Utilization and Ingredient cost by individual claimant, listing the drug name and dosage, quantity, day supply, submitted charge, allowable charge, paid)	☐	☐				
5. Cost Sharing Report (Amounts determined to be ineligible, amounts applied to copays and coinsurance, and amounts adjusted for COB)	☐	☐				

Report Type	Yes	No	Cost	Frequency	Available by Unique Account Structure or Sub-Group	Available in total
6. Detailed Utilization Report (# of prescriptions submitted by single source brand, multi-source brand and generic drugs, including average AWP, Ingredient cost per Rx, Dispensing fee, and average days' supply)	☐	☐				
7. Top Drug Report (detail of cost and utilization by top drug products)	☐	☐				
8. Specialty Drug Reporting	☐	☐				
9. High Amount Claimant report	☐	☐				
10. Therapeutic Interchange Report detailing success rates and cost impacts of PBM initiated interchanges % if % or drug utilization review	☐	☐				
11. Drug Utilization Review activity and Savings Report by type of edit)	☐	☐				
12. Formulary Savings and Rebate report	☐	☐				
13. Prior Authorization and other clinical program reporting	☐	☐				
14. Pharmacy cost and utilization reporting (includes number of patients, scripts, dollar volume)	☐	☐				
15. Transcripts of customer service call recordings and detailed call notes upon request (please indicate how soon the report will be available after the call has occurred)	☐	☐				
16. RDS Subsidy Cost Reports	☐	☐				
17. Other Reports	☐	☐				

BM must be able to provide the Authority access to claim and utilization reports electronically. Please confirm which reports in the table above that will meet this requirement.

Standard reports must be archived indefinitely or available for downloading electronically from the PBM site.

L. PRESCRIPTION REIMBURSEMENT ISSUES

PRESCRIPTION REIMBURSEMENT ISSUES	RESPONSE
1. What is your proposed source for AWP data? a. First DataBank b. Med-Span c. Redbook d. Other	
2. How often are AWP prices updated in your adjudication system? a. Daily b. Weekly c. Monthly d. Annually e. Other	
3. What percent of your network pharmacy contracts include the "lesser of retail price, MAC price, or discounted price" provision? a. 0-20% b. 21-40% c. 41-60% d. 61-80% e. 81-100%	
4. Will you guarantee on a dollar-for-dollar basis that the average, realized AWP discounts for brand and generic drugs and quoted dispensing fees will be no less than those quoted at Retail and Mail Order for the life of the Contract?	
5. Explain in detail how network pharmacies' U&C prices are captured and reported.	
6. Describe the retail network pharmacy reimbursement process in detail.	
7. Are there financial incentives to network pharmacies, physicians and other providers that are tied to utilization rates, compliance goals, quality of care outcomes, or other performance results? If so, explain and include any incentive-based dispensing fees, bonuses, withholds, retroactive capitations, etc.	
8. Do you maintain multiple contracts with individual pharmacies at varying reimbursement rates? If yes, explain.	
9. Describe any financial or other incentives you are willing to offer based on increased Internet utilization for mail order claim submission in recognition of the inherent cost savings.	
10. Do your MAC price lists vary contractually between network pharmacies? If yes, why?	
11. Explain in detail the process you propose regarding Plan verification of drug manufacturer revenue transparency.	
12. Define your electronic process for determining a product's brand or generic status for both retail and mail order claims using First DataBank and/or Medi-Span definitions.	

PRESCRIPTION REIMBURSEMENT ISSUES	RESPONSE
13. How often are your retail network provider contracts renegotiated? a. Annually b. Every two years c. Every 3 to 5 years d. Other	
14. Is it possible for a retail pharmacy to submit NDC numbers for adjudication that contain AWP prices designed to maximize their discounted ingredient costs?	
15. How do you ensure that submitted NDC's at retail are indicative of pharmacy drug purchasing patterns?	
16. Does your organization share in any financial remuneration that retail pharmacies receive from drug manufacturers or other sources?	
17. Specify if you are able to readily provide a detailed listing of all of the various ingredients that are included in multi-ingredient compound claims and confirm multi-ingredient compounds can take a specified cost-share.	
18. Please confirm your ability to support member cost-share plan designs based on cost share amounts (i.e. copays and/or coinsurance amounts), day supplies, and/or pharmacy. a. Dollar thresholds b. Dollar thresholds along with days' supply at retail c. Dollar thresholds along with days' supply at retail and or mail service d. Dollar thresholds along with days' supply and specific pharmacies or pharmacy chains	

Complete the following table indicating the amount that would be collected from the member for each prescription claim scenario (copays are illustrative).

Rx Cost	Scenario 1 (Retail)	Scenario 2 (Retail)	Scenario 3 (Mail Order)	Scenario 4 (Mail Order)
a. Ing. Cost plus Disp. Fee plus Sales Tax	$9.00	$9.00	$22.00	$22.00
b. Copay/Coinsurance	$10.00	$5.00	$35.00	$5.00
c. U&C	$25.00	$25.00	$55.00	$55.00
d. Amount Collected from Member	Dollars.	Dollars.	Dollars.	Dollars.
e. Amount Charged to the Plan	Dollars.	Dollars.	Dollars.	Dollars.

Will the retailers provide the lower of the discounted plan cost plus dispensing fee, member cost, U&C, or retail price for plan adjudication?

How do you guarantee that members always receive this lowest price? What procedures are established to ensure the pharmacy is in compliance with this provision?

M. NETWORK MANAGEMENT & QUALITY ASSESSMENT

Complete the following table. Check off those elements that are included in your pharmacy selection process and provide the percentage of pharmacies that satisfy the following selection criteria elements.

NETWORK MANAGEMENT & QUALITY ASSESSMENT	RESPONSE		
	Standard Selection Criterion	**Percent of Pharmacies that Satisfy Criteria**	**Comments**
1. Complete the following table. Check off those elements that are included in your pharmacy selection process and provide the percentage of pharmacies that satisfy the following selection criteria elements.			
a. Require unrestricted licensure			
b. Review malpractice coverage and history			
c. Require full disclosure of current litigation and other disciplinary activity			
d. Require signed application/agreement			
e. Require current DEA registration			
f. On-site review of pharmacy location and appearance			
g. Review hours of operation and capacity of network pharmacies to handle the added volume the Plan would generate			
h. On-site electronic access to patient data			
2. Describe any incentives or programs in place with providers designed to increase generic dispensing and formulary compliance. Explain in detail.			
3. Describe the process in place to ensure that the Plan is credited for prescriptions filled but not obtained (Return to Stock situations).			
4. What procedures are established to ensure that network pharmacies are in compliance with negotiated MAC provisions and prices?			
5. List any pharmacy chains excluded from your proposed retail pharmacy network.			
6. Provide the total number of pharmacies included in your proposed pharmacy network.			
7. Summarize the quality assurance programs your organization presently has in place and list the most important actions these programs have taken in the past year to improve performance.			
8. Do you monitor individual physician prescribing patterns?			
If so, what action is taken with prescribers who have a high degree of non-compliance or outlier prescribing?			
9. If you provide mail order benefits through a third party, explain any audit procedures in place to ensure proper dispensing and pricing practice adherence.			
10. What safeguards exist for preventing breaches in patient confidentiality with regard to pharmacy/medical claims information?			

NETWORK MANAGEMENT &	RESPONSE
11. Will you guarantee that the Plan will be charged the generic price and the member is charged the generic copay if a generic is out of stock?	
12. How do you capture pharmacy errors?	
List the top 5 reasons for errors (e.g., wrong dosage).	
13. Does your organization comply with all HIPAA regulations?	
14. Are the retail and mail order network contracts solely owned and operated by your organization?	
If not, explain the contractual relationship you have with outside parties.	
15. Does your organization own any network pharmacies, including mail and/or specialty?	
16. Will the Plan have the ability to pend payments to pharmacies identified by the Plan and reported to PBM as engaging in suspicious dispensing practices?	
17. Will the Plan receive an 180-day notice, when possible, of any event or negotiation that may cause a disruption in the retail pharmacy network access?	
18. Based on all Plan retail prescriptions provided, please prepare a "disruption" analysis and complete the following table. (**Your analysis is to exclude all pharmacies and prescriptions with a <u>Mail</u> indicator.**) a. Total number of network retail pharmacies b. Total retail pharmacy numbers in claims data c. Total retail pharmacy numbers in claims data in your network d. Total retail NDCs in claims data Total retail NDCs in claims data in your network e. Total number of claims that are covered under your proposed formulary	

N. FORMULARY MANAGEMENT & REBATES

FORMULARY MANAGEMENT & REBATES	RESPONSE
1. Do you receive formulary rebates from manufacturers of generic drugs? If yes, how will these be shared with the Plan?	
2. If you require a formulary management fee, indicate amount or percentage proposed.	
Other than these fees, do you guarantee that 100% of all rebates collected be passed through to the Plan?	
3. Describe how your preferred drug list is established. Include how specific drugs are selected and how often your P&T Committee meets	
4. Are any P&T Committee members employed by or under Contract with any drug manufacturers?	
Are any P&T members directly employed by your organization?	
5. Can you support custom changes to the preferred drug list at the request of the Plan?	
6. Describe your process for defining "preventive drugs" for PPACA and High Deductible Plan purposes? How would you handle disputes between the Plan's preventive drugs lists and your standards? How will you support the associated cost share tiers?	
7. How many different standard preferred drug lists do you presently support?	
8. How many custom preferred drug lists do you presently support?	

FORMULARY MANAGEMENT & REBATES	RESPONSE
9. Will you guarantee that any preferred drug lists switches which are not economically advantageous to the Plan on an ingredient cost basis will be reported and reimbursed to the Plan on a dollar-for-dollar basis using the least expensive, therapeutically equivalent alternative drug as the basis for reimbursement?	
10. Can the Plan be given the ability to authorize non-formulary overrides directly?	
11. What percent of all available brand drugs are excluded from your formulary or preferred drug listing (based on total number of Rx dispensed for plans with an open formulary)?	
12. Are any generic drugs considered "non-preferred" on your proposed formulary (i.e., subject to the "non-preferred" copay)? If yes, please describe in detail and provide examples.	
13. Please provide the percentage of non-formulary brand drugs that have a generic equivalent.	
14. What percent of all available brand drugs are non-preferred (not on your preferred drug list)?	
15. Do you have a Formulary Grievance Process in place to address member concerns regarding preferred drug list alternatives? If yes, explain this process in detail.	
16. Do you have the capabilities to have a specified cost-share for Multi-Source Brand drugs regardless of formulary status? (e.g., 75% co-insurance for all multi-source brands). Specify if there are system limitations where formulary coding supersedes any specific cost share coding specified for multi-source brands.	
17. Do you have the capabilities to support a turn-key value-based benefit design or evidence-based benefit design? Specify the therapeutic classes that would be targeted.	
18. How do you adjudicate vaccine claims with or without the associated administration charges from the pharmacy? Specify if there are any limitations. (e.g., specific vaccines need for supplemental pharmacy network, etc.)	

O. PRESCRIPTION DRUG DATA

1. For the Plan's top 100 retail brand prescriptions provided, please indicate whether each brand drug will be considered "preferred" or "non-preferred." Please make sure that you answer "Yes" for only those situations where the exact drug listed is considered "preferred." For example, if Flonase is listed and is not considered "preferred" on your proposed formulary, then you should answer "No", even though the generic equivalent may be considered "preferred" (i.e., you should only answer "Yes" if the brand Flonase is considered "preferred").

2. For the Plan's attached top 100 mail brand prescriptions provided, please indicate whether each brand drug will be considered "preferred" or "non-preferred." Please make sure that you answer "Yes" for only those situations where the exact drug listed is considered "preferred." For example, if Flonase is listed and is not considered "preferred" on your proposed formulary, then you should answer "No", even though the generic equivalent may be considered "preferred" (i.e., you should only answer "Yes" if the brand Flonase is considered "preferred").

3. Based on the Plan's attached detailed claim-by-claim prescription drug data provided, please indicate what percent of retail and mail generic and brand prescriptions are currently considered "preferred" on your proposed formulary:

	Retail	Mail
a. Preferred Generics as a Percent of all Generics:	%	%
b. Preferred Brands as a Percent of all Brands:	%	%

P. MAIL ORDER PROGRAM

MAIL ORDER PROGRAM	RESPONSE
1. Complete the following for your proposed mail order facility.	
a. Where will the mail-order facility location for the Plan be?	
b. What are the days and hours of operation for this facility?	
c. What was the total number of prescriptions filled in calendar year 2019 for this facility?	
d. How many total Rxs could be accurately filled on a daily basis?	
e. Number of full-time Clinicians/ Pharmacists on staff at facility?	
f. Number of Registered Pharmacists?	
g. Number of Pharmacy Technicians?	
h. Number of Other Clinical Staff? (specify)	
i. Which organizations are used for delivery services?	
2. Does your organization own the mail service facility?	
If this is a subcontractor, whom do you Contract with?	
3. Describe the process for ordering prescriptions by mail and include a sample envelope.	
4. Describe your process for ordering refills by mail, phone, fax, and the Internet. What percentages of refills are currently received by mail, phone, fax, and Internet?	
a. Mail	
b. Phone	
c. Fax	
d. Internet	

MAIL ORDER PROGRAM	RESPONSE
5. How far in advance may members order a refill on a 90-day supply prescription?	
a. 90 days in advance	
b. 60-89 days in advance	
c. 30-59 days in advance	
d. less than 30 days in advance	
e. Other	
6. Describe your process of filling/ordering prescriptions, refills, and split-prescriptions. Do you have an automatic refill process with a standard refill-too-soon threshold? Are you able to send email reminders for refills?	
7. Will you agree that all mail order discount guarantees will be based on lowest listed NDC-level AWP cost?	
If not, state your suggested pricing basis.	
8. Will mail order pricing apply to all Rxs dispensed through mail order facilities?	
9. Confirm that you will prorate co-payments at mail service, as applicable under the current plan design	
10. How many calendar days advanced notice must a member provide in order to guarantee that their supply is received before the existing supply is depleted?	
a. Less than 7 days	
b. 7-9 days	
c. 10-14 days	
d. Greater than 14 days	
11. What is the average time in calendar days between receipt of claim and delivery to patient (include delivery time)?	
12. Can you provide a system edit to facilitate physician outreach in order to avoid partial fills? Explain.	
13. What will you set the threshold for the uncollected member cost share at mail at?	
14. Does your organization, or your associated facilities, repackage drug products for use in filling mail order prescriptions? If yes, does the AWP for repackaged drugs match the AWP of the same package size of the source labeler? If not, describe how you establish the AWP for your repackaged NDCs	
15. Do you offer a pill-splitting program? If yes, provide program details, member/Plan Sponsor cost share logic and potential savings through program enrollment.	
16. Describe your policy on too-early refills and emergency supplies. Outline your process for prescriptions which are ordered prior to the first available refill date.	

MAIL ORDER PROGRAM	RESPONSE		
17. Using the table below, provide the mail order performance statistics, over the past three years, for the facility being proposed:	**2018**	**2019**	**2020**
a. Mail Facility Name			
b. Total number of prescriptions dispensed			
c. Utilization as a percent (%) of capacity			
d. Average turn-around time (no intervention required)			
e. Average turn-around time (intervention required)			
f. Average Generic Dispensing Rate for all facilities			
g. Average Generic Substitution Rate for all facilities			
18. Explain the process for providing members with a short-term retail prescription supply in the case of delayed delivery of their mail order prescription.			
19. How are members notified when a mail order prescription is delayed due to the following circumstances?			
a. A prescription requiring clarification from the physician or physician's agent (e.g., missing quantity, illegible drug name).			
b. A clean prescription where the delay is due to operational, capacity, or drug supply issues.			
c. A clean prescription where the delay is a result of a therapeutic switch intervention.			
d. Other			
20. Describe your quality controls to ensure accurate dispensing of prescriptions.			
How many levels of review take place and who conducts the reviews?			
21. Describe online integration, if any, with retail pharmacies to ensure non-duplication and to identify potential adverse interaction.			
22. What are your contingency plans and procedures for providing backup service in the event of strike, natural disaster, or backlog?			
23. How often do you switch generic manufacturers for particular products?			
How are members notified of the switch?			
24. How often are therapeutic interchanges performed at mail order, if at all? If so, please explain applicable drug products and rationale.			
25. Are on-site audits performed at your mail service pharmacies?			
Describe the frequency and types of audits performed and by whom.			
26. Describe the process for notifying members of prescriptions not on the formulary.			
27. Describe the process for notifying members of the expiration date of their prescription.			
28. Describe the process for notifying members of their next refill date and the number of refills remaining.			

MAIL ORDER PROGRAM	RESPONSE
29. Describe your system of providing patient-advisory information with prescriptions filled.	
30. What percentage of prescriptions receives a patient-information supplement?	
a. 0 to 20%	
b. 21 to 40%	
c. 41 to 60%	
d. 61 to 80%	
e. 81 to 100%	
31. When do you bill the patient?	
a. before the prescription is filled	
b. after the prescription is filled	
32. How do you provide notification of a product recall (such as Vioxx) to the Plan and members?	
33. How do you handle the following situations?	
a. No co-pay included in envelope	
b. Bounced check from patient	
c. Terminated/not authorized credit card	
34. Does mail order have a retail site facility that will offer mail order discount?	
35. Please indicate your mail order pharmacies' usage, if any, of DAW 5 for processing claims. Which drug products are assigned DAW 5 codes? Please describe your DAW 5 processing protocol and rationale.	
36. Do you have a mandatory mail program? If yes, describe the program in detail. Will you exclude certain medications from mandatory mail? (e.g., controlled substances, specialty medications)	
37. Please describe any additional service or value benefits provided by your mail order service pharmacies.	
38. Please indicate what payment method options exist for members at your mail order facility. (Please specify: Visa, MasterCard, Check, American Express, Debit Cards, Cash, etc.)	

Q. SPECIALTY PHARMACY PROGRAM

SPECIALTY PHARMACY PROGRAM	RESPONSE
1. Explain any programs offered by your organization designed to encourage appropriate utilization of specialty drug products.	
2. What are your cost saving guarantees on your specialty drug programs?	
3. Detail any disease and therapy management programs you offer (include steps and costs).	
4. Identify how many members you currently manage as well as the total number of Rxs dispensed for the same disease states noted in the previous question.	
5. Explain the formulary decision and drug selection process as it pertains to specialty drugs.	
6. Do you currently administer a Specialty Rx Formulary?	
a. If yes, include the formulary in electronic format.	
b. If yes, please confirm your organization can support a specialty cost share tier for select plan designs.	
7. Will a member incur any additional costs for the delivery of	

SPECIALTY PHARMACY PROGRAM	RESPONSE
specialty drugs?	
a. If so, outline all billing/payment methods and all associated costs.	
8. Confirm that members will continue to be able to receive specialty prescriptions dispensed at retail pharmacies, and that these prescriptions are included under the retail guarantees.	
9. Please describe your organization's ability to limit specialty medication utilization to 30 days' supply per month.	
10. What differentiates your company and capabilities from other specialty drug vendors in a very competitive industry?	
11. Explain your side-effect counseling process.	
a. To which drugs and conditions does this process apply?	
12. Does your organization currently engage in outcomes reporting? Explain.	
13. Do you currently have a specialty/biotech drug P&T Committee?	
a. If yes, explain the role, function, and structure and how it differs from your traditional P&T Committee.	
14. Do you agree to renegotiate specialty product pricing terms on an annual basis with the Plan?	
15. Do you agree to include a Contract provision enabling the Plan to "carve-out" specialty drug services annually without impact to non-specialty contractual provisions, terms, and pricing?	
16. Explain in detail each point at which you make patient contact in the specialty drug dispensing and management process.	
17. Provide the customer and enrollee service or value benefits provided by your specialty drug pharmacies (e.g., sharps disposal units at no cost upon request for injectable drug users, etc.)	
18. Please indicate what payment method options exist for members at your specialty facility. (Please specify: Visa, MasterCard, Check, American Express, Debit Cards, Cash, etc.)	

R. MEDICARE PART D RDS

Regarding the Medicare Part D Retiree Drug Subsidy (RDS) program**:**

MEDICARE PART D RDS	RESPONSE
1. Regarding the Medicare Part D Retiree Drug Subsidy (RDS) program	
a. Confirm that your organization understands that the Plan is enrolled in the Medicare Part D RDS program. The Authority's plan year ends December 31.	
b. Confirm that you will provide hands-on support for the Authority to file for the RDS program.	
c. Confirm that your organization understands that the Plan is enrolled in the Medicare Part D RDS program. The Authority's plan year ends December 31st.	
d. Confirm that you will provide hands-on support for the Authority to file for the RDS program.	

MEDICARE PART D RDS	RESPONSE
2. For the Authority, for each Medicare-eligible Retiree who is age 65 and older, plus any known Medicare-eligible dependents of theirs, who received benefits for Medicare Part D "Covered Drugs", during the requested data period, confirm that you are able to provide aggregate prescription drug data for each individual that contains the following elements (only for claims that are Medicare Part D covered drugs), in an Excel format, to include:	
a. Unique de-identifiable claimant ID number	
b. A unique de-identifiable member ID number	
c. Claimant coverage status (disabled active, retired, dependent of retiree)	
d. Claimant date of birth	
e. Total claims paid by NEIHBP	
f. Total drug costs (including dispensing fees and sales tax, but not including admin fees.)	
g. Total claims paid by the claimant	
h. Total rebates* *If rebates cannot be provided by each individual claimant can you provide rebate information in aggregate for Medicare retirees or total rebates for NEIHBP if not separated by eligibility?	
3. The Authority needs to be able to determine from the data you submit, the Total Charge, Total Plan Paid Amount, and Total Member Paid Amount for each individual Medicare-eligible member. Confirm your ability to provide this data.	
4. The Authority requires that its vendor be flexible, accurate, and timely when it comes to preparation of data that is needed for submission to CMS under the subsidy reporting obligations. With this in mind,	
a. Confirm that you agree to provide an initial Retiree Eligibility List for each plan year.	
b. Confirm that you agree to be a "designee" and submit this Retiree Eligibility List directly to CMS/RDS by the due date.	
c. Indicate the name and email address of this "designee."	
d. If you will not be a designee for direct submission of retiree eligibility data to CMS, confirm that the Retiree Eligibility List that you provide to the client be in the required format for CMS, and be provided to client at least 60 days before the list is due to CMS.	
5. Monthly updates to the Retiree Eligibility List	
a. Confirm that you agree to provide a monthly Retiree Eligibility List for each plan year.	
b. Confirm that you agree to be a "designee" and submit this Retiree Eligibility List directly to CMS/RDS monthly.	
c. Indicate the name and email address of this "designee."	
d. If you will not be a designee for direct submission of retiree eligibility data to CMS, confirm that the Retiree Eligibility List that you provide to the client be in the required format for CMS.	
6. For the Retiree Eligibility List Response Files sent by CMS/RDS in response to an eligibility list transmission, confirm that you agree to research eligibility problems and rejects and provide timely updates (adds/deletes) back to CMS/RDS?	
7. Describe how you ensure adequate reporting to the Authority of the manufacturer rebates retained by the PBM in lieu of administrative fees.	
8. Will the RDS application affect the amount of rebates received by the Authority? If so, describe	

MEDICARE PART D RDS	RESPONSE
9. Explain how you calculate the "Estimated Cost Adjustment" (ECA) for RDS cost reports. (The ECA is an estimate of the rebates, discounts, and chargeback's for each month. This estimate is supposed to be based on historical data and calculated according to generally accepted actuarial principles.)	
10. How do you propose to submit claims information for drugs that may be payable under either Medicare Part B or D?	
11. Do you use the CMS simplified methodology, which allows a Plan Sponsor to reduce costs by 0.3 percent rather than identifying drugs that could be payable under Part B or D? If not, what other method is used?	
12. How do you make sure the subsidy is not requested for only drugs that do not qualify for RDS because they are specifically excluded from Medicare Part D?	
13. Confirm that you will assist the Authority with the annual reconciliation that must be performed within 15 months after the end of the plan year, and describe the services you will provide. **14.** If the Authority chooses your firm, what Coordination of Benefits (COB) issues do you foresee that may affect the Authority who has retirees age 65 and older for whom they have filed for the Medicare Part D subsidy?	
15. If an individual has prescription drug coverage under the Authority's Rx plan and also enrolls in another Medicare Part D prescription drug plan, how do you identify such a situation at the point of sale?	
16. What will your computer system indicate the pharmacist is to do with a person who presents with dual Medicare Part D coverage?	
17. Can you coordinate with other Medicare Part D prescription drug plans?	
18. Do you perform the coordination of benefits at the point of sale or do paper claims have to be submitted? a. At the point of sale b. Paper claims have to be submitted	
19. Confirm that you agree to be a "designee" with Cost Reporting privileges and submit cost reports directly to CMS.	
20. Indicate the name and email address of this designee.	
21. Which method of submitting cost reports to CMS/RDS do you intend to use (mainframe-to-mainframe or manual data entry to RDS secure Web site)?	
22. Indicate your vendor ID number for mainframe-to-mainframe	
23. Indicate your vendor ID number for manual data entry to RDS secure Web site.	
24. How often are you willing to submit cost reports? a. Monthly b. Quarterly c. Annually	
25. Confirm you will notify the Authority and their consulting firm each time the PBM submits a cost report to CMS. Confirm you will make cost reports and claims information available to the Authority or an entity designated by the Authority for the purpose of a client audit?	
26. If you will not be the designee for Cost Reporting, confirm you will provide a Cost Report to the Authority in the "manual data entry to RDS secure Web site" format and by the date indicated by the Authority.	
27. Does the frequency of cost report submission affect fees charged?	
28. The Authority will require that the selected PBM continue to provide the data necessary to support Cost Reporting to CMS, even after Contract termination, for the period of time during that the Authority had a Contract with your organization. Confirm you agree to provide this data.	

MEDICARE PART D RDS	RESPONSE
29. Is there an additional charge for this post-Contract termination data reporting?	
30. A PBM (or other administrator) must contractually acknowledge that the information it will provide to the client will be used by the client for the purpose of obtaining federal funds. Provide a copy of your certification language. a. Attached b. Not attached	
31. Outline your Compliance Plan to prevent Fraud, Waste, and Abuse with respect to the RDS.	
32. What other issues related to RDS filing does the Authority need to know about your ability or inability to support them through this subsidy process?	
33. Confirm you agree to retain all records associated with RDS for the CMS-prescribed time limits at no extra charge. Describe the safeguards used to prevent the unauthorized use and disclosure of data exchanged under RDS.	
34. Provide a copy of any Contract you require for RDS services. a. Attached b. Not attached	
35. The Successful Proposer(s) must agree to continue all RDS cost reporter services after termination for the covered subsidy year at no additional charge. In addition, the Successful Proposer(s) will continue to assist in the RDS reconciliation process for the covered subsidy year after termination at no additional charge. Confirm that you agree to this.	
36. The Successful Proposer(s) must agree to assist the Authority with not only the reconciliation but also the application process.	

S. RDS ADMINISTRATION FEE QUOTE

Please provide a per-eligible-member-per-month fee for RDS services.

Retiree Drug Subsidy Fee Quote	Part-D Eligible Member PMPM Fee
a. PBM submits all required reporting to CMS	$0.00
b. PBM submits all required reporting to the Authority	$0.00

Please provide a detailed list of all services included in the above fee. Please describe all services <u>not</u> included in the above quoted fee.

T. CERTIFICATION LETTER FOR PRESCRIPTION DRUG

As an officer of the following corporation, I certify that all of the information included in this Proposal is true and accurate.

Signature _____

Name _____

Title _____

Date _____

Attachment 1D. - Acknowledgment and Statement of Exceptions Form for the Prescription Drug Program

Re: New Jersey Turnpike Authority

We have reviewed the Proposal specifications contained in this RFP and are in agreement with those requirements except as stated or referenced below (or on the attached sheet(s)):

Company Name	**Signature**
Date	**Title**

SECTION VII E F G – COBRA, FSA AND HSA QUESTIONNAIRE

A. GENERAL REQUIREMENTS FOR ALL PROPOSERS)

1. Provide an answer to each question for each coverage line you are submitting and do not leave blank or unanswered questions.
2. Answer each question directly and concisely. Long-winded answers will be deemed unresponsive. Please avoid referring to attachments or collateral materials in lieu of answers. Do not include promotional materials.
3. The proposer(s) will be held accountable for accuracy/validity of all answers.
4. Please remember, RFP responses will become part of the Contract between the winning proposer(s) and the Authority.
5. Submit your responses electronically, using MS Word format.

B. SCOPE OF SERVICES

Please indicate which lines of business you are submitting Proposals for and reply separately for each:

	COBRA Administration	**FSA Administration**	**HSA Administration**
Please answer Yes or No under each offering	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please complete the questions that follow:

C. COMPANY BACKGROUND

1. How long has your company been operational? Has your company been known by any other names(s) in the last ten years? Is your company a division or subsidiary of a parent firm?
2. Do you currently have an office in New Jersey?
3. Do you have an affiliation with other entities either directly or indirectly? Please explain the nature of these arrangements and, if available, prepare a chart showing the affiliations and ownership connections.
4. How many employees are currently employed at your company (at the offices that would be serving the Authority), including clerical and support staff? What was the total 12 months ago? Is your firm anticipating any expansion or reorganization in the next year? If yes, please explain.
5. Do you plan to sub-contract any portion of the services required to another firm? If yes, please answer the following:
6. Which of the services would you plan to sub-contract and to which company?
7. Would you take responsibility for the quality, timeliness and accuracy of these services?
8. Describe how your staff would interface with the staff of the sub-contractor(s).
9. Please confirm that you are licensed to do business in the State of New Jersey. In addition, as the Contract will be issued in New Jersey, please confirm that the Contract will be in full accord with the laws of that state.
10. Provide a sample Contract that you would propose for the Authority. What is the term of each Contract that would apply to this Proposal and what are its termination provisions?

11. The Authority wishes to include in the Contract the right to cancel the Contract at any time should it find administration services to be unsatisfactory. Do you agree to include this provision in your Contract?
12. Are you willing to provide performance guarantees as part of the Contract? If so, provide the performance standard you are willing to offer, the financial penalty (maximum dollar amount) you will agree to pay if the standard is not met, and the method of measuring the penalty.
13. Designate the individual(s) with the following responsibilities. Include the name, title, and address of each individual, along with a brief description of his/her qualifications and experience.

	Response
a. The individual(s) representing your company during the Proposal process	
b. The individual(s), who will be assigned to the overall ongoing management	
c. The individual(s) responsible for day-to-day service	

D. FINANCIAL PROFILE

All financial information will be held in confidence.

1. Has your company, its affiliates or any of its staff, principals or owners ever been subject to a governmental or criminal investigation involving the requested services? Please describe.
2. Please describe any type of external audits performed of your operations including but not limited to SAS-70 (SSAE 16) and the frequency of these audits. Please include a copy of your most recent SAS-70/SSAE 16 (or other external audit).
3. Is your organization subject to Payment Card Industry ("PCI") Data Security Standard ("DSS") compliance? Provide a brief description of your compliance program.
4. What fidelity and surety insurance or bond coverage do you carry to protect your clients? Specifically describe the type and amount of the fidelity bond insuring your employees that would protect the authority in the event of a loss. Please note that if you are selected as a finalist you will be required to furnish a copy of all such policies.
5. Has your firm or any client administered by your firm ever sustained a fidelity loss or claim? If yes, please provide details.

E. ORGANIZATIONAL EXPERIENCE AND REFERENCES

1. How long has your firm been administering health reimbursement accounts? Please list the number of years your company has provided the service.
2. How long has your firm been providing debit card administration?
3. Describe your company's experience administering COBRA, FSA, HSA benefit programs for Public Sector clients.
4. What percentage of your organization's total revenue is represented by the administration of FSAs or HSAs?
5. How many clients are you currently administering? How many additional are expected during the next 6 months?

6. Of your company's current clients, what three would be viewed as peer groups for the services requested by this Public Sector client? Include the following information:
    a. Client name
    b. Principal location
    c. Number of covered members
    d. Client contact including name, title, and phone number
    e. Services provided (e.g., FSA, HSA, debit cards, customer service, online transactions, etc.)
    f. Effective date of Contract
7. Has any client terminated the administration services of your firm during the past five years? If so, please provide the names along with the dates and reason for each termination. May they be contacted?
8. Describe how your company keeps its staff apprised of legislative updates. Indicate the scope of your company's technical and regulatory research ability, including staff and access to legal resources.
9. Describe how your company keeps its clients abreast of on-going changes within your industry.

F. FSA AND HSA ADMINISTRATION

1. Please describe your ability and your approach to providing the FSA and HSA administration services.
2. Can your claims system automatically use HSA monies to reimburse for deductibles and co-payments or are members required to submit a paper claim for reimbursement?
3. Will you provide seminars and other educational activities upon request from the Authority to promote these programs?
4. Please provide the Claim Turnaround Time (number of business days from receipt) and Claim Accuracy for each type of benefit: Health Care FSA and HSA, and Dependent Care FSA:

	Expected Turnaround Time	**Actual Turnaround Time**	**Percentage of all Claims Processed**
a. Paper Claims			
b. Electronic Claims			

Claim Accuracy – Total Claims for CY2020

	Number of Claims	**% Dollar Accuracy**	**% Error Frequency**
c. Valid Claims			
d. Ineligible Claims			

5. The Authority requires that the following services be provided in administering the FSA and HSA program. Please complete the following table. Indicate if your organization will perform the following services for the Authority.

Service	Will your organization perform the following services, indicate?		Explain the way in which you will provide each of these services
	Yes	No	
a. Communication to employees	☐	☐	
b. Web-based on-line tool for enrollment & inquiries	☐	☐	
c. Initial setup of employee accounts	☐	☐	
d. Processing of requests for reimbursement, including eligibility verification	☐	☐	
e. Ongoing record keeping of accounts	☐	☐	
f. Issuance of reimbursement drafts and pertinent documentation	☐	☐	
g. Employee notification of account balances near year-end	☐	☐	
h. Periodic accounting and statistical reports (include examples)	☐	☐	
i. Banking arrangement for financing the FSA programs	☐	☐	
j. Employee Statement Mailings - How frequently will you mail statements?			

If your Proposal does not include all of these services, or includes other additional services, please describe in detail. Also, please indicate the cost of each service in the Financial Section.

Describe the information that will be required from the employee to submit a valid claim for FSA benefits reimbursement, i.e., do they need a copy of the EOB from the health carrier confirming their out of pocket, etc.

6. How often would reimbursements be made to members?

	Vendor Response
a. Health care reimbursement?	*Text*
b. Dependent care reimbursement account?	*Text*
c. Can the schedule be different for different benefits?	☐ *Yes* ☐ *No*
d. Do you require an initial deposit?	☐ *Yes* ☐ *No*
e. If so, how much?	*Text*

7. Indicate how contributions, accounting, and reimbursements are handled by your system.

8. Can your system accommodate changes to an employee's election during the plan year due to:
   a. employee status changes
   b. family status changes
   c. changes in eligibility

9. How does your system check for duplicate expenses and verify plan maximums?

10. Describe your method for ensuring that benefit terminations are adequately and timely handled. How does the system track termination dates? Describe how you would handle a retroactive termination regarding claims reimbursement and enrollment.

11. What safeguards exist against an ineligible member attempting to gain reimbursement under the program?

12. Can your system flag certain recurring expenses that have already been substantiated? (i.e., will you require substantiation of a recurring eligible expense each time the expense is submitted or only the first time the expense is submitted?)

13. Does the system maintain covered dependent and beneficiary information?

14. Can your system administer multiple plan years concurrently and allow dual records during the first months of a new plan year? Can your system automatically enroll eligible employees who elect to continue to participate?

15. How are deposits to members' accounts entered to the system? On-line? From members' elections? Payroll extract?

16. How do you handle overpayments and underpayments?

17. How will forfeitures be handled for year-end accounting?

18. How are requests which exceed a member's account balance handled? Is the employee paid the balance of his account and the unpaid request amount pended for future automatic payments?

19. Will the system allow employees to submit reimbursement requests for eligible expenses incurred during the prior year, for a period of no more than 90 days after the end of the plan year?

20. Describe the way in which the banking arrangement works. Include the timing of the funds; any deposit amount required in the account; its term (weekly, monthly); how it is determined and any interest earned on the deposit or on amounts held in the account until checks are cashed.

21. What correction facilities are provided to reverse deposits, requests, payments?

22. Do you offer direct deposit of reimbursements? If yes, does an additional fee apply?

23. What type of back up procedures are in place to maintain data integrity?

24. Provide samples of communication materials to be distributed by the vendor to all members including but not limited to:

    a. Procedures for obtaining reimbursement

    b. Procedures for appealing an adverse reimbursement determination

    c. Claim forms

    d. Claim substantiation when using debit card

25. Please describe what measures you take to assure quality in service, claims paying and communications.

26. Please describe your procedures and capabilities for handling a mid-benefit year transition. How do you obtain and incorporate file accumulators for account balances, etc. from the current administrator for application to individual files? Do you accept electronic file transfers, printed explanation of benefit statements, etc.? Identify any limitations that apply.

27. Please indicate if you will agree to send the file feed for opening the account and issuing the debit card.

G. DEBIT CARDS

1. Describe your debit card services. Is a proprietary card provided or is an outside vendor used?

2. With what other companies do you Contract in order to provide debit card services (e.g. bank, credit card company, etc.). Describe the services provided by your company and those contracted to other companies, and the contractual arrangements.

3. Describe which individual account arrangements you can provide debit card services for (e.g., FSA, HRA, HSA, Dependent Care, etc.)?

4. Will you provide a private label card with Authority logo prominently displayed?

5. Are you capable of issuing different colored/designed cards for each account type (HSA, General Purpose FSA, Limited Purpose FSA, etc.)?

6. Describe how you pay claims during the 90-day grace period for FSAs.

7. Describe your procedures to correct claim errors, including what notice is provided to the Plan Sponsors and individual claimant?

8. Have you ever administered a claim that has been investigated by the IRS for lack of substantiation or other compliance concerns? If so, describe the investigation and results.

9. For each of the four requirements, describe how your program complies with IRS requirements:

    a. Employee certification requirements

    b. Limiting reimbursements to qualified vendors

    c. Review and substantiation of every claim

    d. Meaningful correction procedure

10. Describe your procedures for terminating the debit card when an employee is terminated or no longer a member in the plan.

11. How many debit cards are provided to each member; are dependents provided with a card?

12. Are members able to access their account information on a website? How frequently are transactions posted on the website? Does the website show whether the claim is pending while expenses are being substantiated?

13. Are debit cards pre-loaded with money from the member's account? Are there limits on the amount of money that is pre-loaded?

14. How often do you send statements to members? Please provide a sample statement.

15. Describe your procedures to correct claim errors, including what notice are provided to the Plan Sponsors and individual claimant.

16. Describe your procedures and policies that prevent abuse of the debit card (e.g. use by the employee to purchase items that are not qualified medical expenses).

17. Describe the fees associated with the debit cards.

18. Describe the banking arrangements necessary to implement your debit card program. Include information about when money transfers would be required and how often.

19. Is there any coordination or automatic third-party substantiation between your program and a third party payer (e.g. major medical program)? If so, please describe.

20. Must all members use the debit card or can individuals elect the debit card option?

21. Must all members use the debit card or can individuals elect to submit paper claims and not activate the debit card? What are member's options with the HRA?

H. COBRA ADMINISTRATION

1. Describe your ability to provide COBRA administration services as outlined in this RFP.

2. How do you identify or are notified of Qualifying Events?

3. What will you require from the Authority to prepare COBRA notifications?

4. Please confirm that you are able to provide the following and describe all functions that are automatically tracked and/or processed through your COBRA system:
    a. Initial COBRA Notice
    b. Election Notice/Enrollment Applications
    c. Coupon mailing/billing statement
    d. Premium collection and tracking/ACH premium deductions
    e. Multiple Qualifying Events
    f. COBRA termination letters, including early termination
    g. Send a notice of conversion privileges, if applicable
    h. Mailing of rate change letters
    i. Updating of system for new plan year's rates and provision of mailing lists to the Authority for communicating plan design changes
    j. Vendor eligibility reporting (electronic)
    k. Distribution of unavailability of COBRA coverage
    l. Monthly reporting
5. Describe how your company keeps its staff apprised of COBRA regulations. Indicate the scope of your company's technical research ability, including staff and access to legal resources.
6. Describe your procedures for the issuance of HIPAA Certificates of Creditable Coverage. Are you able to send eligibility files to the Authority's PBM administrator directly? Are you able to issue file feeds in the standard HIPAA 834 format and/or the vendor's proprietary format?

I. ENROLLMENT SERVICES

1. Do you offer employee self-service for benefits enrollment (annual open enrollment, life event changes, and new hires)?
2. Describe how your benefits enrollment system interfaces with employer payroll systems.
3. Please describe your enrollment assistance capabilities.

J. ACCOUNT MANAGEMENT AND CUSTOMER SERVICE

1. Describe how general account service would be handled. What is the location of the office that would provide day-to-day account service? Who would be responsible for daily ongoing administrative issues? How would account service be coordinated?
2. Provide a brief overview of the administration office you would propose for the Authority. How long has it been operational? What types of benefit plans does it handle? What volume of employer contributions and enrollments are handled? What is the expected daily workload per processor?
3. Provide a brief overview of the customer service office you would propose for the Authority. What is the location and hours of operation of the office that would provide day-to-day service? How long has it been operational? What types of services does it provide?

4. Indicate how many individuals, by level (e.g., application processors, supervisors, etc.), would be assigned to this account. Would staff be fully dedicated to the Authority? Do you anticipate hiring additional staff to accommodate this client if you are the Successful Proposer(s)?

5. Describe your phone system and the call routing capabilities. How do you handle incoming calls during non-business hours?

6. Indicate the ways in which your organization is able to accommodate any telephonic special needs of members.

	Check all that apply
a. No special accommodations	
b. Have a TDD (Telecommunications Device for the Deaf) or other voice capability for the hearing impaired	
c. Accommodate non-English speaking enrollees by contracting with an independent translation company	

7. Please describe your current Internet capabilities as they relate to customer service including what features are available, what information can be accessed by clients, what information can be accessed by employers, and what information can be accessed and updated (self-service) by members using the Internet. If you do not currently use the Internet for customer service functions, do you plan to do so in the future? If so, please describe your plan and the timeframe for implementing that plan.

8. Please confirm that you will be able to provide the Authority Administration with online, inquiry only access to your system to view member and employer records. Please describe what information and reports would be available to access.

9. The Authority is interested in the customer service performance of the administrative office that you would propose for the Authority. Please provide your most recent performance statistics for the following categories:

	Statistics
a. Percent of calls answered within a specified number of seconds	_____ % within _____ seconds
b. Abandoned call rate	
c. Frequency in which callers receive a busy signal	
d. Of calls requiring additional research, percentage responded to within 48 hours	

10. How is your customer service staff trained?

11. Describe the supervision function. Who would be responsible for daily ongoing administrative issues? How would account service for the Authority be coordinated? If your firm is selected, do you anticipate hiring additional staff? If so, how many and in what category?

12. Describe your quality assurance program.

13. Do you conduct customer satisfaction surveys? If yes, please provide the satisfaction percentage for the last 2 years. If not, will you be willing to conduct surveys on behalf of the Authority if you are selected?

14. Describe how you measure client satisfaction:

a. How do you measure satisfaction with your guaranteed quality and service levels?

b. Do you provide periodic reports to your clients indicating satisfaction or failure to meet quality and service levels? How do your clients monitor performance? What type of reports do you provide clients for monitoring your performance? Will you be willing to self-monitor?

15. Will a toll-free number be made available to members to handle inquiries regarding benefit/plan design, UR, disease management, eligibility, claim status, or other service issues? Please specify whether the number will be dedicated to the Authority or shared. (check only one)

a. ☐ Yes, at no extra charge
☐ Yes, at a charge of $_____ (Please include this fee in Table 1 of the Financial Section)
☐ No

16. What hours will the telephone lines be staffed by actual member service representatives? (Please do not include hours the telephone line will be staffed by an answering service. Include weekend hours, if applicable.)

a. Hours: _____

K. CONTRACT/SERVICE AGREEMENT

1. Provide a copy of the proposed Contract for review.

2. Please list any known, substantial changes in your reimbursement arrangements with providers that could or will take place within the next 12 months.

3. Will you agree to notify the Authority immediately if the network or a provider loses any accreditation, licenses, liability insurance coverage, security, or bonding?

4. Will you provide 30-day advance notice of significant changes in policies, practices, affiliations, or staffing?

5. The Authority will require mutually agreed upon provisions in your organization's Contract, which unilaterally indemnify the Authority against liability for non-fiduciary breaches, such as negligence and malfeasance. Will you agree to provide this?

6. Have you agreed to the termination provision outlined in our Proposal requirement section for the Authority and for your firm?

L. COMPUTER SYSTEM & SUPPORT

1. Please describe your FSA, HSA, COBRA benefits administration system (hardware, platform, software, programming language, etc.). Describe how you would track and capture eligibility information, benefit payments, account balances, etc. Please be specific.

2. Does your system have integrated imaging/scanning and workflow capabilities?

3. Please indicate in the table below, what components of the computer application were (a) developed in-house, (b) purchased, or (c) licensed. If software is purchased or licensed, please indicate from whom.

Function	Developed In-House	Purchased	Licensed	Year of Last Major Modifications	Name of Software Vendor
a. Enrollment					
b. FSA/HSA Administration					
c. COBRA Administration					
d. Imaging/Scanning					
e. Customer Service					
f. Workflow					
g. Other (Please Specify)					

4. For licensed software, are you authorized to modify it or must you receive permission from the licensor?

5. Do you have programmers on staff? If so, please describe the staffing of your IT department (number of staff by type).

6. Do you have a policy for dealing with the client's data should the client wish to select another service provider? If yes, explain.

7. Do you have a system and data file back-up policy? If yes, please outline. If it includes off-site storage of back-up media, please give address of such site and frequency.

8. Describe your disaster recovery program and business resumption strategy.

9. Describe how your system will interface with the Authority, specifically if the Authority contracts with your firm solely for debit card administration.

M. REPORTING CAPABILITIES

1. In addition, you will be expected to meet certain minimum reporting requirements. Reports by participating employer/local should include the following:

   a. Monthly/quarterly/annual summary report showing account transactions and other pertinent information;

   b. Monthly activity reports showing the types of transactions/disbursement processed, broken down by category;

c. Annual presentation and report to include a summary of the FSA, HSA, COBRA activity analysis.

Please confirm your ability to comply with the above reporting requirements, as well as any deviations from the requirements.

2. Describe other reports you would be prepared to provide or that you provide as part of your standard reporting package. Provide samples of these reports and detail the frequency and availability of each.

3. Would you provide ad-hoc data reports at the Authority's request? If so, please describe your ad-hoc data reporting capabilities. Would there be additional fees for these reports? If so, please provide your pricing schedule, including computer-programming time per hour.

N. HIPAA ADMINISTRATION SIMPLIFICATION PROVISIONS

1. Describe the process used by your company to comply with HIPAA EDI, Privacy, and Security requirements. Have you received external or independent certification regarding your HIPAA compliance?

2. Who is the key individual in your organization responsible for compliance with the HIPAA Administrative Simplification provisions? Please identify that individual by name and title.

3. Regarding the HIPAA/HITECH Final Rule, have you identified all subcontractors affected and will you execute Business Associate Agreements with them?

4. Is your staff trained on all Privacy and Security requirements? Describe your training program and enforcement policy.

5. Does your system produce sufficient audit trails to satisfy the HIPAA Privacy and Security regulations?

6. How is security set up in the system? What are the different levels of security?

7. Is your system's database encrypted?

8. Are data backups encrypted? Do you store backup media off-site and if so, how are they transported off site?

9. Are all electronic transmissions of PHI, including eligibility files, authorizations, reports, etc., encrypted or sent via secure means? Which encryption methods do you support for e-mails and file transmissions? Please describe.

10. What are your procedures for data destruction prior to hardware and media disposal?

O. IMPLEMENTATION AND TRANSITION ISSUES

1. Please confirm that you understand the requested scope of services and that you will be able to complete all implementation activities within 90 days of being awarded the Contract. What is the minimum amount of time recommended to ensure a clean transition of the proposed programs?

2. Please confirm that you will be able to successfully implement the FSA, HSA and COBRA programs effective no later than January 1, 2022. Describe your implementation process.

3. Are all implementation costs included in your basic fees? If no, please identify all additional charges in Tables 2 and 3 of the Fee Section.

P. PERFORMANCE STANDARDS AND GUARANTEES

1. Would you be willing to provide performance guarantees? What performance guarantees would you be willing to include in a Contract with the Authority? Provide the performance standard for each service category (e.g., timely implementation, claims coding and financial accuracy, turnaround time, reporting, etc.), the financial penalty (maximum dollar amount or percentage of administrative fees) you will agree to pay if the standard is not met, and the method of measuring the penalty:
    a. How do you measure satisfaction with your guaranteed quality and service levels?
    b. Do you provide periodic reports to your clients that can track and show actual performance and service levels? How do your clients monitor performance? What type of reports do you provide clients for monitoring your performance? Will you be willing to self-monitor and self-report?
    c. Please describe your financial penalties for failure to meet guarantees and the threshold that would trigger such penalties.

Q. PROPOSED FEES

Monthly fees should include all administration services outlined in this request for Proposal. If you are proposing fees on a bundled/flat monthly basis, which may differ from the suggested breakdown, ensure that all services are accounted for and indicate "Included" in the appropriate fee box. List in Table 3 any services that you would not provide or that are not included in your fees.

Please be advised that if your quotes are not "firm" or "final" you must clearly indicate it in your Proposal and explain exactly what information will be needed in order for the quote to become final. In providing fee estimates please keep in mind the following:

Please complete the tables that are at the end of this section. Include all assumptions used to develop the fees. In preparing the tables, please keep in mind the following:

1. If you are quoting on a per-capita basis, please use the headcounts provided and show all calculations;
2. Any set-up fees to transfer records from one system and/or manual records to your recordkeeping system should be listed separately; and
3. Any special fees or charges of any kind for services or supplies that will not be covered by your proposed per-capita fee must be disclosed in your Proposal. Please describe any services or supplies you will not cover.

4. Please confirm that:

	Confirmed	Not Confirmed	Comments
a. All fees are guaranteed for 36 months from Contract inception. Fees are guaranteed for 12 months upon renewal after the initial Contract expiration (at the Authority's option), and that all future rate adjustments will be subject to annual renewal (e.g., at least 12 months) in the absence of benefit revisions	☐	☐	
b. All future rate adjustments will be communicated at least 60 days in advance of the Effective Date	☐	☐	
c. Fees are payable at the end of the 30-day grace period	☐	☐	
d. Will you agree to Performance Guarantees with financial penalties?	☐	☐	
e. Fees should include the cost of routine printing and mailing such as, annual statements, etc.	☐	☐	
f. Guarantee a post-termination administrative fee of no more than your last month's monthly fee	☐	☐	
g. Transfer all records to the Trustees or the successor administrator within 30 days of termination in a form that is acceptable to the recipient	☐	☐	

5. Describe how you handle the banking arrangement for FSA, HSA and COBRA benefits, what type of accounts you would propose for the Authority, and your strategy for eliminating or minimizing banking fees.
6. In the event of termination, would you transfer claim information and other administrative records to any vendor who replaced you at no charge?
7. In connection with ERISA Section 408(b)(2) Disclosures, please describe all fee sharing arrangements or any other benefits that you, your affiliates, or your subcontractors have received, or reasonably expect to receive in connection with the services requested, other than direct compensation from the Authority. This description should also identify the services, for which any indirect compensation is received, the basis for the compensation, and the payer of the indirect compensation.

8. Table 1: Summary of Fees

Service	Monthly Fee		
	Year 1	**Year 2**	**Year 3**
a. Individual Account Administration 1) FSA 2) HSA 3) Debit Cards			
b. COBRA Administration			
c. Other Administration Fees: 1) Open Enrollment Support 2) Enrollment Kits 3) Communication Materials 4) 800 Number (Specify shared or dedicated) 5) Postage 6) Printing of Forms			
d. Total Monthly Fees			
e. Total Annual Fees			

9. Table 2: First Year Set Up Fees

Service	Set-Up Fees (Year 1 Only)
a. Initial Set-Up Charge	
b. Development of Communication Materials (e.g., transition announcement letters, etc.)	
c. Other (Specify)	
d. Total Set-Up Fees	

10. Table 3: Fees and Services

a. List of all services that are included in fees (Please specify all services as this list will be included in a Contract agreement should your firm be selected)
b. Any special fees, charges or expenses of any kind not included in the base administrative fees
c. List of optional services not included in fees, along with associated fees

R. CERTIFICATION LETTER FOR COBRA, FSA AND/OR HSA ADMINISTRATION

As an officer of the following corporation, I certify that all of the information included in this Proposal is true and accurate.

Signature _____

Name _____

Title _____

Date _____

Attachment 1EFG. - Acknowledgment and Statement of Exceptions Form for the Cobra, FSA or HSA Administration (Please indicate each)

Re: New Jersey Turnpike Authority

We have reviewed the Proposal specifications contained in this RFP and are in agreement with those requirements except as stated or referenced below (or on the attached sheet(s)):

Company Name	**Signature**
Date	**Title**

APPENDICES

1. **Draft Services Agreement**

2. **State Contractor Political Contribution Compliance Public Law 2005, Chapter 51 and Executive Order 117**

3. **Detail Required for Weekly/Monthly Claims Invoices – Medical**

4. **Detail Required for Weekly Claims Invoices – Dental**

5. **Detail Required for Weekly Claims Invoices - Vision**

APPENDIX 1:
DRAFT SERVICES AGREEMENT

AGREEMENT FOR _____

NOTE: DRAFT AGREEMENT IS A STANDARD AGREEMENT USED BY THE AUTHORITY. AGREEMENTS WILL BE CUSTOMIZED BASED UPON THE SPECIFIC LEVEL OF COVERAGE AND COMPENSATION AS NECESSARY.

THIS SERVICES AGREEMENT (the "Agreement") is dated and effective_____, 202_ by and between the New Jersey Turnpike Authority, a body corporate and politic of the State of New Jersey, with its principal offices located at One Turnpike Plaza, Woodbridge, New Jersey 07095 (the "Authority"); and_____, a _____ of the State of _____, having its principal offices at _____(the "Consultant").

WITNESSETH:

WHEREAS, the Authority requires the services of a professional firm with adequate staff and experience to provide_____; in accordance with a Request for Proposal, dated as of _____(collectively, with all addenda, the "RFP", attached hereto as Exhibit A); and

WHEREAS, the Consultant is a professional company which is proficient in _____and has submitted to the Authority a written Proposal, dated_____; and

WHEREAS, the Consultant was invited to make an oral presentation to the Authority on _____, following which the Consultant was further invited to submit a best and final offer ("BAFO"); and

WHEREAS, on _____, the Consultant submitted in writing a BAFO which clarified and expanded upon the statements contained in the aforesaid _____ Proposal (collectively, with the initial _____ Proposal dated_____,20__ , the "Proposal", attached hereto as Exhibit B); and

WHEREAS, the Authority evaluated the Proposal in accordance with the criteria stated in the RFP and, after comparison with other submitted Proposals was deemed to be the most advantageous to the Authority; and

WHEREAS, on _____ the Authority adopted Agenda Item _____ awarding a professional services Contract to the Consultant; and

WHEREAS, the Authority wishes to memorialize and enter into this Agreement with the Consultant setting forth the terms and conditions of the parties' rights and obligations with respect to the procurement of the services as hereinafter defined;

NOW THEREFORE, in consideration of the mutual covenants contained herein, the parties agree as follows:

1. DEFINITIONS.

"Authority" shall mean the New Jersey Turnpike Authority as established in accordance with *N.J.S.A.* 27:23-1, *et seq*., and shall be the members of the Authority acting in accordance with said statute.

"Consultant" shall mean _____, with its principal offices located at _____.

"Completion Consultant" shall mean the consultant that the Authority selects and uses, pursuant to Section 8 of the Agreement, to complete the Services upon termination of the Consultant pursuant to Section 7 hereof.

"Director" shall refer to the Authority's [department head] or his/her designee acting on his/her behalf as employees of the Authority with regard to this Agreement.

"Services" shall refer to _____in accordance with the Proposal and the RFP. The RFP and the Proposal are incorporated by reference into this Agreement and attached thereto as Exhibits A and B, respectively.

All other defined terms as used in this Agreement and not defined herein shall have the same meaning as defined and used in the RFP (Exhibit A) or the Proposal (Exhibit B), as the case may be.

2. COMPENSATION.

(a) The authorized amount of compensation to be paid to the Consultant under this Agreement shall be as attached to Exhibit C attached here to and made part of. Payments shall include all professional fees, administrative service fees and all material expenses. The Authority shall have the right to audit all payroll and direct costs or expenses of the Consultant in accordance with Section 11 of this Agreement. The Consultant shall keep available, for Authority inspection, records of all costs and expenses for a period of not less than five (5) years after the term of this Agreement.

(b) No increase in the fees or expenses set forth in Section 2(a) hereof shall take effect unless such increased fees or expenses are approved by the members of the Authority in accordance with the statutes and laws of the State of New Jersey. The Consultant acknowledges and agrees to its responsibility to maintain control of all fees and expenses, and further acknowledges and agrees that the total compensation in the amount of $_____ is a total amount not to be exceeded and is sufficient to complete the Services under the terms of this Agreement.

(c) Any payments made to the Consultant by the Authority under the terms of this Agreement shall not be deemed a waiver of the Authority's right to seek damages for remediation in the event there are any deficiencies in the Services.

(d) In the event of any conflicting claim or claims by the Consultant regarding the right to receive payments that may be due, or to become due, from the Authority under the terms of this Agreement, the Authority may withhold the amount of payments pertinent to such conflicting claim or claims, as determined by the Authority, until such dispute, or disputes, be finally resolved to the reasonable satisfaction of the Authority.

(e) With the award of the Agreement, the Consultant shall receive its payment(s) electronically and invoices should be emailed to: invoicefb@njta.com. In order to receive payments via automatic deposit from the Authority, the Consultant shall complete and return the "Authorization Agreement for Direct Payments (ACH Credits)" Form with an **original voided check or bank letter**. The Form must include the ABA number (routing or transit number), bank account number and indicate whether the bank account is a checking or savings account. The Form and instructions are located in the Instruction to Bidders on the Authority's website http://www.njta.com/doing-business/goods-and-services. The Consultant shall email the completed Form along with the required voided check or bank letter to achvendor@njta.com.

3. STANDARD OF CARE. The Director may disapprove any item of Service rendered by the Consultant if it is not in accordance with the requirements of the Agreement or the standard of care of the Consultant as set forth herein. The Consultant represents and warrants that it shall exercise that degree of care and skill ordinarily exercised under similar circumstances by members of its profession performing the kind of services hereunder and practicing in the same or similar locality at the same time. In the event of non-fulfillment of the foregoing warranty, upon written demand of the Authority, the Consultant shall perform such corrective services (within the original scope of work) as may be necessary to conform to the foregoing warranty; provided further however, it is understood that the Director shall have the right throughout the term of the Agreement to review the Consultant's work and request reasonable remedial efforts and corrections, provided that such changes or corrections are substantially consistent with the RFP and the Proposal, and are limited to ensuring that the Consultant has provided the Services in accordance with the requirements of this Agreement and this standard of care. All costs incurred by the Consultant in performing any corrective Services shall be borne by the Consultant.

4. SERVICES. The Consultant represents itself to be experienced and competent to perform the Services in accordance with the requirements of this Agreement and the Standard of Care set forth in Section 3 herein. The Consultant agrees that the Services to be performed hereunder shall be those specified in the RFP and the Proposal. Should any ambiguity or conflict exist among the Agreement, the RFP, and the Proposal in the interpretation, scope or content of any term or condition, the language in the body of each of these documents shall supersede one another and control according to the hierarchy set forth in Section 25.

5. TERM. This Agreement shall be in effect for a period of _____year(s) from the Effective Date of this Agreement. This Agreement also provides the Authority with the option for_____additional (1) year extension(s) of the Services with the concurrence of the Consultant for additional services necessary or incidental to the subject matter of this Agreement. During the term of the Agreement the Authority will have the right to procure additional services at the pricing and in conformity with the Services outlined in the Proposal.

6. PERSONNEL. The Consultant agrees that the key personnel identified in the Proposal will be those individuals that are assigned to the Services, and that the assignment of such individuals is a material term of this Agreement. The Consultant agrees to promptly notify the Authority in writing of the identity of any individuals that it desires to assign to perform the Services as a replacement for, or in addition to, the key individuals named and listed in the Proposal. All replacements shall be subject to the approval of the Authority; provided, however, that such approval will not be unreasonably withheld if any replacement possesses

qualifications and experience that are equal to, or greater than, the subject of the replacement.

7. TERMINATION. Notwithstanding any other provision in the Agreement, the Agreement may be terminated or suspended by the parties pursuant to the following terms and conditions;

(a) The Authority may terminate the Agreement as follows:

(i) Immediately upon failure by the Consultant to remedy a material breach of its obligations under the Agreement within five (5) days of the date of written notice from the Authority of such material breach;

(ii) For convenience, upon thirty (30) days prior written notice by Authority;

(iii) Immediately, if the Consultant shall become insolvent or make an assignment for the benefit of the creditors or files a voluntary petition in bankruptcy, or if any involuntary petition in bankruptcy is filed against the Consultant and the act of bankruptcy alleged is not removed or dismissed within sixty (60) days;

(iv) Immediately upon the indictment of an owner of the Consultant.

(b) The Consultant may terminate the Agreement as follows:

(i) Upon sixty (60) days prior written notice to the Authority from the Consultant upon failure by the Authority to remedy a material breach of its obligations under this Agreement within sixty (60) days of written notice from the Consultant to cure such material breach.

(c) Upon termination of the Agreement by either party and upon receipt by the Consultant of payment for all outstanding fees and charges, the files (including electronic files) pertaining to Authority matters, Authority's papers and property shall be returned promptly to the Authority upon request.

8. RIGHTS UPON TERMINATION. In the event of a termination, pursuant to Section 7 hereof, the total amount paid to the Completion Consultant exceeds the compensation stated in this Agreement, the Consultant shall pay the Authority any reasonable excess cost incurred by the Authority as a result of engaging the Completion Consultant.

9. OBLIGATION FOR TRANSITION. At such time as this Agreement is terminated, whether pursuant to Section 7 hereof or by the expiration of the term and/or extension of the term pursuant to Section 5 hereof, the Consultant will make all reasonable efforts, in cooperation with the Authority and such parties as may be selected by the Authority to perform the Services after the termination of this Agreement in order to effect a smooth transition of services. In furtherance of this commitment, the Consultant shall, for example, but without limitation, retain and timely transfer all relevant files (including electronic files) to the appropriate recipient, confer with the Authority, and with any other party at the Authority's instruction.

10. FORCE MAJEURE. Neither party shall be liable for any delays or failure in

performance due to causes beyond its control, including but not limited to, acts of any government, war, natural disasters, strikes, civil disturbances, fires, equipment failure or failures of third parties to provide (or delays in so providing) equipment, software or services. The parties shall act, to the extent reasonably possible, to minimize any such delays. In the event either party is subject to delays due to such a cause for more than sixty (60) days, either party may, at its option, terminate this Agreement for convenience upon written notice to the other, or, upon mutual agreement, extend the time for performance by the period of time equal to the time lost, whether the delay is less than sixty (60) days or not.

11. RIGHT TO AUDIT. Consultant shall:

(a) Permit during ordinary business hours for the term of this Agreement and for a period of five (5) years after final acceptance of the Services, the examination and audit by the officers, employees and representatives of the Authority of such records and books relating to the Services and also any records and books of any company which is owned or controlled by the Consultant, or which owns or controls the Consultant, if said company performs services similar to those performed by the Consultant anywhere in the State of New Jersey.

(b) If any audit pursuant to Section 11(a) requires the Authority's officers, employees and representatives to travel outside the State of New Jersey to the Consultant's principal place of business where the Consultant's records and books are maintained, then the Consultant shall bear the additional cost of the audit.

(c) The Authority shall provide reasonable prior notice to the Consultant of any anticipated audit under this Section.

12. INSURANCE. The Consultant shall procure and maintain at its own expense, for the entire term of the Agreement, insurance for liability for damages imposed by law, in accordance with Section V of the RFP.

NOTWITHSTANDING THAT MINIMUM AMOUNTS OF INSURANCE COVERAGE CARRIED OR REQUIRED TO BE CARRIED BY THE CONSULTANT ARE SPECIFIED HEREIN, THE LIABILITY OF THE CONSULTANT SHALL NOT BE LIMITED TO THE AMOUNTS SO SPECIFIED AND SHALL EXTEND TO ANY AND ALL LIABILITY IN EXCESS OF THE INSURANCE COVERAGES SO PROVIDED NOR SHALL THESE MINIMUM LIMITS PRECLUDE THE AUTHORITY FROM TAKING ANY ACTION AVAILABLE TO IT UNDER THE PROVISIONS OF THE AGREEMENT OR OTHERWISE IN LAW OR EQUITY.

13. INDEMNIFICATION. The Consultant agrees to defend, indemnify and save harmless the Authority, its officers, employees, and agents and each and every one of them against and from all liabilities, judgments, threatened, pending or completed actions, suits, demands for damages or costs of every kind and description actually and reasonably incurred (including attorneys' fees and costs and court costs) (collectively "Liabilities") including, without implied limitations, Liabilities for damage to property or Liabilities for injury or death of the officers, agents and employees of either the Consultant or the Authority), resulting from any act or omission or willful misconduct of the Consultant or any of its officers, agents, sub-consultants, or employees in any manner related to the subject matter of this Agreement. In the event that the Consultant fails to defend, indemnify and save harmless the Authority, its officers, employees, and agents and each and every one of them in accordance with this Section, any money due to the Consultant under and by virtue of this Agreement as shall be considered

necessary by the Authority may be retained by the Authority and held until any and all Liabilities shall have been settled and suitable evidence to that effect furnished to the Authority. The obligations in this Section shall survive the termination, expiration or rescission of this Agreement.

14. EEO/AFFIRMATIVE ACTION. The Consultant agrees that:

1. It does not discriminate in the hiring or promotion of any minorities, as designated by the Equal Employment Opportunity Commission of the United States of America, or the Division on Civil Rights of the New Jersey Department of Law and Public Safety; and that it does not discriminate against any person or persons on the basis of race, religion, color, national origin, nationality, ancestry, sex, marital status, domestic partnership status, familiar status and affectional or sexual orientation;

2. In the hiring of persons for the performance of work under this contract or any subcontract hereunder, or for the procurement, manufacture, assembling or furnishing of any such materials, equipment, supplies or services to be acquired under this contract, no contractor, nor any person acting on behalf of such contractor or subcontractor, shall, by reason of race, creed, color, national origin, ancestry, marital status, gender identity or expression, affectional or sexual orientation or sex, discriminate against any person who is qualified and available to perform the work to which the employment relates;

3. No contractor, subcontractor, nor any person on his behalf shall, in any manner, discriminate against or intimidate any employee engaged in the performance of work under this contract or any subcontract hereunder, or engaged in the procurement, manufacture, assembling or furnishing of any such materials, equipment, supplies or services to be acquired under such contract, on account of race, creed, color, national origin, ancestry, marital status, gender identity or expression, affectional or sexual orientation or sex;

4. There may be deducted from the amount payable to the contractor by the contracting public agency, under this contract, a penalty of $ 50.00 for each person for each calendar day during which such person is discriminated against or intimidated in violation of the provisions of the contract; and

5. This contract may be canceled or terminated by the contracting public agency, and all money due or to become due hereunder may be forfeited, for any violation of this section of the contract occurring after notice to the contractor from the contracting public agency of any prior violation of this section of the contract.

In addition, the Consultant agrees to complete the appropriate forms attached as follows:

(a) Mandatory Affirmative Action Language; and

(b) State of New Jersey Affirmative Action Employee Information Report ("Form AA-302")

However, if the Consultant maintains a current Letter of Federal Approval, or a current Certificate of Employee Information Report Approval as issued by the Department of the Treasury, State of New Jersey, it may be submitted in lieu of the Form AA-302.

15. DIVISION OF REVENUE REGISTRATION. [Pursuant to the terms of *N.J.S.A.*

52:32-44, the Consultant is required to provide to the Authority proof of valid business registration with the Division of Revenue in the Department of the Treasury, prior to entering into an agreement with the Authority. No agreement shall be entered into by the Authority unless the Consultant first provides proof of valid business registration. The Consultant is required to receive from any sub-consultant it uses for goods and services under this Agreement, proof of valid business registration with the Division of Revenue. No sub-consultant agreement shall be entered into on account of any agreement with the Authority unless the sub-consultant first provides proof of valid business registration.

16. CONFIDENTIALITY.

(a) Each party agrees that all information and materials shared under the terms of this Agreement are privileged and shall be held in strict confidence by the receiving party and shall only be used in connection with the purposes of this Agreement to conduct such other activities as are necessary and proper to carry out the purposes of this Agreement. Each party shall take all necessary and appropriate measures to ensure that any person who is granted access to any shared information or materials or who participates in work on common projects or who otherwise assists any counsel or technical consultant in connection with the performance of this Agreement complies with the terms of this Agreement. Each party shall protect from disclosure all information and materials shared by the parties and their respective counsel, or with technical consultants, to the fullest extent permitted by law.

(b) Upon the termination or expiration of this Agreement, to the extent reasonably practicable, confidential materials shall be returned to the disclosing party, including all copies thereof. Following termination, each party shall remain obligated to preserve the confidentiality of all confidential information received or disclosed pursuant to this Agreement.

(c) In the event information or materials disclosed under this Agreement are sought by a third party by way of subpoena, request pursuant to the Open Public Records Act, *N.J.S.A.* 10:4-6 *et seq*., or by any other manner, the party receiving the request will promptly notify the other party to enable it to respond to such request and each party shall take all necessary and appropriate steps to invoke any applicable privileges to prevent disclosure, and the Consultant shall have primary responsibility to defend any attempt by a third party to obtain from the Authority any information which the Consultant considers to be confidential.

17. NEWS RELEASES. No news releases pertaining to the Services shall be made without the Authority's prior approval which shall not be unreasonably withheld, conditioned or delayed.

18. NOTICES. Any notices to the Parties pursuant to the terms of this Agreement shall be in writing and addressed to:

As to [Consultant]: _____
_____
_____

As to New Jersey Turnpike Authority: [Department Head]
New Jersey Turnpike Authority
P.O. Box 5042
Woodbridge, New Jersey 07095

With a copy to:

Director of Law
New Jersey Turnpike Authority
P.O. Box 5042
Woodbridge, New Jersey 07095

19. PERSONAL LIABILITY. In carrying out the provisions of this Agreement, or in exercising any power or authority granted it by its position, the Consultant agrees that neither the members of the Authority nor any officer, agent or employee of the Authority shall be personally charged by the Consultant with any liability.

20. APPLICABLE LAWS. The Consultant shall perform the Services in compliance with all applicable Federal, state, and local laws, ordinances, rules, regulations and orders.

21. GOVERNING LAW. The terms of this Agreement shall be governed by and construed under the laws of the State of New Jersey. Any action brought by either party involving any dispute related to this Agreement shall be brought only in the Superior Court of the State of New Jersey.

22. INDEPENDENT CONSULTANT. Neither party shall be considered nor hold itself out as an agent of the other, it being acknowledged that neither party has the authority to bind the other. The Consultant shall perform the Services as an independent contractor.

23. ASSIGNMENT. This Agreement, or any part thereof, shall not be assigned by the Consultant, without the specific prior written permission of the Authority. Any attempted assignment without such prior permission shall be null and void.

24. FOREIGN CORPORATION. The Consultant agrees that, if applicable, it shall register as a "Foreign Corporation" with the Office of the Secretary of New Jersey, designating a resident agent for the service of process and shall provide written proof of such registration prior to the Authority's execution of this Agreement.

25. INTEGRATION. This Agreement, together with Exhibits A and B, constitutes the entire Agreement between the parties and supersedes all provisions, agreements, promises, representations, whether written or oral, between the parties with respect to the subject matter herein.

Should any ambiguity or conflict exist among this Agreement, Exhibit A (the RFP) and Exhibit B (the Proposal) in the interpretation, scope or content of any term or condition, the language in the body of each of these documents shall supersede one another and control according to the following hierarchy:

(a) Agreement;

(b) RFP (Exhibit A)

(c) Proposal (Exhibit B);

[Notwithstanding the foregoing, the following sections of the Proposal shall take precedence over Section _____of the RFP.]

26. PARTIES BOUND. This Agreement shall be binding upon the Consultant and the

Authority, their respective successors and assigns.

27. SEVERABILITY. If any provision of this Agreement shall be declared invalid or illegal for any reason whatsoever, then, notwithstanding such invalidity or illegality, the remaining terms and provisions of this Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision did not exist herein.

28. CODE OF ETHICS. The Consultant is advised that the Authority has promulgated a Code of Ethics pursuant to the laws of the State of New Jersey, a copy of which has been previously provided. By entering into this Agreement, the Consultant agrees to be subject to the intent and purpose of said code and to the requirements of the State Ethics Commission.

29. PROFESSIONAL SERVICES AGREEMENT. This Agreement between the parties is an Agreement for Professional Services within the meaning of the Statutes and Laws of the State of New Jersey.

30. SECTION HEADINGS. The Section headings herein contained have been inserted only as a matter of convenience or reference and in no way define, limit or describe the scope or intent of any terms or provisions of this Agreement.

31. AMENDMENT. This Agreement may be amended only by a written document signed by duly authorized representatives of each of the parties hereto.

32. WAIVER. Should either of the parties hereto fail to exercise or enforce any provision of this Agreement, or waive any right in respect thereto, such failure or waiver shall not be construed as constituting a waiver or a continuing waiver of its right to enforce any other provision or right.

33. CONSTRUCTION. Words used herein, regardless of the number and gender used, shall be deemed and construed to include any other number, singular or plural, and any other gender, masculine, feminine or neuter, as the context requires, and, as used herein, unless the context requires otherwise, the words "hereof", "herein", and "hereunder" and words of similar import shall refer to this Agreement as a whole and not to any particular provisions hereof. "Including", as used herein, means including without limitation.

[Signatures on following page]

IN WITNESS THEREOF, the Parties have caused their duly authorized representatives to execute this Agreement and to affix their respective corporate seals on the day and year first above written.

ATTEST:

NEW JERSEY TURNPIKE AUTHORITY

_____

Kim Schurman
Secretary to the Autority

By:_____
John M. Keller
Executive Director

[Corporate Seal]

Approved by the Law Department

_____

ATTEST:

NAME OF CONSULTANT

_____

[Name]
[Title]
[Corporate Seal]

By:_____
[Name]
[Title]

Services Agreement

Exhibit A

[RFP]

Services Agreement

Exhibit B

[Proposal]

Services Agreement

Exhibit C

[Compensation]

APPENDIX 2: STATE CONTRACTOR POLITICAL CONTRIBUTIONS COMPLIANCE PUBLIC LAW 2005, CHAPTER 51 AND EXECUTIVE ORDER 117

In order to safeguard the integrity of State government procurement by imposing restrictions to insulate the award of State contracts from political contributions that pose the risk of improper influence, purchase of access, or the appearance thereof, Executive Order 134 (McGreevey) was signed on September 22, 2004 and became effective October 15, 2004. EO134 was applicable to all State agencies, the principal departments of the executive branch, any division, board, bureau, office, commission within or created by a principal executive branch department, and any independent State authority, board, commission, instrumentality or agency. EO134 was superseded by P.L. 2005, c. 51, signed into law on March 22, 2005 ("Chapter 51"). In September 2008, Executive Order 117 (Corzine) was signed and became effective November 15, 2008. EO117, which applies only prospectively, extends Chapter 51's political contribution restrictions by expanding the definition of "business entity" to include, for example, more corporate shareholders and sole proprietors. EO117 and Chapter 51 contain restrictions and reporting requirements that will necessitate a thorough review of their provisions by bidders.

Pursuant to the requirements of Chapter 51 and EO117, the terms and conditions set forth in this Appendix are material terms of any Contract entered into by the Authority.

DEFINITIONS

For the purpose of this Appendix, the following shall be defined as follows:

a) "**Contribution"** – means a contribution reportable by the recipient under the New Jersey Campaign Contributions and Expenditures Reporting Act, P.L. 1973, c. 83, *N.J.S.A.* 19:44A-1 *et seq.*, and implementing regulations set forth at *N.J.A.C.* 19:25-7 and *N.J.A.C.* 19:25-10.1 *et seq.*, made on or after October 15, 2004. As of January 1, 2005, contributions in excess of $300 are reportable.

b) "**Business Entity"** – means any natural or legal person; business corporation (and any officer, person, or business entity that owns or controls 10% or more of the corporation's stock); professional services corporation (and any of its officers or shareholders); limited liability company (and any members); general partnership (and any partners); limited partnership (and any partners); in the case of a sole proprietorship: the proprietor; a business trust, association or any other legal commercial entity organized under the laws of New Jersey or any other state or foreign jurisdiction, including its principals, officers, or partners. The definition of a business entity also includes (i) all principals who own or control more than 10 percent of the profits or assets of a business entity; (ii) any subsidiaries directly or indirectly controlled by the business entity; (iii) any political organization organized under section 527 of the Internal Revenue Code that is directly or indirectly controlled by the business entity, other than a candidate committee, election fund, or political party committee; and (iv) if a business entity is a natural person, that person's spouse, civil union partner or child, residing in the same household, except for contributions by spouses, civil union partners, or resident children to a candidate for whom the contributor is eligible to vote, or to a political party committee within whose jurisdiction the contributor resides.

PROHIBITION ON THE AGREEMENTS/BREACH OF EXISTING THE AGREEMENT

As set forth in Chapter 51 and EO117, the Authority shall not enter into a the Agreement to procure from any Business Entity services or any material, supplies or equipment, or to acquire, sell or lease any land or building, where the value of the transaction exceeds $17,500, if that Business Entity has solicited or made any contribution of money, or pledge of contribution, including in-kind contributions, to a candidate committee and/or election fund of any candidate for or holder of the public office of Governor or Lieutenant Governor, or to any State, county or municipal political party committee, or legislative leadership committee during specified time periods.

Further, it shall be a breach of the terms of any Contract with the Authority for any Business Entity who has been awarded the Contract, during the term of the Contract or any extension thereof, to:

(i) make or solicit a contribution in violation of Chapter 51 or EO117;
(ii) knowingly conceal or misrepresent a contribution given or received;
(iii) make or solicit contributions through intermediaries for the purpose of concealing or misrepresenting the source of the contribution;
(iv) make or solicit any contribution on the condition or with the agreement that it will be contributed to a campaign committee or any candidate of holder of the public office of Governor or Lieutenant Governor, or to any State, county or municipal party committee, or legislative leadership committee;
(v) engage or employ a lobbyist or consultant with the intent or understanding that such lobbyist or consultant would make or solicit any contribution, which if made or solicited by the Business Entity itself, would subject that entity to the restrictions of Chapter 51 or EO117;
(vi) fund contributions made by third parties, including consultants, attorneys, family members, and employees;
(vii) engage in any exchange of contributions to circumvent the intent of Chapter 51 or EO117; or
(viii) directly or indirectly through or by any other person or means, do any act which would subject that entity to the restrictions of Chapter 51 or EO117.

CERTIFICATION AND DISCLOSURE REQUIREMENTS

Prior to the award of any Contract or agreement, the Authority shall notify any Business Entity to which it intends to award a Contract of the need to submit to the Authority a completed Certification and Disclosure of Political Contributions form, as issued by the State Treasurer. **The intended awardee will receive the applicable form from the Authority's Procurement and Materials Management Department to be completed and returned to the Authority for submission to the State Treasurer.**

In completing this form, the Business Entity must certify that no contributions prohibited by Chapter 51 or EO117 have been made by the Business Entity and must report all contributions the Business Entity made during the preceding four years to any political organization organized under 26 U.S.C. § 527 of the Internal Revenue Code that also meets the definition of a "continuing political committee" within the meaning of *N.J.S.A.* 19:44A-3(n) and *N.J.A.C.* 19:25-1.7. Failure to submit the required forms will preclude award of the Contract at issue, as well as future Contract opportunities.

Upon approval by the State Treasurer, the Authority will prepare the Services Agreement for execution. However, if the State Treasurer determines that any contribution or action by a Business Entity poses a

conflict of interest in the awarding of the Contract or agreement at issue, the State Treasurer shall disqualify the Business Entity from award of such Contract.

Once approved by the State Treasurer, a Business Entity's Political Contributions Certification is valid for a two (2) year period from the date of approval. If, prior to the award of a Contract, the State Treasurer confirms to the Authority that the intended awardee has an approved certification that will remain valid for the term of the Contract, the Authority may waive the requirement that the awardee complete an additional Certification and Disclosure of Political Contributions form.

Any Business Entity entering into a Contract with the Authority is required, on a continuing basis, to report to the Authority any contributions it makes during the term of the Contract, and any extension(s) thereof, at the time any such contribution is made. Such reports shall be subject to review by the Authority and the State Treasurer. If the State Treasurer determines that any such contribution poses a conflict of interest, such contribution shall be deemed a material breach of the Contract or agreement at issue.

APPENDIX 3:
DETAIL REQUIRED FOR WEEKLY/MONTHLY CLAIMS INVOICES – MEDICAL

There are 3 claims invoices for the Medical program. They are as follows:

1. The Weekly Medical Claims Invoice
2. The Monthly Capitation Invoice
3. The Monthly "Other Medical" Invoice

WEEKLY CLAIMS INVOICE DETAIL

The Weekly Medical Claims Invoice needs to include the following detail:

- Week Start Date
- Week End Date
- Main Group
- SubGroup
- Department Code
- Package Code
- Major Product Code
- Subscriber ID (Social Security Number)
- Subscriber Last Name
- Patient First Name
- Patient Relationship Code
- Incurred Date
- Paid Date
- Amount Paid

MONTHLY HMO CLAIMS INVOICE DETAIL

For the HMO claims, the same detail as listed but provided monthly:

- Main Group #
- Group #
- Sub Group #
- Subscriber ID # (Social Security #)
- Subscriber Last Name
- Patient First Name
- Incurred Date
- Paid Date
- Other Carrier Charges
- Amount Paid

MONTHLY CAPITATIONS INVOICE DETAIL

Capitations are the fixed price paid to providers for each contract enrolled in the particular program associated with the capitation. For each capitated product, Horizon agrees to list the following for each person where a capitated fee applies:

- Month Billed
- MAIN Group#
- SUB Group#
- Subscriber Name
- Subscriber ID (Social Security #)
- Date of Birth
- Gender

- CITY STATE ZIP
- Capitated Amount
- Federal ID of Vendor
- Vendor being paid the Capitation

This detail would be needed for any Capitation charged to the Authority on an invoice. Current capitations are paid to Primary Care Physicians, Behavioral Health vendors, and Labs. The goal is to know the amount and why it is being paid.

MONTHLY "OTHER HEALTH" CLAIM INVOICE DETAIL

Other Health Claim expenses are those that are not defined as Medical Claims or Capitation. Examples are CareCore, Out of Network Pricing, Fraud, Subrogation, GME, State Assessments, etc. In all of these situations, the following detail is requested so that the amount can be properly allocated:

- MAIN Group#
- SUB Group#
- Subscriber Name
- Subscriber ID (Social Security #)
- Dollar Amount associated with the invoice
- Reason for the amount invoiced

APPENDIX 4:
DETAIL REQUIRED FOR WEEKLY/MONTHLY CLAIM INVOICES – DENTAL

WEEKLY CLAIMS INVOICE DETAIL

The Weekly Dental Claims Invoice needs to include the following detail:

- Group Number
- Sub Group Number
- Claim Number
- Paid Date
- Subscriber Name
- Subscriber SSN
- Member Delta Dental Issued ID
- Patient Name
- Relationship to Subscriber
- Date of Service (Incurred Date)
- Paid Amount

APPENDIX 5:
DETAIL REQUIRED FOR WEEKLY/MONTHLY CLAIM INVOICES – VISION

WEEKLY CLAIMS INVOICE DETAIL

The Weekly Claims Invoice needs to include the following detail:

- "Invoice Number"
- Group Number
- Sub Group Number
- Member Last Name
- Member First Name
- Member ID (Social Security Number)
- Patient Last Name
- Patient First Name
- Relationship to Member
- Date Of Service
- Provider #
- Associate ID
- Procedure Code
- Provider Amount
- Lab Procedure Code
- Lab Amount
- Admin Amount
- Line Total
- Lens Options
- Member DOB
- Member Status
- Member ID (Davis Issued)
- Plan Design
- DOB
- Gender
- Relationship
- Date Of Service
- NPI #
- Provider Last Name
- Provider First Name
- Provider DBA Name
- Provider Address
- Provider City
- Provider State
- Provider Zip Code
- Provider Telephone #
- Claim Processed Date
- Check Number
- Pay Date
- Procedure Code
- Provider Amount
- Lab Procedure Code
- Lab Amount

- Admin Amount
- Line Total
- Dilation "Diagnosis Code
- Lens Options
- Allowable Amount
- Patient Copay
- Exam Copay
- Material Copay
- Patient Non Plan Expense
- Material Retail Charges

APPENDIX 6:
DETAIL REQUIRED FOR WEEKLY/MONTHLY CLAIM INVOICES – PHARMACY

Minimum Required Detail Needed to Support Weekly Rx Invoice

The following detail is provided for EACH claim transaction.

- Date of Invoice
- NABP#
- Dispensing Pharmacy Name
- Pharmacy Address
- Pharmacy Phone #
- Pharmacy Fed Tax ID
- Script #
- Fill Date
- NDC #
- Drug Name
- Refill Code
- Quantity
- Days Supply
- Cost Basis
- Ingredient Cost
- Dispensing Fee
- Copay Amount
- Sales Tax
- Claim Amount
- Administration Fee
- Patient Name (Last, First)
- Patient Date of Birth
- Patient Gender
- Patient Social Security #
- Patient Relationship to Subscriber
- Member ID (DOB
- Subscriber Name (Last, First)
- Prior Authorization Code/Reference
- DAW Code (Dispensed as Written)
- Compound Code
- Drug AWP
- Drug Type
- Group Code
- Sub Group Code
- Rx Plan Design
- GCN
- Therapeutic Class
- U & C AMT
- Generic Retail Identifier
- Generic Mail Order Identifier
- Single Source Retail Identifier
- Multi-Source Retail Identifier
- Single Source MO Identifier
- Multi-Source MO Identifier
- Preferred Brand Retail Identifier
- Non-Preferred Brand Retail Identifier
- Preferred Brand MO Identifier
- Non-Preferred Brand MO Identifier