NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

REQUEST FOR PROPOSALS #2014-MH-1

"MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM FOR THE EMPIRE PLAN, EXCELSIOR PLAN AND STUDENT EMPLOYEE HEALTH PLAN"

RELEASE DATE: **March 13, 2014**

PROPOSAL DUE DATE: **May 20, 2014**

IMPORTANT NOTICE: A Restricted Period under the Procurement Lobbying Law is currently in effect for this Procurement and will remain in effect until State Comptroller approval of the resultant contract. During the Restricted Period for this Procurement ALL communications must be directed, in writing, solely to the Procurement Manager as listed below and shall be in compliance with the Procurement Lobbying Law and the NYS Department of Civil Service "*Rules Governing Conduct of Competitive Procurement Process*" (refer to RFP, Section II: Procurement Protocol and Process).

Department of Civil Service Contact for Inquiries and Submissions for this Solicitation:

Procurement Manager
Employee Benefits Division, Room 1106
New York State Department of Civil Service
Albany, New York 12239
(518) 402-2096

E-mail: MHSA2014RFP@cs.state.ny.us

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Jerry Boone
Commissioner
New York State Department of Civil Service

Robert W. DuBois
Director
New York State Department of Civil Service
Employee Benefits Division

SECTION I: INTRODUCTION

A. Purpose

The purpose of this Request for Proposals (RFP or Procurement), entitled "Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan" is to secure the services of a qualified Offeror to administer The Empire Plan, Excelsior Plan and Student Employee Health Plan Mental Health and Substance Abuse Program (MHSA Program).

(1) It is the Department of Civil Service's (Department) intent to enter into a contract (Agreement) with one (1) Offeror selected as a result of this RFP. The Agreement will be for a term of five (5) years with one optional extension period of up to eleven (11) months at the sole discretion of the Department, commencing on the first Day of the month following a minimum 90-Day implementation period after the Office of the State Comptroller approves the Agreement, during which the selected Offeror shall be responsible for administering the MHSA Program in accordance with the terms and conditions of the Agreement.

The Offeror must agree to be bound by its Proposal which will be explicitly incorporated by reference into the executed Agreement. The Department will only contract with a single Offeror, which will be the sole contact with regard to all provisions of the Agreement. If the Offeror's Proposal includes Key Subcontractors or Affiliates, the Offeror will be considered the Prime Contractor, and the Offeror shall assume full responsibility for the fulfillment of all of the Contractor responsibilities under the Agreement. This RFP and other relevant information may be reviewed at: www.cs.ny.gov/MHSA2014RFP/index.cfm

Note: Refer to Section VIII: Glossary of Terms, for definitions of terms used throughout this RFP.

B. Overview of the New York State Health Insurance Program

The New York State Health Insurance Program (NYSHIP) was established by the New York State Legislature in 1957 to provide essential health insurance protection to New York State (NYS) Employees, Retirees, and their eligible Dependents. Chapter 56 of the Laws of 2010 amended the law to allow the New York State Employee Health Insurance Plan the option to be self-funded. Specifically, the law states that the President of the Civil Service Commission "may provide health benefits directly to plan participants, in which case the president is hereby authorized to purchase a contract or contracts with one or more firms qualified to administer, on New York State health benefit plan's behalf, the plan of benefits." Public authorities, public benefit corporations, and other quasi-public entities, such as the NYS Thruway Authority and the Dormitory Authority may choose to participate in NYSHIP; those that do are called Participating Employers (PEs). Article XI of the NYS Civil Service Law also allows local units of government such as school districts, special districts, and municipal corporations to participate in NYSHIP; those local government units which choose to participate in NYSHIP are called Participating Agencies (PAs). At present, there are approximately 453 NYS agencies, 93 PEs, and 798 PAs in NYSHIP. Under Article XI of the Civil Service Law, as amended, and 4 New York Code of Rules and Regulations (NYCRR) Part 73, as amended, the President of the New York State Civil Service Commission, who also serves as the Commissioner of the Department, through the Department's Employee Benefits Division (EBD), is responsible for the ongoing administration of NYSHIP.

NYSHIP currently covers over 589,635 NYS, PA and PE Employees and retirees. Eligible covered Dependents bring the total number of covered lives to approximately 1,222,500.

NYSHIP currently provides health benefits coverage through The Empire Plan, a Participating Provider Organization (PPO) with managed care components, and 10 Health Maintenance Organizations (HMOs). The Excelsior Plan is a lower cost version of The Empire Plan available to PAs. Additionally, the Student Employee Health Plan (SEHP) is administered through The Empire Plan contracts. SEHP is a health benefits plan for graduate student Employees of the New York State and New York City University systems. NYS and PE employees and retirees may elect to enroll in either The Empire Plan or in HMOs offered

through NYSHIP. NYSHIP offers only The Empire Plan and the Excelsior Plan to PAs. PAs may, and frequently do, offer HMOs directly to their own Employees and retirees as an alternative to Empire Plan coverage.

C. Overview of The Empire Plan, Excelsior Plan and Student Employee Health Plan

The Empire Plan, Excelsior Plan, and SEHP (collectively referred to as the Program) are comprehensive health benefit programs for New York's public Employees and their families. The Program is sponsored by the Council on Employee Health Insurance (CEHI). The Council is composed of the President of the Civil Service Commission, the Director of the Governor's Office of Employee Relations (GOER), and the Director of the Division of the Budget (DOB). The Department holds the contracts with the Program carriers/third party administrators. All components of the Program are self-funded.

This RFP seeks to secure the services of a qualified Offeror under a self-funded Administrative Services Only (ASO) arrangement for the MHSA Program. The Employee Benefits Division (EBD) within the Department is responsible for the administration of the Program. The Empire Plan currently has over 528,000 Enrollees with approximately 1,096,000 covered lives. The Empire Plan benefit design has four (4) main parts including:

1. Hospital Program benefits that include coverage for hospital inpatient stays and Emergency Care that are primarily medical as opposed to psychiatric or substance abuse issues, as well as outpatient services. This program is currently administered by Empire BlueCross BlueShield;

2. Medical Program benefits that include coverage for medical and surgical services under the Participating Provider and the Basic Medical Programs and includes several specialty programs. This program is currently administered by UnitedHealthcare Insurance Company (UHC) of New York;

3. Prescription Drug Program benefits that include coverage for prescription drugs dispensed through retail network pharmacies, and through the Mail Service Pharmacy

Process, through the Specialty Pharmacy Program, and through non-network pharmacies. This program is currently administered by CVS/Caremark [CVS Caremark]; and

4. Mental Health and Substance Abuse Program benefits that include coverage for network services through participating provider and non-network services. This program is currently administered by ValueOptions, Inc. [ValueOptions].

The benefit design of The Empire Plan is the result of collective bargaining between NYS and the various unions representing its Employees. Benefits are administratively extended to non-represented NYS Employees, Employees of PAs and PEs, and retirees. Therefore, the benefit design is subject to change from time to time as the result of those negotiations, and there are variations in The Empire Plan's benefit design among the bargaining units. The benefit design cannot deviate from that which has been collectively bargained. The majority of the active workforce is represented by various unions, and union participation in the design and oversight of NYSHIP is active and ongoing. The Excelsior Plan, available to NYS local governments who participate with NYSHIP, is a more affordable version of The Empire Plan. It offers many of the same features and benefits of The Empire Plan, with a higher degree of Cost Sharing by covered individuals. The collective bargaining units and the unions representing the collective bargaining units are identified in Exhibit II.A2 as well as the other groups that participate in the Program.

The Empire Plan also affords benefits to members of the SEHP through the various Empire Plan contracts with the Administrators. The SEHP was established in 1994 through collective bargaining. The SEHP became part of NYSHIP in 2002 to provide basic health insurance protection to graduate student Employees of the State University of New York and their eligible Dependents. This benefit was extended to the graduate student Employees of the City University of New York (CUNY) on January 1, 2009. Like The Empire Plan, the SEHP includes hospital, medical, managed mental health and substance abuse benefits, and prescription drug benefits. In 2013, the SEHP had a combined hospital, medical, managed mental health and substance abuse, and prescription drug benefit annual limit of $2,000,000. No annual combined SEHP benefit limit is permitted for plan years beginning January 1,

2014. SEHP covers an average of 5,600 Employees; their eligible covered Dependents bring the total number of average covered lives to approximately 6,900.

As required under the Mental Health Parity and Addiction Equity Act (MHPAEA), effective January 1, 2012, annual Deductibles and out-of-pocket Coinsurance Maximums are shared between the Program's medical, hospital and mental health and substance abuse (MHSA) carriers/third party administrators. The annual shared Deductible and out-of-pocket Coinsurance Maximums vary by group. See **Exhibit II.B** for a summary of shared accumulators by group. Currently, the Program's medical carrier/third party administrator oversees administration of the shared accumulators through daily claims processing files. See **Exhibit II.F5** for the file layout of the shared accumulator claims files.

Also required under MHPAEA, the Program completed a review of the quantitative and non-quantitative treatment limits. See **Exhibit II.L** for a summary of non-quantitative treatment limitations under the Empire Plan Medical Program. As currently designed, the Program is compliant with the MHPAEA interim regulations with regard to Cost Sharing, Pre-Certification requirements, concurrent review and utilization review for inpatient and outpatient services; we anticipate that some modifications will need to be made on January 1, 2015 as a result of the recently issued final regulations. The Program's MHSA and medical carrier/third party administrators interact on a regular basis to ensure that the Program remains parity compliant.

Effective January 1, 2013, the MHSA Program was required to comply with the NYS Autism mandate (Chapters 595 and 596 of the Laws of 2011) to provide coverage for the screening, diagnosis, and treatment of Autism Spectrum Disorder (ASD). This coverage includes assessments, evaluations or tests to diagnose ASD, medications, psychiatric and psychological care, and therapeutic care, including services provided by licensed speech therapists, occupational therapists, social workers and physical therapists. The Program's medical and MHSA carriers/third party administrators currently cover the vast majority of mandated benefits with the exception of Applied Behavioral Analysis (ABA). Effective January 1, 2014, the MHSA Program applies an annual maximum of 680 hours per individual for ABA services allowed by Chapter 56 of the Laws of 2013.

Effective January 1, 2014, the MHSA Program was required to comply with the Provider Non-Discrimination provisions of the Affordable Care Act (citation). The MHSA Program currently provides non-network coverage to MHSA providers acting within the scope of their license.

D. Overview of the Mental Health and Substance Abuse Program

Program coverage for mental health and substance abuse services has been part of the Empire Plan since its inception in 1986. In 1992, the Empire Plan was redesigned to provide coverage for MHSA services separate from hospital and medical benefits and, since that time, the MHSA benefit has been insured and administered as a separate program within the Empire Plan which provides both Network and out-of-network benefits.

A primary component of the Network benefit is a stable and adequate panel of quality behavioral health providers. The MHSA Program network is currently composed of a mix of licensed psychiatrists, psychologists, licensed and registered clinical social workers, psychiatric nurses and nurse practitioners, Certified Structured Outpatient Rehabilitation Programs, residential treatment centers, group homes, Partial Hospitalization Programs, hospitals, group practices and licensed Certified Behavioral Analysts (CBA). To assure there is the opportunity to supplement clinical care with community programs, the Network also includes alternative treatment programs such as half-way houses and treatment programs for dually diagnosed individuals and programs certified by the NYS Office of Alcoholism and Substance Abuse Services. For the Agreement that results from this RFP, the Offeror may include in the Network Provider-types who are licensed at the highest level in their State and who are providing Covered Services within their licensure. For NYS, this includes LCSW-R and LCSW who qualify for the R-designation.

Since the MHSA Program guarantees access to the Network level of benefit, if an appropriate Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, the Contractor must make a Single Case Agreement with a Non-Network Provider for services at the Network level of benefits.

Recognizing the importance of providing individualized, appropriate treatment in the least restrictive option possible, the MHSA Program utilizes a Clinical Referral Line and care management. The Clinical Referral Line is staffed by licensed clinicians experienced in the assessment and treatment of mental health and substance use disorders, and is maintained by the Contractor as a Program-dedicated telephone line available twenty four hours a day, seven days a week from anywhere in the United States. Callers can reach the Clinical Referral Line through the NYSHIP toll-free number. The Clinical Referral Line gives callers a thorough clinical assessment which, in turn, helps the Contractor identify the most appropriate treatment setting and provider for referral. Once a referral is received, the caller is guaranteed that the provider is a Network Provider.

Clinical Management assesses the medical necessity of the proposed care so as to best meet the treatment needs of the Enrollee and evaluate whether appropriate care is rendered at the least restrictive level. Clinical Management is especially important where the case is complex and continuing review is necessary to determine if treatment goals are being met. Clinical Managers coordinate care with the Enrollee's family, primary care provider, treating facility, and provider to follow the Enrollee through their treatment plan.

For inpatient services other than emergencies, including alternate levels of care such as halfway houses and residential treatment centers, Network care should be pre-certified to ensure the highest level of benefits. If the Enrollee is referred to inpatient treatment from the Clinical Referral Line, the Network Provider is responsible for contacting the Contractor to begin the pre-certification process. During this process, Clinical Managers apply the Contractor's clinical and medical necessity criteria as well as utilization management techniques. Thereafter, the Clinical Manager discusses the proposed treatment with staff at the facility which includes either the facility attending provider or an internal utilization review nurse. The Clinical Manager determines medical necessity by reviewing the symptoms, diagnosis, history, treatment goals, and planned interventions against the Contractor's clinical criteria.

If the Clinical Manager cannot determine the medical necessity of an inpatient admission, the case is automatically reviewed by the Contractor's Peer Reviewers. Peer Reviewers must be either psychiatrists or Ph.D. psychologists, with a minimum of five years of clinical experience. Clinical Management also includes concurrent inpatient reviews that occur with variable frequency depending on the level of care and the complexity of the case. Clinical Managers closely monitor the Enrollee's transition from inpatient to outpatient care with appropriate discharge planning to make certain that appointments are kept and the Enrollee is compliant with medications.

The following services are covered under the MHSA Program, subject to applicable Cost Sharing:

1. Outpatient Care
    a. Emergency Care at a hospital for treatment of MHSA when there is no inpatient admission following the care;
    b. Office Visits;
    c. Psychiatric Second Opinion;
    d. Substance Abuse-Structured Outpatient Rehabilitation Program;
    e. Twenty (20) Family Sessions per year when Enrollee is in a Structured Outpatient Substance Abuse Rehabilitation Program and, if the Enrollee is not in active treatment and the family member is covered under the same Empire Plan enrollment, twenty Family Sessions per year;
    f. Psychological Testing and Evaluations with prior approval from the Contractor;
    g. Medically Necessary Ambulance Services for MHSA care;
    h. Electro-Convulsive Therapy with prior approval from the Contractor;
    i. Crisis Intervention (Copays waived for up to three (3) visits per crisis);
    j. Home-Based Counseling;
    k. Registered Nurse Practitioners;
    l. Telephone Counseling;
    m. Applied Behavioral Analysis for the treatment of Autism, subject to a 680 hour annual cap, effective January 1, 2014; and
    n. Medication Management

2. Inpatient and Alternate Levels of Care
    a. Hospital Services;
    b. Residential Treatment Facilities; Halfway Houses and Group Homes. Limited coverage only for SEHP);
    c. Partial Hospitalization and other Hospital-Based Alternate Levels of Care such as Intensive Outpatient; Day Treatment 23 Hour Extended Bed and 72 Hour Crisis Bed;
    d. Psychiatric Treatment or Consultation while you are a MHSA Inpatient;
    e. Psychiatric Consultations on a Medical Unit; and
    f. Prescription Drugs when dispensed by an Approved Facility, residential or day treatment program.

Exhibit II.B2 of this RFP provides the applicable Copayments by plan and Employee group. Also, for informational purposes, the Department's current Empire Plan Certificate of Insurance, SEHP Summary Plan Description and the NYSHIP Benefit Plan Comparison are included as **Exhibits II.C, II.C2 and II.D** of this RFP.

The MHSA Program does not have an Employee Assistance Program (EAP) component. There is a Statewide EAP for New York State Employees staffed by NYS Employees who participate as volunteers; however, EAPs do not have a formal role in the MHSA Program. They are not permitted to make referrals, nor can the Contractor accept clinical information from the EAP unless the Enrollee is included in the conversation (i.e., either physically present or on a conference call). Some EAP volunteers have professional degrees in mental health fields, some are certified EAP counselors, and others have various levels of training. EAP volunteers have been provided the opportunity to receive training regarding the MHSA Program and are encouraged to assist Employees in accessing MHSA services through the MHSA Program. Participating Employers and Participating Agencies may have no EAP, some have internal EAPs, and others have contracted, professional EAPs.

Finally, Enrollees use the Empire Plan identification card, the Excelsior identification card and the SEHP identification card to access MHSA Network services. The Offeror is not responsible for the production and distribution of identification cards, nor will a MHSA Program-specific identification card be accepted as part of the MHSA Program benefit design.

SECTION II: PROCUREMENT PROTOCOL AND PROCESS

A. Rules Governing Conduct of Competitive Procurement Process

1. Timeline/Key Events

RFP Release Date	March 13, 2014
Exhibit I.K Procurement Lobbying Offeror's Affirmation of Understanding & Agreement Due Date	See below*
Request for Data Necessary to Submit a Proposal Suggested Date (See Section III.G of this RFP)	March 28, 2014
Pre-Proposal Conference	April 2, 2014
Questions Due Date	April 9, 2014, 5:00pm ET
Release Date of Official Responses to Questions	April 16, 2014
Exhibit I.J Notice of Bidding Intention Due Date	May 19, 2014
Proposals Due Date	May 20, 2014, 3:00pm ET
Anticipated Contract Start Date	Upon OSC Approval of the Agreement

***** Prior to the Offeror's initial contact with the Department, the Offeror must complete and submit **Exhibit I.K** Procurement Lobbying Offeror's Affirmation of Understanding & Agreement to the MHSA Program Procurement Manager**.**

2. Procurement Lobbying Limitations

a. Pursuant to State Finance Law sections 139-j and 139-k, this Procurement imposes certain procurement lobbying limitations. Offerors are restricted from making contacts during the Procurement's "Restricted Period" (from the issuance of the RFP until the date of the Contract's final approval by the OSC) to other than designated staff of the Department and the Executive Branch of New York State government, unless the contact falls within certain statutory exceptions ("permissible contacts"). For purposes of this Section II.A.2 of the RFP, "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids (i.e., Proposals) in response to the RFP. Staff is required to obtain certain information from Offerors and others whenever there is a contact about the Procurement during the Restricted Period, and is required to make a determination of the Offeror's responsibility that addresses the Offeror's compliance with the statutes' requirements. Findings of non-responsibility result in rejection for contract award, and if an Offeror is subject to two non-responsibility findings within four years the Offeror also will be determined ineligible to submit a

proposal on, or be awarded a contract for four years from the date of the second non-responsibility finding. The Procuring Agencies' Policy and associated procedures are included as **Exhibit I.L, "Procurement Lobbying Policy: Restrictions on Contacts During the Procurement Process"** to this RFP. Further information about these requirements can be found at:
http://www.ogs.ny.gov/aboutOGS/regulations/defaultAdvisoryCouncil.html

b. In order to ensure public confidence and integrity in the procurement process, the Department will strictly control all communications between any Offeror and participants in the evaluation process, from the date the RFP is released until the Contract is approved by OSC. "Offeror" means any individual or entity, or any employee, agent, consultant, or person acting on behalf of such individual or entity, who contacts the Department or any other State governmental entity about a governmental procurement during that procurement's restricted period, whether or not the caller has a financial interest in the outcome of the governmental procurement; provided, however, that a governmental agency (or its employees) that communicates with the Department regarding a governmental procurement in the exercise of its oversight duties shall not be considered an Offeror. "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids in response to the solicitation document. All contacts, inquiries, questions, filings and submissions of Proposals in regard to the RFP must be directed, in writing, by mail, facsimile or e-mail, as applicable, solely to the MHSA Program Procurement Manager. An Offeror's failure to comply with this requirement may result in the Offeror's disqualification from this Procurement.

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager
Employee Benefits Division, Room 1106
NYS Department of Civil Service
Albany, New York 12239

For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager
NYS Department of Civil Service
Employee Benefits Division
Agency Building 1
Empire State Plaza
Albany NY 12239
Fax: 518-402-2835
E-mail: MHSA2014RFP@cs.state.ny.us

Additionally, prospective Offerors and Offerors are strictly prohibited from making any contacts or inquiries concerning the Procurement with any member, officer or employee of any NYS governmental entity other than the Department from the date the RFP is released until the Contract is approved by OSC subject only to the specific exceptions listed below. Further, any Offeror shall not attempt to influence the Procurement in any manner that would result in a violation or an attempted violation of Public Officers Law sections 73(5) or 74.

c. The following contacts are exempted from the provisions of paragraph 3 of section 139-j and as such do not need to be directed to the MHSA Program Procurement Manager pursuant to section 139-k:

(1) the submission of written Proposals in response to the RFP;

(2) the submission of written questions by a method set forth in RFP when all written questions and responses are to be distributed to all Offerors who have expressed an interest in the Procurement;

(3) participation in a demonstration, conference or other means for exchange of information in a setting open to all potential bidders provided for in RFP;

(4) complaints by an Offeror regarding the failure of the MHSA Program Procurement Manager to respond to an Offeror's authorized contacts, when such complaints are made in writing to the Department's Office of the General Counsel, provided that any such written complaints shall become a part of the procurement record;

(5) communications by a successful Offeror(s) who has been tentatively awarded a contract and is engaged in communications with the Department solely for the purpose of negotiating the terms of the Contract after having been notified of tentative award;

(6) contact by an Offeror to request the review of a procurement award when done in accordance with the procedure specified in the solicitation document;

a. contacts by an Offeror in protests, appeals or other review proceedings (including the apparent successful Offeror and its representatives) before the Department seeking a final administrative determination, or in a subsequent judicial proceeding; or

b. complaints of alleged improper conduct in the Procurement when such complaints are made to the NYS Attorney General, Inspector General, District Attorney, or to a court of competent jurisdiction; or

c. written protests, appeals or complaints to the NYS Comptroller's office during the process of contract approval, where the NYS Comptroller's approval is required provided that the NYS Comptroller shall make a record of such communications and any response thereto which shall be entered into the procurement record pursuant to State Finance Law Section 163; or

d. complaints of alleged improper conduct in a governmental procurement conducted by a municipal agency or local legislative body to the NYS Comptroller's office; and

(7) communications between Offerors and governmental entities that solely address the determination of responsibility by a governmental entity of an Offeror.

d. It is ***mandatory*** that all prospective Offerors/Offerors complete Part 1 of **Exhibit I.K**, **"Procurement Lobbying Offeror's Affirmation of Understanding and Agreement"** affirming their understanding of, and agreement to, comply with the procurement lobbying requirements set forth in State Finance Law §139-k and §139-j. A completed **Exhibit I.K** must be submitted to the MHSA Program Procurement

Manager **prior to a prospective Offeror making its initial contact with the Department** (e.g., attendance at the Pre-Proposal Conference, submission of a Notice of Bidding Intention Form (**Exhibit I.J),** submission of questions, etc. or concurrent with an Offeror's submission of its Proposal, whichever shall occur first). Offerors are advised that whenever any of the Offeror's officers, employees, agents or consultants contacts the Department, they should be prepared to provide their name, address, telephone number, place of principal employment, occupation, and whether they were retained, employed or designated, by or on behalf of the Offeror to appear before or contact the Department in regards to this Procurement. To that end and to streamline the process, Offerors are requested to complete and submit Part 2 of **Exhibit I.K** entitled, "Designated Offeror Contact" for each officer, employee, agent or consultant authorized by the Offeror to appear before or contact the Department in regards to this Procurement before appearing or before or at the time such contact is initiated.

Additionally, at the time a Proposal is submitted to the Department, the Offeror is required to provide a completed "Offeror's Certification of Compliance Pursuant to State Finance Law §139-k" form. This certification is included as **Exhibit I.P** of this RFP.

3. Notice of Bidding Intention Form

Filing of this notice is **not** mandatory; however, to assist the Department in better managing the procurement process, prospective Offerors, whether they intend to submit a Proposal in response to this RFP or not, are requested to complete a **"Notice of Bidding Intention Form"** (**Exhibit I.J**) and submit it to the MHSA Program Procurement Manager by the Notice of Bidding Intention Deadline as set forth in Section II.A.1. The completed form may be submitted either in hardcopy, at the address provided in Section II.A.2.b. or electronically at: MHSA2014@cs.state.ny.us

On the Notice of Bidding Intention Form, New York State certified Minority and Women-Owned Businesses (M/WBE) may request that their firm's contact information be included on a list of M/WBE firms interested in serving as a subcontractor for this Procurement. The listing will be publicly posted on the Procurement webpage at: www.cs.ny.gov/MHSA2014RFP/index.cfm for reference by the bidding community. A

firm requesting inclusion on this list should send a copy of its NYS M/WBE certification with its completed Notice of Bidding Intention Form. Nothing prohibits an M/WBE vendor from proposing as a prime contractor.

4. Pre-Proposal Conference

A Pre-Proposal Conference will be held on April 2, 2014 at 10:00 a.m. in the Office of General Services Meeting Room 125 - Southeast Concourse Level of the Empire State Plaza, Albany, NY. Attendance is not mandatory, but is strongly encouraged for Offerors intending to submit a Proposal.

Each Offeror is requested to send no more than three (3) representatives to the Pre-Proposal Conference. If your organization plans to attend the Pre-Proposal Conference, please notify the MHSA Program Procurement Manager via facsimile or e-mail at the address noted in Section II.A.2.b. at least five (5) business days before the conference with the name and affiliation of each person attending. Information regarding directions to the Empire State Plaza, available parking and security requirements, may be found at: http://ogs.ny.gov/ESP/CT/plaza.asp. On the date of the conference, visitors may be required to present photo identification. Prospective Offerors are advised to allow sufficient time to go through security.

5. Submission of Errors or Omissions in the RFP Document

By participating in activities related to this Procurement, and/or by submitting a Proposal in response to this RFP, prospective Offerors agree to be bound by its terms, including, but not limited to, this process by which a prospective Offeror may submit errors or omissions for consideration. In the event that a prospective Offeror believes there is an error or omission in the RFP, the prospective Offeror may raise such issue according to the following provisions:

a. Process for Submitting Assertions of Errors or Omissions in RFP Document

(1) ***Time Frame***: Assertions of errors or omissions in the procurement process which are or should have been apparent prior to the Proposal Due Date must be received by the Department, in writing, five (5) business days after the Release Date of Official Responses to Questions specified in Section II.A.1.

(2) ***Content***: The submission alleging the error or omission must clearly and fully state the legal and/or factual grounds for the assertion and must include all relevant documentation.

(3) ***Format of Submission***: All submissions asserting an error or omission must be in writing and submitted to the MHSA Program Procurement Manager at the following address:

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager
Employee Benefits Division, Room 1106
NYS Department of Civil Service
Albany, New York 12239

For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager
NYS Department of Civil Service
Employee Benefits Division
Agency Building 1
Empire State Plaza
Albany NY 12239

The envelope or package must clearly and prominently display the following statement:

"Submission of Errors or Omissions for the
Mental Health and Substance Abuse Program for the
Empire Plan, Excelsior Plan and Student Employee Health Plan
Request for Proposals # 2014MH-1"

Any assertion of an error or omission which does not conform to the requirements set forth in this section shall be deemed waived by the prospective Offeror and the prospective Offeror shall have no further recourse.

b. The Review Process for Assertions of Errors or Omissions in RFP Document

The Department shall conduct the review process for submission of errors or omissions. The Commissioner may appoint a designee who will review the submission and make a recommendation to the Commissioner as to the disposition of the matter. The Commissioner's designee may be an employee of the Department but, in any event, shall be someone who has not participated in the preparation of this RFP, the evaluation of Proposals, or the selection decision. At the discretion of the Commissioner, or the Commissioner's designee, the prospective Offeror may be given the opportunity to meet with the Commissioner or the Commissioner's designee, as the case may be, to support its submission. The prospective Offeror may, but need not, be represented by counsel at such a meeting. Any and all issues concerning the manner in which the review process is conducted shall be determined solely by the Commissioner or the Commissioner's designee.

The Commissioner, or the Commissioner's designee, shall review the matter, and the Commissioner shall issue a written decision within twenty (20) business days after the close of the review process. If additional time for the issuance of the decision is necessary, the prospective Offeror shall be advised of the delay and of the time frame within which a decision may be reasonably expected. The Commissioner's decision will be communicated to the party in writing and shall constitute the agency's final determination in the matter.

The Department reserves the right to determine and to act in the best interests of the State in resolving any assertion of error or omission in the RFP document. As a consequence of reviewing the assertion, the Department may elect to extend the Proposal Due Date as may be appropriate. Notice of any such extension will be provided to all organizations who registered via mail, facsimile or e-mail. Notice of any extension will also be posted to: www.cs.ny.gov/MHSA2014RFP/index.cfm

6. Submission of Questions

In the event a prospective Offeror has any substantive or procedural questions concerning the content of the RFP document, those questions can be submitted in the following manner to:

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager
Employee Benefits Division, Room 1106
NYS Department of Civil Service
Albany, New York 12239

For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager
NYS Department of Civil Service
Employee Benefits Division
Agency Building 1
Empire State Plaza
Albany NY 12239
Fax: 518-402-2835
E-Mail: MHSA2014RFP@cs.state.ny.us

Prospective Offerors may submit questions to the MHSA Program Procurement Manager, in writing, via e-mail, facsimile or mail. The Department strongly urges prospective Offerors to submit the questions via e-mail. Each question should cite the particular RFP section, page number and paragraph number to which it refers. All responses will be considered unofficial until issued or confirmed in writing by the Department on the procurement website. Only those questions due prior to 5:00 p.m. Eastern Time (ET), on the Questions Due Date as shown in Section II.A.1. of this RFP, will be accepted.

To expedite its responses, the Department has provided a question template form which prospective Offerors are requested to use in submitting questions regarding the RFP (see RFP, [**Exhibit I.R**] "Question Template").

After the Questions Due Date, the Department will provide to all organizations who have registered, e-mail notification of the posting of all questions received and the Department's Official Responses to said questions. The aforementioned information will be posted to: www.cs.ny.gov/MHSA2014RFP/index.cfm and all registered potential Offerors will be notified of the posting to this site.

7. Submission of Proposal

a. Submission Requirements

The Offeror's Proposal must be organized and separated into three (3) separate parts: Administrative Proposal, Technical Proposal, and Cost Proposal. To facilitate the evaluation process, Offerors must submit fourteen (14) separately bound hard copies (two (2) ORIGINALS and twelve (12) copies) and one (1) electronic copy (CD) **of each of the three (3) parts** of the Offeror's Proposal. Electronic submissions must be in Adobe Acrobat, as applicable. These forty-two (42) documents and three (3) CDs are collectively hereafter referred to as "Submissions."

Each ORIGINAL hard copy of each part must be marked "ORIGINAL," contain original signatures of an official(s) authorization to bind the Offeror to its provisions on all forms submitted that require the Offeror's signature and should be numbered sequentially, i.e. Original #1, Original #2. The remaining twelve (12) hard copies of each part may contain a copy of the official's signature and should be numbered sequentially (e.g. Copy #1, Copy #2, etc). Please note that for each of the three (3) parts, hard copies of each marked "Original #1" will be deemed controlling by the Department when viewing the Proposal.

Proposals should be placed and packaged together, by part, in sealed boxes/envelopes. Each sealed box/envelope should contain a label on the outside of the container which contains the information below.

New York State Department of Civil Service
Request for Proposals # 2014MH-1
"Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan"

OFFEROR NAME
OFFEROR ADDRESS

Indicate content, as applicable
ADMNISTRATIVE, TECHNICAL or COST PROPOSAL
There must be no cost information included in the Offeror's Administrative Proposal or Technical Proposal.

All Proposals must be sent to the following:

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager
Employee Benefits Division, Room 1106
NYS Department of Civil Service
Albany, New York 12239

For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager
NYS Department of Civil Service
Employee Benefits Division
Agency Building 1
Empire State Plaza
Albany NY 12239

For those Offerors who plan to have the Proposal hand delivered, arrangements for acceptance of the packages must be made in accordance with procurement security procedures. **To make such arrangements, the Department requests that the Offeror notify the MHSA Program Procurement Manager forty-eight (48) hours prior to delivery. All Proposals must be received by 3:00 p.m. ET on the Proposal Due Date as set forth in Section II.A.1 of the RFP.** ***No exceptions will be made for late submission or delays in delivery of the Proposal***. If the Proposal is delivered by mail or courier, the Department recommends that it be sent "return receipt requested," so the Offeror obtains proof of timely delivery.

All Proposals submitted become the property of the Department. Any proposal received after 3:00 p.m. ET on the Proposal Due Date will not be accepted by the Department and may be returned to the submitting entity at the Department's discretion.

The Department will accept amendments and/or additions to an Offeror's Proposal if the amendment and/or addition is received by the Department **prior** to 3:00 p.m. ET on the Proposal Due Date. All amendments to an Offeror's Proposal must be submitted in writing, in accordance with the format set forth in Section II.A.7. of this RFP, and will be included as part of the Offeror's Proposal, if accepted by the Department as provided above.

Offerors are cautioned to verify the content of their Proposal before submission. Except for material received from an Offeror in response to a request by the Department, the Department will not accept amendments or additions to a Proposal if such material is received after 3:00 p.m. ET on the Proposal Due Date. Offerors are encouraged to submit the Proposal Submission Checklist (**Exhibit I.A**) to facilitate verification of Proposal contents. An Offeror's request to withdraw a Proposal after the Proposal Due Date may be considered at the sole discretion of the Department.

b. Formatting Requirements

The Administrative Proposal, Technical Proposal, and Cost Proposal each should comply with the following formatting requirements (Failure to comply with the formatting requirements herein below may, but will not necessarily, result in the Proposal being deemed non-responsive and may, but will not necessarily, result in rejection of the Proposal):

(1) ***Binding of Proposal****:* The Administrative, Technical, and Cost Proposals must be separately bound. The official name of the organization(s), the Proposal Due Date , and "Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan" must appear on the outside front cover of each copy of the Offeror's Administrative, Technical, and Cost Proposal. If the Proposals are submitted in loose-leaf binders, the official name(s) of the organization(s) and "Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan" also must appear on the spine of the binders;

(2) ***Table of Contents****:* Each Proposal must include a table of contents;

(3) ***Index Tabs****:* Each major Section of the Proposal and each Exhibit must be labeled with an index tab that completely identifies the title of the Section or Exhibit as named in the table of contents;

(4) ***Pagination****:* Each page of the Proposal, including Exhibits, must be labeled on the upper right with the Section title and Section reference, page number, and date. Pages within each Section and Exhibit must be numbered consecutively;

(5) ***Proposal Updates/Corrections****:* Each Offeror must submit its Proposal so that any update pages required by the Department can be easily incorporated into the Proposal. Should it be necessary for an Offeror to submit additional information in support of its Proposal, it must be submitted in accordance with the following: upon written notification by the Offeror and agreement by the Department, new or replacement pages may be placed in the Proposal. All new or replacement pages will show the date of the revision and indicate the portion of the page being changed. This latter requirement will be fulfilled by drawing vertical lines down both margins of all affected passages. All new/ replacement pages will be noted by the Department on the errata sheet to be placed at the front of the Proposal copy; and,

(6) ***Required Content of Proposals****:* The Proposal shall consist of three parts: 1) the Administrative Proposal, which must respond to the requirements set forth in Section III of this RFP; 2) the Technical Proposal, which must respond to the requirements set forth in Section IV of this RFP; and 3) the Cost Proposal, which must respond to the requirements set forth in Section V of this RFP.

c. <u>Material Deviations</u>

New York State Law prohibits NYS from awarding a contract based upon material deviations from the specifications, terms, and conditions set forth in the RFP. Consequently, each Offeror's Proposal must conform to the specifications, terms, and conditions set forth in this RFP and prospective Offerors are strongly advised to raise issues and/or concerns relating to this procurement during the question and answer phase rather than taking exceptions within their Proposals. Material deviations from the specifications, terms, and conditions set forth in the RFP may render the Proposal non- responsive and may result in rejection of the Proposal.

In general, a material deviation is one that would (1) impair the interests of NYS, (ii) place the successful Offeror in a position of unfair economic advantage, (iii) place other Offerors at a competitive disadvantage, or (iv) which, if it had been included in the original RFP, could have formed a reasonable basis for an otherwise qualified Offeror to change its determination concerning the submission of a Proposal.

Offerors are advised that Offeror's standard, pre-printed material (including but not limited to: product literature, order forms, manufacturer's license agreements, standard contracts or other pre-printed documents), which are physically attached or summarily referenced in the Offeror's Proposal, unless specifically required by the RFP to be submitted as part of the Offeror's Proposal, will not be considered as having been submitted with or intended to be incorporated as part of the official offer contained in the Proposal, but rather will be deemed by the State to have been included by Offeror for informational or promotional purposes only.

In order to be deemed responsive to this RFP, the Offeror shall submit a Proposal which independently satisfies all of the requirements set forth in this RFP, without substitution or modification ("stated requirements"). The Proposal will be evaluated against the requirements and specifications set forth in this RFP to determine the "best value" submission.

As stated above in part, New York State Law prohibits NYS from awarding a contract based upon material deviations from the specifications, terms, and conditions set forth in the RFP. Consequently, each Offeror's Proposal must conform to the specifications, terms, and conditions set forth in this RFP. In addition to, but not in lieu of, its response to the RFP's stated requirements, the Offeror may propose supplemental, "or equal", additional or alternative terms (Extraneous Terms) to the stated requirements within the Proposal, provided that, in the State's sole judgment, the Extraneous Term(s) does not constitute material deviations to the stated requirements. Proposed Extraneous Term(s) may only be considered by the State to the extent that such Extraneous Term(s) constitute non-material deviations from the requirements set forth in the RFP as determined in the Department's sole discretion. Material deviations from the specifications, terms, and conditions set forth in the RFP may render the Proposal non-responsive and may result in rejection of the Proposal.

Therefore, in order for Extraneous Term(s) to be considered, the Extraneous Term must:

1. independently satisfy the applicable requirement(s) of the RFP on its own merits;

2. be clearly and separately identified as an "Extraneous Term" within the Administrative, Technical and/or Cost Proposals - Extraneous Terms Submission; and
3. be separately evaluated and scored in accordance with the bid evaluation criteria.

If the Offeror proposes to include Extraneous Terms in its official Proposal, the Offeror must meet all of the following requirements:

a. Each proposed Extraneous Term must be specifically enumerated in a separate section of the applicable Submission(s) (Administrative, Technical and/or Cost) labeled "Extraneous Terms Submission," using the format as set forth in **Exhibit I.X** entitled, "Extraneous Terms Template."

b. The "Extraneous Terms" section must be in a writing prepared by Offeror and may not include any pre-printed literature or vendor forms;

c. The writing must identify by part, section and title the particular RFP requirement (if any) which the Offeror proposes to supplement by inclusion of the Extraneous Term, with a brief description of the specific provision being modified by the Extraneous Term; and

d. The Offeror shall enumerate the proposed additional or alternative term from the RFP requirement, and the reasons therefore.

Only those terms meeting the above requirements (a) through (d) shall be considered as having been submitted as part of the formal offer.

Extraneous Term(s) submitted on standard, pre-printed forms (including but not limited to: product literature, order forms, manufacturer's license agreements, standard contracts or other pre-printed documents), which are physically attached or summarily referenced in the Proposal, or that, in the State's sole judgment, have not been submitted in compliance with the above requirements (a) through (d) above, will not be considered as having been

submitted with or intended to be incorporated as part of the official offer contained in the Proposal, but rather will be deemed by the State to have been included by Offeror for informational or promotional purposes only.

Absent the State's express written acceptance and incorporation of an Extraneous Term, acceptance and/or processing of the Proposal shall not constitute the State's acceptance of Extraneous Term(s) or be deemed a waiver of the State's rights set forth herein.

8. Notification of Award

A proposed award notification letter will be sent to the selected Offeror indicating a conditional award subject to successful contract negotiations. The remaining Offerors will be notified of the conditional award and the possibility that failed negotiations could result in an alternative award. No public discussion or news releases relating to this RFP, the associated procurement process, including but not limited to the bid solicitation, proposal evaluation and award and contract negotiation processes or the Agreement shall be made by any Offeror or their agent without the prior written approval of the Department.

9. Debriefing

As stated in RFP, Section II.A.8 above, proposed award notification letters will be sent to the selected and non-selected Offerors. At that time, Offerors will be advised of the opportunity to request a Debriefing and the timeframe by which such requests must be made, dependent upon the nature of the Debriefing, i.e., pre-award or post-award. Debriefings are subject to the Department's Debriefing Guidelines which are set forth in **Exhibit I.H**. entitled, "NYS Department of Civil Service Debriefing Guidelines." An unsuccessful Offeror's written request for a debriefing shall be submitted to:

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager
Employee Benefits Division, Room 1106
NYS Department of Civil Service
Albany, New York 12239

or all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager
NYS Department of Civil Service
Employee Benefits Division
Agency Building 1
Empire State Plaza
Albany NY 12239
Fax: 518-402-2835
E-Mail: MHSA2014RFP@cs.state.ny.us

10. Submission of Award Protests

By participating in activities related to this Procurement, and/or by submitting a Proposal in response to this RFP, all Offerors agree to be bound by its terms including, but not limited to, the process by which an Offeror may submit protests of the selection award for consideration. In the event that an Offeror decides to protest the selection decision, the Offeror may raise such issue according to the following provisions.

a. Process for Submitting Post Award Protests of the Selection Decision

(1) ***Time Frame:*** Any protest of the selection decision must be received no later than ten (10) business days after an Offeror's receipt of written notification by the Department of a conditional award.

(2) ***Content:*** The submission of the protest must clearly and fully state the legal and/or factual grounds for the protest and must include all relevant documentation.

(3) ***Format of Submission:*** All submissions of protest must be in writing and submitted to the MHSA Program Procurement Manager at the following address:

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager
Employee Benefits Division, Room 1106
NYS Department of Civil Service
Albany, New York 12239

For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager
NYS Department of Civil Service
Employee Benefits Division
Agency Building 1
Empire State Plaza
Albany NY 12239

A protest of the selection decision must have the following statement clearly and prominently displayed on the envelope or package:

"Submission of Selection Protest for the Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan"

Any assertion of protest which does not conform to the requirements set forth in this section shall be deemed waived by the Offeror, and the Offeror shall have no further recourse.

b. <u>Review of Submitted Protests</u>

The Department shall conduct the review process of submitted protests. The Department's Commissioner may appoint a designee to review the submission and to make a recommendation to the Commissioner as to the disposition of the matter. The Commissioner's designee may be an employee of the Department but, in any event, shall be someone who has not participated in the preparation of this RFP, the evaluation of Proposals, or the selection decision. At the discretion of the Commissioner, or the Commissioner's designee, the Offeror may be given the opportunity to meet with the Commissioner or her designee, as the case may be, to support its submission. The Offeror may, but need not, be represented by counsel at such a meeting. Any and all issues concerning the manner in which the review process is conducted shall be determined solely by the Commissioner, or the Commissioner's designee. The Commissioner, or the Commissioner's designee, shall review the matter, and the Commissioner shall issue a written decision within twenty (20) business days after the close of the review process. If additional time for the issuance of the decision is necessary, the Offeror shall be advised of the delay and of the time frame within which a decision may be reasonably expected. The Commissioner's decision will be

communicated to the party in writing and shall constitute the Department's final determination in the matter.

In the event that an Offeror protests the selection decision, the Department shall continue contract negotiations regarding the terms and conditions of the agreement with the selected Offeror pending the outcome of the protest. Any Offeror whose Proposal might become eligible for a conditional award in the event that the intended selection is disqualified may be asked to extend the time for which their Proposal shall remain valid.

The Department reserves the right to determine and to act in the best interests of the State in resolving any post award selection protest.

11. Department of Civil Service Reservation of Rights

In addition to any rights articulated elsewhere in this RFP, the Department reserves the right to:

a. Make or not make an award under the RFP, either in whole or in part.

b. Prior to the bid opening, amend the RFP. If the Department elects to amend any part of the RFP, notification of the amendment will be provided to all organizations who submitted a Procurement Registration Form and/or a Procurement Lobbying Offeror's Affirmation of Understanding and Agreement **(Exhibit I.K.)** via e-mail, facsimile or mail. Any amendments will also be posted to: www.cs.ny.gov/MHSA2014RFP/index.cfm

c. Prior to the bid opening, direct Offerors to submit Proposal modifications addressing subsequent RFP amendments;

d. Withdraw the RFP, at any time, in whole or in part, at the Department's sole discretion, prior to OSC approval of award of the contract.

e. Waive any requirements that are not material;

f. Disqualify any Offeror whose conduct and/or Proposal fails to conform to any of the mandatory requirements of the RFP;

g. Require clarification at any time during the Procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an Offeror's Proposal and/or to determine an Offeror's compliance with the requirements of this RFP;

h. Reject any or all Proposals received in response to this RFP, at its sole discretion;

i. Change any of the scheduled dates stated in this RFP;

j. Seek clarifications and revisions of Proposals;

k. Establish programmatic and legal requirements to meet the Department's needs, and to modify, correct, and/or clarify such requirements at any time during the Procurement, provided that any such modifications would not materially benefit or disadvantage any particular Offeror;

l. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the Offerors;

m. For the purposes of ensuring completeness and comparability of the Proposals, analyze submissions and make adjustments or normalize submissions in the Proposal(s), including the Offeror's technical assumptions, and underlying calculations and assumptions used to support the Offeror's computation of costs, or to apply such other methods it deems necessary to make level comparisons across Proposals;

n. Use the Proposal, information obtained through any site visits, management interviews, and the Department's own investigation of an Offeror's qualifications, experience, ability or financial standing, and any other material or information submitted by the Offeror in response to the Department's request for clarifying information, if any, in the course of evaluation and selection under this RFP;

o. Negotiate with the successful Offeror within the scope of the RFP in the best interests of the Department;

p. Utilize any and all ideas submitted in the Proposal(s) received;

q. Conduct contract negotiations with the next responsible bidder, should the Department be unsuccessful in negotiating with the selected Offeror; and

r. Unless otherwise specified in the RFP, every offer is firm and not revocable for a minimum period of 365 days from the Proposal Due Date as set forth in the RFP.

12. Limitation of Liability

The Department is not liable for any cost incurred by any Offeror prior to approval of the Agreement by OSC. Additionally, no cost will be incurred by the Department for any prospective Offeror or Offeror's participation in any procurement related activities.

The Department has taken care in preparing the data accompanying this RFP (hard copy Exhibits, website Exhibits, and sample document exhibits). However, the Department does not warrant the accuracy of the data; the numbers or statistics which appear in hardcopy Exhibits, website Exhibits, and sample document exhibits referenced throughout this RFP which are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation. Accordingly, prospective Offerors should rely upon and use such numbers or statistics in preparing their Proposals at their own discretion.

B. COMPLIANCE WITH APPLICABLE RULES, LAWS, REGULATIONS & EXECUTIVE ORDERS

This Procurement is being conducted in accordance with, and is subject to, the competitive bidding laws of the State of New York (New York State Finance Law, Article 11) and it is governed by, at a minimum, the legal authorities referenced below. All Offerors must fully comply with the provisions and set forth in this Section II.B. of the RFP. The Department will consider for evaluation and selection purposes only those Offerors who agree to comply with these provisions whose Proposal contains the Statements, Formal Certifications, and Exhibits submissions required hereunder.

1. Public Officers Law

All Offerors and Offerors' employees and agents must be aware of and comply with the requirements of the New York State Public Officers Law ("POL"), particularly POL Sections 73 and 74, as well as all other provisions of New York State law, rules and regulations, and policy establishing ethical standards for current and former NYS employees. In signing its Proposal, each Offeror guarantees knowledge and full compliance with such provisions for purposes of this RFP and any other activities including, but not limited to, contracts, bids, offers, and negotiations. Failure to comply with these provisions may result in disqualification from the procurement process, termination, suspension or cancellation of the Agreement and criminal proceedings as may be required by law. Per RFP Section III.C, Offerors must submit an affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed contracts, engagements, or affiliations, by submitting a completed **Exhibit I.M** in the Offeror's Administrative Proposal.

2. Omnibus Procurement Act of 1994 and its 2000 Amendment

Offerors are hereby notified that, if their principal place of business is located in a foreign or domestic jurisdiction that penalizes New York State vendors, and if the goods or services they offer would be produced or performed substantially outside New York State, the Omnibus Procurement Act of 1994 and its 2000 amendments require that they be denied contracts which they otherwise could obtain.

The list of jurisdictions subject to this provision is set forth in Article 20 of Appendix A.

3. Contractor Requirements and Procedures for Business Participation Opportunities for NYS Certified Minority and Women-Owned Business Enterprises (MWBE) and Equal Employment Opportunities ("EEO") for Minority Group Members and Women

New York State Law:

Pursuant to New York State Executive Law Article 15-A, the Department recognizes its obligation under the law to promote opportunities for the maximum feasible participation of certified minority and women-owned business enterprises and the employment of minority group members and women in the performance of the Department's contract. By submitting a Proposal in response to this procurement, the Offeror agrees to comply with the provisions of the RFP, including but not limited to Appendix D, entitled "Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures" and the requirements set forth herein.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises: Evidence from New York" (the "Disparity Study"). The Disparity Study can be accessed through Google search keywords : http://www.esd.ny.gov/MWBE/Data/NERA_NYS_Disparity_Study_Final_NEW.pdf .

The report found evidence of statistically significant disparities between the level of participation of minority and women-owned business enterprises in state procurement contracting versus the number of minority and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that the Department establish goals for maximum feasible participation of New York State Certified minority and women-owned business enterprises ("MWBE") and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs:

For purposes of this Procurement, the Department hereby establishes an overall goal of 20% for MWBE participation as relates only to the administrative cost component of the overall cost of the Contract. The Contractor must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that the Procuring Agencies may withhold payment pending receipt of the required MWBE documentation. The directory of New York State Certified MWBEs can be viewed at:
https://ny.newnycontracts.com/FrontEnd/VendorSearchPublic.asp

For guidance on how the Procuring Agencies will determine the Contractor's "good faith efforts," refer to 5 NYCRR §142.8.

In accordance with 5 NYCRR §142.13, Offeror/Contractor acknowledges that if it is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such finding constitutes a breach of Contract and the Department may withhold payment from the Contractor as liquidated damages.

Such liquidated damages shall be calculated as an amount equaling the difference between: (1) all sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and (2) all sums actually paid to MWBEs for work performed or materials supplied under the Contract.

By submitting a Proposal, the Offeror/Contractor agrees to submit the following documents and information as evidence of compliance with the foregoing:

a. Offerors are required to submit a MWBE Utilization Plan - Form MWBE-100 (**Exhibit I.O**.) setting forth the Offeror's proposed plan to utilize MWBEs as subcontractors and suppliers under the Contract and a Certification of Good Faith Efforts - Form MWBE-104 (**Exhibit I.Q**.) with their Proposal. Any modifications or changes to the MWBE Utilization Plan after contract award and during the term of the Contract must be reported on a revised MWBE Utilization Plan and submitted to the

Department. If the Offeror is requesting a waiver or partial waiver of the MWBE goals on Exhibit I.Q, the Offeror must also complete and submit MWBE-101 with the Administrative Proposal.

b. The Department will review the submitted MWBE Utilization Plan and advise the Offeror of the Department's acceptance or issue a notice of deficiency prior to contract award.

c. If a notice of deficiency is issued, the Offeror agrees that it shall respond to the notice of deficiency within seven (7) business days of receipt by submitting to the MHSA Program Procurement Manager, a written remedy in response to the notice of deficiency. If the written remedy that is submitted is not timely or is found by the Department to be inadequate, the Department shall notify the Offeror and direct the Offeror to submit, within five (5) business days, a request for a partial or total waiver of MWBE participation goals on Form MWBE-101 entitled "Request for Waiver Form" available at: http://www.cs.ny.gov/pio/mwbe-eeo-forms.cfm. Failure to file the waiver form in a timely manner may be grounds for disqualification of the bid or proposal.

d. The Department may disqualify an Offeror as being non-responsive under the following circumstances:
   (1) If an Offeror fails to submit a MWBE Utilization Plan;
   (2) If an Offeror fails to submit a written remedy to a notice of deficiency;
   (3) If an Offeror fails to submit a request for waiver, if applicable; or
   (4) If the Procuring Agencies determine that the Offeror has failed to document good faith efforts.

Contractors shall attempt to utilize, in good faith, any MBE or WBE identified within its MWBE Utilization Plan, during the performance of the Contract. Requests for a partial or total waiver of established goal requirements made subsequent to contract award may be made at any time during the term of the Contract to the Department, but must be made no later than prior to the submission of a request for final payment on the Contract.

Contractors are required to submit a Contractor's Quarterly M/WBE Contractor Compliance Reports - Form MWBE-103 to the Department's Contract Manager, at the address set forth in the Agreement, by the 10th day following each end of quarter over the term of the Contract documenting the progress made toward achievement of the MWBE goals of the Contract. Form MWBE-103 is available at: http://www.cs.ny.gov/pio/mwbe-eeo-forms.cfm

Equal Employment Opportunity Requirements:

By submission of a Proposal in response to this procurement, the Offeror/Contractor agrees with all of the terms and conditions of Appendix A including Article 12 - Equal Employment Opportunities for Minorities and Women. The Contractor is required to ensure that it and any subcontractors awarded a subcontract over $25,000 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor, shall undertake or continue programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability, or marital status. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of compensation. This requirement does not apply to: (i) work, goods, or services unrelated to the Contract; or (ii) employment outside New York State.

Offeror/Contractor further agrees to submit with its Proposal an EEO Staffing Plan – Form EEO-100 (**Exhibit I.G**) identifying the anticipated work force to be utilized on the project and if awarded the contract, will, upon request, submit to DCS, a workforce utilization report identifying the workforce actually utilized on the Contract if known.

Further, pursuant to Article 15 of the Executive Law (the "Human Rights Law"), all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor and any subcontractors will not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital

status, or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

Please Note: Failure to comply with the foregoing requirements may result in a finding of non-responsiveness, non-responsibility and/or a breach of the Contract, leading to the withholding of funds, suspension or termination of the Contract or such other actions or enforcement proceedings as allowed by the Contract.

Per RFP Section III.C, executed copies of:

Exhibit I.G entitled "EEO Staffing Plan (form EEO-100),"

Exhibit I.Q entitled, "Certification of Good Faith Efforts (form MWBE-104)"; and

Exhibit I.O entitled, "MWBE Utilization Plan (form MWBE-100)"
must be submitted as part of the Offeror's Administrative Proposal.

4. Americans with Disabilities Act

The Contractor will be required to assure its compliance with the Americans with Disabilities Act (42 USC§12101 et. seq.), in that any services and programs provided during the course of performance of the Agreement shall be accessible under Title II of the Americans with Disabilities Act, and as otherwise may be required under the Americans with Disabilities Act by submitting a completed Compliance with Americans with Disabilities Act form **(Exhibit I.N)** in the Offeror's Administrative Proposal.

5. MacBride Fair Employment Principles Act & Non-Collusive Bidding Certification

In accordance with Chapter 807 of the Laws of 1992, Offerors must certify whether they or any individual or legal entity in which the Offeror holds a ten percent (10%) or greater ownership interest, or any individual or legal entity that holds a ten percent (10%) or greater ownership in the Offeror have business operations in Northern Ireland. If an Offeror does have business operations in Northern Ireland, they must certify that they are taking lawful steps in good faith to conduct such business operations in accordance with the MacBride Fair Employment Opportunity Principles relating to nondiscrimination in

employment and freedom of workplace opportunity regarding such operations in Northern Ireland, and shall permit independent monitoring of their compliance with such principles.

The Department also requires that Offerors certify that prices in their Proposal have been arrived at independently without collusion, consultation, communication or agreement for the purpose of restricting competition with any other Offeror or competitor. In addition, that unless required by law, the prices quoted in the Offeror's Proposal have not been knowingly disclosed by the Offeror and will not knowingly be disclosed by the Offeror prior to opening, directly, indirectly, to any other Offeror or to any competitor. Offerors must also certify that no attempt has been made or will be made by the Offeror to induce any person, partnership or corporation to submit or not to submit a proposal for the purpose of restricting competition. An executed copy of the combined MacBride Act statement form and Non- Collusive Bidding Certification (**Exhibit I.D**) is required to be submitted in the Offeror's Administrative Proposal.

6. <u>Vendor Responsibility Requirements – State Finance Law §163</u>

New York State Finance Law §163 requires contracts for services and commodities be awarded on the basis of lowest price or best value "to a responsive and responsible Offeror." Furthermore, §163(9)f requires the Procuring Agencies to make a determination of responsibility of the proposed contractor prior to making an award.

To assist the Department in evaluating the responsibility of Offerors, a completed **"New York State Standard Vendor Responsibility Questionnaire"** must be submitted in the Offeror's Administrative Proposal. A person legally authorized to represent the Offeror must execute the questionnaire. To the extent that the Contractor is proposing the use of Key Subcontractors or Affiliates (i.e., part of the Offeror's proposed Account Team) and expected to receive more than $100,000 in payments during the term of the Agreement, the Offeror must submit a completed "New York State Standard Vendor Responsibility Questionnaire" for each Key Subcontractor or Affiliate completed by a person legally authorized to represent the Key Subcontractor or Affiliate.

The Department recommends that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System; however, vendors may choose to complete and submit a paper questionnaire. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at: http://www.osc.state.ny.us/vendrep/vendor_index.htm or go directly to the VendRep System online at: https://portal.osc.state.ny.us.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the Office of the State Comptroller's Help Desk at 866-370-4672 or 518-408-4672 or by email at:

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form.

7. Tax Law Section 5-a Certification Regarding Sales and Compensating Use Taxes

Section 5-a of the New York Tax Law requires that any contract valued at more than $100,000 entered into by a NYS agency shall not be valid, effective, or binding against the agency unless the Contractor certifies to the Tax Department that it is registered to collect New York State and local sales and compensating use taxes, if the Contractor made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000, measured over a specified period. In addition, the Contractor must certify to the Tax Department that each Affiliate and Key Subcontractor of such Contractor exceeding such sales threshold during a specified period is registered to collect New York State and local sales and compensating use taxes. For the purpose of this requirement, "affiliate" means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent. The Contractor also must certify to the procuring state entity that it filed the certification with the Tax Department and that the certification is correct and complete. Accordingly, in the event the value of the Agreement exceeds $100,000, the Contractor

must file a properly completed Form ST-220-CA (**Exhibit I.E**) with the Department and a properly completed Form ST-220-TD (**Exhibit I.F**) with the Department of Taxation & Finance before the Contract may take effect. In addition, after the Agreement has taken effect, the Contractor must file a properly completed Form ST-220-CA with the Department if the Agreement's term is renewed. Further, a new Form ST-220-TD must be filed with the Department of Taxation & Finance if no ST-220-TD has been filed by the Contractor or if a previously filed Form ST-220-TD is no longer correct and complete.

Submission of these forms (ST-220-CA and ST-220-TD) is not required at time of Proposal submission; however, the selected Offeror will be required to complete and submit these forms as a condition of contract award. These forms may also be found at: www.tax.ny.gov/forms/sales_cur_forms.htm

8. Disclosure of Proposal Contents – Freedom Of Information Law ("FOIL")

NOTICE TO OFFEROR'S LEGAL COUNSEL

All materials submitted by an Offeror in response to this RFP shall become the property of the Department and may be returned to the Offeror at the sole discretion of the Department. Proposals may be reviewed or evaluated by any person, other than one associated with a competing Offeror, designated by the Department. Offerors may anticipate that Proposals will be evaluated by staff and consultants retained by the Department and may also be evaluated by staff of other NYS agencies interested in the provision of the subject services including, but not limited to, the Governor's Office of Employee Relations and the Division of the Budget, unless otherwise expressly indicated in this RFP. The Department has the right to adopt, modify, or reject any or all ideas presented in any material submitted in response to this RFP.

To request that materials be protected from FOIL disclosure, the Offeror must follow the procedures below regarding the New York State Freedom of Information Law (FOIL). If an Offeror believes that any information in its Proposal or supplemental submission(s) constitutes proprietary and/or trade secret information and desires that such information not be disclosed if requested pursuant to the New York State Freedom of Information Law, Article 6 of the Public Officers Law, the Offeror must make that assertion by

completing **Exhibit I.C "Freedom of Information Law – Request for Redaction Chart."** The Offeror must complete the form specifically identifying by page number, line, or other appropriate designation, the specific information requested to be protected from FOIL disclosure and the specific reason why such information should not be disclosed. Page 2 of **Exhibit I.C** contains information regarding appropriate justification for protection from FOIL disclosure. Vague, non-specific, summary allegations that material is proprietary or trade-secret are inadequate and will not result in protection from FOIL disclosure.

The completed **Exhibit I.C** must be submitted to the Department at the time of its Proposal submission; it should be included with the Requested Redactions (CD and Hard Copy), described below. It should not be included in the Offeror's Proposal. If the Offeror chooses not to assert that any Proposal material and/or supplemental submission should be protected from FOIL disclosure, the Offeror should so advise the Department by checking the applicable box on **Exhibit I.C** and submitting it to the Department at the time of its Proposal submission, but separately from its Proposal. If a completed **Exhibit I.C** form is not submitted, the Department will assume that the Offeror chooses not to assert that any proposal material or supplemental submission, as applicable should be protected from FOIL disclosure.

The FOIL-related materials described herein will not be considered part of the Offeror's Proposal and will not be reviewed as a part of the Procurement's evaluation process.

Requested Redactions (CD and Hard Copy):

At the time of Proposal submission, the Offeror is required to identify the portions of its proposal that it is requesting to be redacted, in accordance with the instructions below, to be used in the event that its proposal is the subject of a Freedom of Information Law (FOIL) request received by the Department:

The Offeror must provide an electronic copy of the Administrative Proposal, the Cost Proposal and the Technical Proposal, each on a separate CD, which reflect the Offeror's requested redactions. Additionally, the Offer must provide a separately bound hardcopy of each of the three Proposal documents with redactions marked that are included on the

CDs. The electronic documents must be prepared in PDF format using the Redaction Function in Adobe Acrobat Professional software, version 8 or higher. Each specific portion of the Proposal documents requested to be protected from FOIL disclosure must be identified using the Adobe **"Mark for Redaction" function; do not use the "Apply Redactions" function.** The resulting documents must show the Offeror's requested redactions as outlined, while the content remains visible. This will allow the Department to either apply or remove requested redactions when responding to FOIL requests. The documents included on the CD and in hard copy must be complete Proposals, including all Exhibits and Attachments. No section may be omitted from the CD or hard copy even if the entire section is requested to be redacted; such sections should be marked for redaction, not removed. For forms, exhibits and charts please mark for redaction only those cells/fields/entries that meet the criteria for protection from FOIL, not the entire page.

During the Proposal evaluation process, the Department may request additional information through clarifying letters and at management interviews. Any requested redactions for additional written material provided by the Offeror in response to the Department's requests also must be submitted following the instructions, above.

9. Compliance with New York State Workers' Compensation Law

Sections 57 and 220 of the New York State Workers' Compensation Law (WCL) provide that the Department shall not enter into any contract unless proof of workers' compensation and disability benefits insurance coverage is produced. Prior to entering into a contract with the Department, the selected Offeror and Key Subcontractor(s) or Affiliates, with more than $100,000 in expected expenses over the life of the contract, if any, will be required to verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that they are properly insured or are otherwise in compliance with the insurance provisions of the WCL. The forms to be used to show compliance with the WCL are listed in **Exhibit I.W** – Compliance with NYS Workers' Compensation Law. Any questions relating to either workers' compensation or disability benefits coverage should be directed to the State of New York Workers'

Compensation Board, Bureau of Compliance at 518-486-6307. You may also find useful information at their website: http://www.wcb.ny.gov.

Submission of the proof of workers' compensation and disability benefits insurance coverage is required at the time of Proposal submission. Failure to provide verification of either of these types of insurance coverage with the Offeror's Administrative Proposal may be grounds for disqualification of an otherwise successful Proposal.

To the extent that the Offeror is proposing the use of Key Subcontractors or Affiliates (i.e., part of the Offeror's proposed Project Team), the Offeror must verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that the Key Subcontractors or Affiliates are properly insured or are otherwise in compliance with the insurance provisions of the WCL.

10. Iran Divestment Act

By submitting a proposal in response to this solicitation or by assuming the responsibility of a Contract awarded hereunder, Offeror/Contractor (or any assignee) certifies that it is not on the "Entities Determined To Be Non-Responsive Bidders/Offerers Pursuant to The New York State Iran Divestment Act of 2012" list ("Prohibited Entities List") posted on the OGS website at: http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf and further certifies that it will not utilize on such Contract any subcontractor that is identified on the Prohibited Entities List. Additionally, Offeror/Contractor is advised that should it seek to renew or extend a Contract awarded in response to the solicitation, it must provide the same certification at the time the Contract is renewed or extended.

During the term of the Contract, should the Department of Civil Service receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, the Department of Civil Service will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the

Department of Civil Service shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, seeking compliance, recovering damages, or declaring the Contractor in default.

The Department of Civil Service reserves the right to reject any proposal, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

11. New York Subcontractors and Suppliers

New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the State and the nation. In recognition of their economic activity and leadership in doing business in New York State, Offerors for this contract for MHSA Program Services or are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract. Such partnering may be as subcontractors, suppliers, protégés or other supporting roles.

Offerors need to be aware that all authorized users of this contract will be strongly encouraged, to the maximum extent practical and consistent with legal requirements, to use responsible and responsive New York State businesses in utilizing services and technology. Furthermore, Offerors are reminded that they must continue to utilize small, minority and women-owned businesses, consistent with current State law.

Utilizing New York State businesses in State contracts will help create more private sector jobs, rebuild New York's infrastructure, and maximize economic activity to the mutual benefit of the Contractor and its New York State business partners. New York State businesses will promote the Contractor's optimal performance under the contract, thereby fully benefiting the public sector programs that are supported by associated procurements.

Public procurements can drive and improve the State's economic engine through promotion of the use of New York businesses by its contractors. The State therefore expects Offerors to provide maximum assistance to New York businesses in their use of the contract. The potential participation by all kinds of New York businesses will deliver great value to the State and its taxpayers. Offerors are required to complete **Exhibit I.U.2**, NYS Subcontractors and Supplies.

SECTION III: ADMINISTRATIVE PROPOSAL REQUIREMENTS

This Section of the RFP sets forth the requirements for the Offeror's Administrative Proposal submission, including the Minimum Mandatory Requirements that must be satisfied to qualify an Offeror to be considered for selection. The Department will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Proposals the Department determines to be in compliance with the requirements set forth in this Section III.

The Offeror's *Administrative Proposal* must respond to all of the following items as set forth below in the order and format specified and using the forms set forth in the RFP. Additional details pertaining to the required forms are found in Section II.B. Compliance With Applicable Rules, Laws, Regulations & Executive Orders, and Section III.

The *Administrative Proposal* must contain the following information, in the order enumerated below:

A. Formal Offer Letter

At this part of its Administrative Proposal, the Offeror must submit a formal offer in the form of the **"Formal Offer Letter"** as set forth in **Exhibit I.S**. The formal offer must be signed and executed by an individual with the capacity and legal authority to bind the Offeror in its offer to the State. Each of the two copies of the Offeror's Administrative Proposal marked "ORIGINAL" requires a letter with an original signature; the remaining copies of the Offeror's Administrative Proposal may contain photocopies of the signature. The Offeror must accept the terms and conditions as set forth in RFP, Section VII and Appendices A, B, C and D and agree to enter into a contractual agreement with the Department containing, at a minimum, the terms and conditions identified in the RFP section and appendices as cited herein (**Note:** Appendix A, "Standard Clauses for New York State Contracts" is basically a compilation of statutory requirements applicable to all persons and entities contracting with NYS and therefore has been deemed to be non-negotiable by the Offices of the Attorney General and the NYS Comptroller. Appendix B, "Standard Clauses for All Department Contracts," Appendix C, "Third Party Connection and Data Exchange Agreement," and Appendix D, "Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures" are compilations of standard clauses/requirements for the contracts and also are non-

negotiable.) If an Offeror proposes to include the services of a Key Subcontractor(s) or Affiliate(s), the Offeror shall be required to assume responsibility for those services as "Prime Contractor." The Department will consider only the Prime Contractor in regard to contractual matters.

B. Minimum Mandatory Requirements

The Department will only accept Proposals from Offerors that attest and demonstrate through current valid documentation to the satisfaction of the Department that the Offeror meets the Proposal's Minimum Mandatory Requirements set forth herein this Section III.B. At this part of its Administrative Proposal, the Offeror must submit a completed **Exhibit I.T "Offeror Attestations Form"** representing and warranting that:

1. the Offeror, as of the Proposal Due Date, possesses the legal capacity to enter into a contract with the Department;

2. the Offeror and/or its Key Subcontractor or Affiliate, as of the Proposal Due Date, provides behavioral management and associated claims adjudication services for a minimum of five million (5,000,000) lives as specified below. The Offeror must provide a detailed list of client organizations with the number of lives served through each client to clearly demonstrate that the Offeror and/or it Key Subcontractor or Affiliate meets the minimum requirement of five million (5,000,000) lives. In determining lives, the Offeror should:

    - Include both at-risk and fee-for-service business;
    - Include Medicaid business;
    - Count all lives [e.g., an employee, a spouse and two (2) eligible dependents count as four (4)];
    - Exclude any non-behavioral health management business; and
    - Exclude any employee assistance program business

3. as of the Proposal Due Date, the Offeror's Empire Plan MHSA Provider Network, as proposed, meets or exceeds all of the following minimum Network access guarantees:

URBAN AREAS

a. Seventy-five percent (75%) of Enrollees will have at least:
   - one (1) Inpatient, ALOC and Outpatient Clinic Groups – Mental Health within five (5) miles; and,
   - one (1) Inpatient, ALOC and Outpatient Clinic Groups – Substance Abuse within five (5) miles.

b. Seventy-five percent (75%) of Enrollees will have at least:
   - one (1) Psychiatrist within three (3) miles; and,
   - one (1) Psychologist within three (3) miles; and,
   - one (1) Masters Level Clinician (who qualifies for R designation in NYS or who has highest level of licensure outside of NYS) within three (3) miles.

SUBURBAN AREAS

c. Seventy-five percent (75%) of Enrollees will have at least:
   - one (1) Inpatient, ALOC and Outpatient Clinic Groups – Mental Health within fifteen (15) miles; and,
   - one (1) Inpatient, ALOC and Outpatient Clinic Groups – Substance Abuse within fifteen (15) miles.

d. Seventy-five percent (75%) of Enrollees will have at least:
   - one (1) Psychiatrist within fifteen (15) miles; and,
   - one (1) Psychologist within fifteen (15) miles; and,
   - one (1) Masters Level Clinician (who qualifies for R designation in NYS or who has highest level of licensure outside of NYS) within fifteen (15) miles.

RURAL AREAS

e. Seventy-five percent (75%) of Enrollees will have at least:
   - one (1) Inpatient, ALOC and Outpatient Clinic Groups – Mental Health within forty (40) miles; and,
   - one (1) Inpatient, ALOC and Outpatient Clinic Groups – Substance Abuse within forty (40) miles.

f. Seventy-five percent (75%) of Enrollees will have at least:
   - one (1) Psychiatrist within forty (40) miles; and,
   - one (1) Psychologist within forty (40) miles; and,
   - one (1) Masters Level Clinician (who qualifies for R designation in NYS or who has highest level of licensure outside of NYS) within forty (40) miles.

To demonstrate satisfaction of this requirement, the Offeror must submit all information required below with their Administrative Proposal, based on the Geo-Coded Census file provided by the Department **(Exhibit III.A)**:

(1) **Exhibit I.Y.2** – Offeror's Proposed MHSA Provider Network File, following the instructions and file layout contained in **Exhibit I.Y.1**;

(2) **Exhibit I.Y.3** – Offeror's MHSA Provider Network Access Prerequisite Worksheet, following the instruction contained therein;

(3) Offeror's GeoAccess Managed Care Accessibility Analysis Report (on CD only) which supports the Offeror's attainment of the Minimum Mandatory Requirements (access standards) reported on **Exhibit I.Y.3**;

(4) **Attestation** – The Offeror must attest that, as of the Proposal Due Date, it holds executed contracts and has completed its credentialing of all Empire Plan MHSA Providers in its proposed Empire Plan MHSA Provider Network File, **Exhibit I.Y.2**. The Offeror must agree to provide documentation, including provider contracts, as required to demonstrate satisfaction of this requirement.

All Enrollees must be counted in calculating whether the Offeror meets the Empire Plan MHSA Provider Network access prerequisite. No Enrollee may be excluded even if there is no provider located within minimum mandatory access requirements.

Note: The Offeror's proposed Empire Plan MHSA Provider network access standards will be scored as part of the evaluation of the Offeror's Empire Plan MHSA Provider network and the Offeror's Network Access Guarantees will be evaluated in accordance with the criteria specified in Section VI, entitled "Evaluation and Selection Criteria."

4. The Offeror understands and agrees to comply with all specific duties and responsibilities set forth in Section IV.B.3 of this RFP, entitled "Implementation," including Section IV.B.3.b.(2) requiring the Offeror to propose a financial guarantee supporting its commitment to satisfy all implementation requirements.

   Note: The Offeror must propose a minimum Implementation and Start-Up Guarantee as a credit to the MHSA Program of at least 50% of the Administrative Fee for each day that all Implementation and Start-up requirements are not met for the period commencing the first day of the month following a 90 day implementation period after the Office of the State Comptroller approves the Agreement resulting from this RFP.

5. The Offeror will maintain and make available as required by the Department a complete and accurate set of records related to the Agreement resulting from this RFP as required by Appendices A and B and the draft Agreement set forth in Section VII of this RFP. This includes, but is not limited to, provider contracts, detailed claim records, and any and all other financial records as deemed necessary by the Department to perform its fiduciary responsibilities to the Empire Plan MHSA Program's participants and to ensure that public dollars are spent appropriately.

6. The Offeror has submitted as part of its Proposal, if so required by the RFP, or will submit all Transmittal letters, Statements, Formal Certifications and Exhibits as required in Section II of this RFP related to the Offeror's compliance with all rules, laws, regulations and executive orders.

7. The Offeror will execute the duties and responsibilities set forth in Section IV of this RFP in strict conformance to the requirements described in that section of the RFP.

8. The Offeror, as of Proposal Due Date, has current URAC-case management, JCAHO, ACHC, NCQA or CARF full accreditation at the proposed primary worksite where case management will be performed for the Program services.

Note: Any Offeror which fails to satisfy any of the above Minimum Mandatory Requirements shall be eliminated from further consideration.

C. Exhibits

At this part of its Administrative Proposal, the Offeror must complete and submit the various Exhibits specified in Section II.B. and Section III of this RFP, in satisfaction of the regulatory requirements described therein. A listing of the required Exhibits is set forth below:

Exhibit Name	Exhibit #
Proposal Submission Requirement Checklist	**Exhibit I.A**
MacBride Statement and Non-Collusive Bidding Certification	**Exhibit I.D**
EEO Staffing Plan (form EEO-100)	**Exhibit I.G**
Offeror's Affirmation of Understanding and Agreement	**Exhibit I.K**
Compliance with Public Officers Law Requirements	**Exhibit I.M**
Compliance with Americans with Disabilities Act	**Exhibit I.N**
MWBE Utilization Plan (form MWBE-100)	**Exhibit I.O**
Offeror's Certification of Compliance Pursuant to State Finance Law §139-k	**Exhibit I.P**
Certification of Good Faith Efforts (form MWBE-104)	**Exhibit I.Q**
Formal Offer Letter	**Exhibit I.S**
Offeror Attestations Form	**Exhibit I.T**
Key Subcontractors or Affiliates	**Exhibit I.U.1**
NYS Supplier & Subcontractor	**Exhibit I.U.2**
Program References	**Exhibit I.V**
Extraneous Terms Template	**Exhibit I.X**
Offeror's Proposed MHSA Participating Provider Network File	**Exhibit I.Y.2**
Offeror's MHSA Provider Network Access Prerequisite Worksheet	**Exhibit I.Y.3**
Confidentiality Agreement and Certificate of Non-Disclosure	**Exhibit I.Z**

Note: If not already provided to the Department prior to Proposal submission, the Offeror must enclose a completed Exhibit I.K "Offeror's Affirmation of Understanding and Agreement."

D. Key Subcontractors or Affiliates

At this part of its Administrative Proposal, the Offeror must provide a statement identifying all Key Subcontractors or Affiliates, if any, that the Offeror will be contracting with to provide MHSA Program services and must, for each such Key Subcontractor or Affiliate identify, complete and submit **Exhibit I.U.1** "Key Subcontractors or Affiliates":

1. provide a brief description of the services to be provided by the Key Subcontractor or Affiliate; and

2. provide a description of any current relationships with such Key Subcontractor or Affiliate and the clients/projects that the Offeror and Key Subcontractor or Affiliate are currently servicing under a formal legal agreement or arrangement, the date when such services began and the status of the project.

   The Offeror must indicate whether or not, as of the date of the Offeror's Proposal, a subcontract (or shared services agreement) has been executed between the Offeror and the Key Subcontractor or Affiliate for services to be provided by the Key Subcontractor or Affiliate relating to this RFP. If the Offeror will not be subcontracting with any Key Subcontractor(s) or Affiliate(s) to provide MHSA Program services, the Offeror must provide a statement to that effect.

E. Reference Checks

At this part of its Administrative Proposal, for the purpose of reference checks, the Offeror must provide four (4) references of current clients and one (1) reference of a former client, for a total of 5 references, for whom the Offeror has supplied services similar to those described in this RFP. The number of covered lives covered by the Offeror for each referenced client must be at least 100,000. If the Offeror is proposing any Key Subcontractors or Affiliates, the references should be with clients for whom the Offeror and Key Subcontractor or Affiliate have jointly supplied services similar to those described in this RFP. For each client reference provided, the Offeror must complete and submit **Exhibit I.V** "Program References." The Offeror shall be solely responsible for providing contact names, e-mail addresses and phone numbers of client references who are readily available to be contacted by the State.

F. Financial Statements

At this part of its Administrative Proposal, the Offeror must provide a copy of the Offeror's last issued GAAP annual audited financial statement. A complete set of statements, not just excerpts, must be provided. Additionally, for each Key Subcontractor or Affiliate, if any, that provides any of the MHSA Program services; which are the subject matter of this RFP, provide the most recent GAAP annual audited statement. If the Offeror, or a Key Subcontractor or Affiliate, is a privately held business and is unwilling to provide copies of their GAAP annual audited financial statements as part of their Proposal, the Offeror/Key Subcontractor/Affiliate must make arrangements for the procurement evaluation team to review the financial statements. **Note:** If financial statements have not been prepared and/or audited, the Offeror /Key Subcontractor/ Affiliate must provide the following as part of its Administrative Proposal: a letter from a bank reference attesting to the Offeror/Key Subcontractor/Affiliate's financial viability and creditworthiness. (Note: For purposes of this reference, the Offeror may not give as a reference, a parent or subsidiary company, a partner or an Affiliate organization.) The letter must include the bank's name, address, contact person name and telephone number and it must address, at a minimum, the following items:

1. a brief description of the business relationship between the parties (i.e., the Offeror/Key Subcontractor/Affiliate and the bank), including the duration of the relationship and the Offeror's current standing with the bank. For example: "*The (Offeror/Key Subcontractor/ Affiliate's name) is currently and has been for "x" number of years a client in good standing";*
2. a description of any ownership/partner relationship that may exist between the parties, if any. (**Note:** One party cannot be the parent, partner or subsidiary of the other, nor can one party be an affiliate of the other); and,
3. any other facts or conclusions the bank may deem relevant to the State in regard to the bank's assessment of the Offeror /Key Subcontractor/Affiliate's financial viability and creditworthiness concerning the nature and scope of the Program Services, which are the subject matter of this RFP, and the Parties (i.e., Department, and the Offeror or the Offeror and Key Subcontractor or Affiliate) contractual obligations should the Offeror be awarded the resultant contract.

G. Request for Data Necessary to Submit a Proposal

Offerors intending to submit a Proposal will require Empire Plan MHSA Program data. The Empire Plan MHSA Program data files can be obtained by sending a letter requesting the files and including a properly executed **Exhibit I.Z**, Confidentiality Agreement and Certificate of Non-Disclosure. The letter must be signed and executed by an individual with the capacity and legal authority to bind the prospective Offeror. The letter and properly executed Confidentiality Agreement and Certificate of Non-Disclosure form must be sent to:

If using the U.S. Postal Service, please use the following address:

MHSA Benefit Services Procurement Manager
Employee Benefits Division, Room 1106
NYS Department of Civil Service
Albany, New York 12239

For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Benefit Services Procurement Manager
NYS Department of Civil Service
Employee Benefits Division
Agency Building 1
Empire State Plaza
Albany NY 12239

The Empire Plan MHSA Program data files will only be sent to those prospective Offerors that request said files via submission of the pre-requisite letter referred to above, accompanied by properly executed **Exhibit I.Z**.

Upon receipt of said letter and form, the prospective Offerors will be sent a CD containing the following Empire Plan MHSA Program data files along with the accompanying record layout and instructions as further described in Exhibit III.A:

1. Market basket of Empire Plan MHSA Program 2013 claims for reference in preparing Exhibit V.A.2 and V.A.3 of the RFP;
2. Empire Plan Geocoded Census data file to be used to prepare the analysis required to complete Exhibit I.Y.3 of the RFP; and
3. Representative sample of MHSA Program providers to be used to complete Exhibit I.Y.4 of the RFP.

Note: Prospective Offerors are solely responsible for the delivery of the pre-requisite letter and properly executed Exhibit I.Z.

The Department is not responsible for delays attributable to United States mail deliveries or any other means of transmittal, or for delays caused by the prospective Offeror due to their submission of incomplete, inaccurate or incorrect information.

SECTION IV: TECHNICAL PROPOSAL REQUIREMENTS

The Department is seeking to award the Agreement to a qualified Offeror to provide Mental Health and Substance Abuse Services for The Empire Plan, Excelsior Plan, and Student Employee Health Plan Mental Health and Substance Abuse Programs (collectively referred to as the MHSA Program). The purpose of this section of the RFP is to set forth the programmatic duties and responsibilities required of the Successful Offeror selected in response to this RFP with whom the Department enters into the Agreement ("Contractor") and to pose questions concerning those duties and responsibilities for response by the Offerors. The Offeror's Technical Proposal must contain responses to all questions (i.e. Required Submissions) in the format requested. Each Offeror may submit only one Technical Proposal. The Technical Proposals will be evaluated based on the Offeror's responses to the questions contained in this Section. Therefore, it is critical that Offerors fully respond to each of the questions presented in this Section IV. Evaluation of all Proposals and the selection of the Successful Offeror shall be based only upon the Offeror's Proposal regarding the duties and responsibilities set forth in the RFP, and shall not be based upon any supplemental material submitted by the Offeror.

Note: Numbers, data, or statistics which may appear in the Exhibits referenced throughout this RFP are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation.

The Department will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Offeror Proposals that it determines to meet the Minimum Mandatory Requirements in Section III and are responsive to the duties and responsibilities set forth in Section IV of this RFP.

Please note that Offerors may not include any cost information in the Technical Proposal including exhibits or attachments. This cost information pertains to the provider fees and Administrative Fees requested in the Cost Proposal. Performance guarantee amounts are to be included in the Technical Proposal. Specific savings estimates (dollars or percentages) should not be quoted in the Technical Proposal or in any exhibits or attachments submitted with the Technical Proposal.

A. Program Administration

1. Executive Summary

The Offeror must describe its capacity to administer the Department's Mental Health and Substance Abuse Program (also hereafter collectively referred to as the "MHSA Program").

a. Required Submission

The Offeror must submit an Executive Summary that describes its capacity to administer the Department's MHSA Program. The Executive Summary must include:

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

(2) A description demonstrating its understanding of the requirements presented in the RFP, and how the Offeror can assist the Department in accomplishing its objectives;

(3) A statement explaining the Offeror's and the Offeror's key Subcontractor's previous experience managing the Mental Health and Substance Abuse Programs of other state governments or large public entities or any other organizations with over 100,000 covered lives, as well as any previous experience managing a self-funded Mental Health and Substance Abuse Program. Detail how this experience qualifies the Offeror and, if applicable, the experience of its Key Subcontractors to undertake the functions and activities required by this RFP; and

(4) An explanation of how the following administrative and operational components will be performed by the Offeror. Include an organizational chart explicitly detailing responsibility for the following functions;

(a) Account Team
(b) Premium Development Services
(c) Implementation
(d) Customer Service
(e) Enrollee Communication Support
(f) Enrollment Management
(g) Reporting

(h) Consulting

(i) Transition and Termination of Contract

(j) Network Management

(k) Claims Processing

(l) Clinical Management/Utilization Review

If the proposed organizational structure has been used in administering the program of another client, provide the client's name and include the client as a reference as required in Exhibit I.V.

2. General Qualifications of the Offeror

The MHSA Program covers over one million lives and incurs costs in excess of $180 million annually. The Offeror/ Contractor must have the experience, reliability and integrity to ensure that each Enrollees' mental health and substance abuse care needs are addressed in a clinically appropriate and cost effective manner. The terms of the Offeror's proposal must demonstrate explicit acceptance of and responsiveness to the MHSA Program's duties and responsibilities set forth in the RFP, ensuring full compliance with the MHSA Program Services.

a. Required Submission

The Offeror must demonstrate that it has the wherewithal to administer the MHSA Program as required by this RFP. Please provide detailed responses to the following:

(1) What experience does the Offeror have in managing/supervising a MHSA program similar to the MHSA Program described in this RFP?

(2) Explain how the Offeror's account team will be prepared to actively manage the administrative, operational and clinical aspects of the MHSA Program?

(3) What internal systems or procedures will the Offeror have in place to provide financial, legal, and audit oversight of its contract with the MHSA Program?

B. Proposed Empire Plan MHSA Program Services

In this section, the Offeror must demonstrate its capacity to provide the required services for administration of the MHSA Program.

1. Account Team

The Department expects the Contractor to have a proactive, experienced account leader and team in place who are dedicated solely to the MHSA Program and who have the authority and expertise to coordinate the appropriate resources to implement and administer the MHSA Program.

a. Duties and Responsibilities

(1) The Contractor must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the MHSA Program during implementation, operation and transition.

(a) The account team must be comprised of qualified and experienced individuals who are acceptable to the Department and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the MHSA Program in an efficient manner;

(b) The Contractor must ensure that there is a process in place for the account team to gain immediate access to appropriate corporate resources and senior management necessary to meet all MHSA Program requirements and to address any issues that may arise during the performance of the Agreement.

(2) The Contractor's dedicated account team must be experienced, accessible (preferably in the New York State Capital Region district) and sufficiently staffed to:

(a) provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department, or other staff on behalf of the Council on Employee Health Insurance or union representatives regarding member-specific claims issues for the duration of the Agreement to the satisfaction of the Department;

(b) immediately notify the Department in writing of actual or anticipated events impacting MHSA Program costs and/or delivery of services to Enrollees such as but not limited to, legislation, litigation, and operational issues.

(3) The Contractor's dedicated account team must ensure that the MHSA Program is in compliance with all legislative and statutory requirements. If the Contractor is unable to comply with any legislative or statutory requirements, the Department must be notified in writing immediately. The Contractor must work with the Department to develop accurate Summary Plan Descriptions (SPDs) and MHSA Program material.

b. <u>Required Submission</u>

(1) Provide an organizational chart and description illustrating how you propose to administer, manage, and oversee all aspects of the MHSA Program. Include the following:

(a) Reporting relationships and the responsibilities of each key position of the dedicated account team; and how the team will interact with other departments such as the call center, clinical services, reporting, auditing, and network management within your organization. Describe how the dedicated account team interfaces with senior management and ultimate decision makers within your organization;

(b) Names, qualifications, and job descriptions of those individuals selected to comprise the dedicated operational and clinical account team for the Offeror. Complete **Exhibit I.B** of this RFP, Biographical Sketch Form, for all key members of the proposed dedicated account team;

(c) Where individuals are not named, include qualifications of the individuals that you would seek to fill the positions; and

(d) Where will your account services, enrollment, claims processing, clinical management, clinical referral line and customer service staff be located, and approximately how many staff members will work in each functional area?

(2) Describe how the dedicated account team will have access to larger corporate resources as well as upper level management. What tools and resources are available to the account team to manage the MHSA Program? What tools will be available to the Department to work with the dedicated account team to manage the MHSA Program?

(3) List the national accreditations and levels (i.e. full, provisional, etc…) that your organization has achieved for the locations that will service the MHSA Program.

2. Premium Development Services

The Contractor must provide underwriting assistance and support to the Department in the development of premium rates chargeable to MHSA Program participants consistent with the interests and goals of the MHSA Program and the State. The Department intends to develop premium rates to be as realistic as possible, taking into account all significant elements that can affect MHSA Program costs including, but not limited to trend factors, changes in enrollment and enacted legislation. The development of premium rates that closely match the actual costs enables the plan to provide rate stability, one of the primary goals of the State, and to meet the budgetary needs of the State and local governments that participate in NYSHIP.

a. Duties and Responsibilities

The Contractor will be responsible for assisting and supporting the Department with all aspects of the premium rate development including, but not limited to:

(1) Providing a team of qualified and experienced individuals who are acceptable to the Department and who will assist and support the Department in developing premium rates consistent with the financial interests and goals of the MHSA Program and the State;

(2) Developing projected aggregate claim, trend and Administrative Fee amounts for each MHSA Program Year. Analysis of all MHSA Program components impacting the MHSA Program cost shall be performed including, but not limited to claims, trend factors, Administrative Fees and changes in enrollment; and

(3) Working with the Department and its contracted actuarial consultant through the annual premium renewal process to further document and explain any premium rate recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.

b. <u>Required Submission</u>

(1) Provide the names, qualifications and job descriptions of those key individuals who will provide premium rate development services for the MHSA Program. Describe their experience in providing financial assistance and support to other large health plans. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key staff involved in the premium rate development.

(2) Describe the general steps that you will follow to develop the annual premium renewal recommendation for submission to the Department. Include any different steps that will be employed to develop the first year premium vs. the premium for subsequent years of the Agreement. Include a description and source of the data you will utilize, assumptions you will use and how these assumptions will be developed, as well as any resources you will utilize.

(3) Confirm your commitment to work with the Department and its contracted actuarial consultant on the annual premium renewal recommendation and your availability to present such recommendation to the Department, Division of the Budget and GOER.

Note: The responses to the above three Required Submissions should be general descriptions of the financial methodology you intend to use for assisting and supporting the Department with the MHSA Program. Responses may **NOT** include any specific cost information or values relative to the development of cost/rate projections and trends for the MHSA Program; that information must be restricted to your Cost Proposal.

3. Implementation

The Contractor must ensure that the MHSA Program is fully functional by the first day of the month following a minimum 90-day implementation period after the Office of the State Comptroller approves the Agreement. The implementation plan must be detailed and comprehensive and demonstrate a firm commitment by the Contractor to complete all implementation activities within the 90-day implementation period.

a. Duties and Responsibilities

(1) During the 90-day implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those specific activities set forth in Section IV.B.3.a(2)(a)--(e). Such implementation activities must be completed no later than the first day of the month following a minimum 90-day implementation period after the Office of the State Comptroller approves the Agreement.

(2) ***Implementation and Start-up Guarantee:*** The Contractor must guarantee that all Implementation and Start-up activities will be completed the first day of the month following a 90-day implementation period after the Office of the State Comptroller approves the Agreement (Implementation Date) so that Contractor can assume full operational responsibility for the MHSA Program on the designated date. For the purpose of this guarantee, the Contractor must, on the designated date, have in place and operational;

(a) A contracted Provider network that meets or exceeds the access standards set forth in Section IV.B.10 of this RFP;

(b) A fully operational Dedicated Call Center, including a Clinical Referral Line, providing all aspects of customer support and clinical services as set forth in Section IV.B.4 and Section IV.B.12 of this RFP. The Dedicated Call Center must be open and operational a minimum of thirty (30) days prior to Program Implementation Date to assist Enrollees with questions concerning Program transition;

(c) A claims processing system that processes claims in accordance with the MHSA Program's plan design and benefits, as set forth in Section IV.B.11 of this RFP;

(d) A claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the Department to correctly pay claims for eligible Enrollees consistent with MHSA Program benefit design and contractual obligations; and

(e) A fully-functioning, customized MHSA Program website available a minimum of thirty (30) days prior to the Program Implementation Date, with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section IV. B.4 of this RFP.

b. <u>Required Submission</u>

(1) Provide an implementation plan (via a detailed narrative, diagram, and timeline) that results in the implementation of the Dedicated Call Center and customized website a minimum of thirty (30) days prior to the Program Implementation Date and implementation of all other MHSA Program services by the Implementation Date, including but not limited to: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. For all tasks that require Department review and approval, a minimum review period of five (5) Business Days must be built into the implementation plan. Include key activities such as member and Provider communications, training of a Dedicated Call Center and Clinical Referral Line staff, report generation, network development, transition benefits, customized website design, eligibility feeds and claims testing.

(2) The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section B.3.a.(2) will be in place on the Implementation Date, with the exception of opening the Dedicated Call Center and completing work on the customized website each of which must be completed a minimum of thirty (30) days prior to the Implementation Date. The Offeror shall propose the forfeiture of a

percentage of the 2015 Administrative Fee (prorated on a daily basis) for each day that all Implementation and Start-Up requirements are not met.

The Standard Credit Amount for each day that all Implementation and Start-Up requirements for the MHSA Program are not met is a minimum of fifty percent (50%) of the 2015 Administrative Fee (prorated on a daily basis). However, Offerors may propose higher percentages.

The Offeror's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is _____ percent (%) of the 2015 Administrative Fee (prorated on a daily basis).

4. Customer Service

The MHSA Program requires that the Contractor provide quality customer service to Enrollees and Providers. The MHSA Program provides access to customer service representatives through The Empire Plan's consolidated toll-free number. Through this toll-free number members access MHSA Program representatives who respond to questions, complaints and inquiries regarding MHSA Program benefits, Network Providers, claim status etc., and, when a call involves a clinical matter, refer the caller to the Contractor's Clinical Referral Line. In 2013, the customer service line received 127,498 calls and the Clinical Referral Line received 90,423 calls for a total of 218,408 calls. The Offeror/Contractor is required to agree to customer service performance guarantees that reflect strong commitments to quality customer service. Exhibit II.I provides the number of members who have utilized the DCS customized MHSA Program website in 2013.

a. **Duties and Responsibilities**

The Contractor will be responsible for all customer support and services including, but not limited to:

(1) Providing Enrollees access to information on all MHSA benefits and services related to the MHSA Program through The Empire Plan consolidated toll-free number twenty-four (24) hours a Day, 365 Days a year;

(2) The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's medical carrier/third party administrator and is available to callers twenty-four (24) hours a Day, 365 Days a year. The Contractor must establish and maintain a transfer connection with AT&T (T-1 line), including a back-up system which will transfer calls to the Offeror's line at their Dedicated Call Center service site. The Contractor must sign a shared service agreement with The Empire Plan's medical carrier/third party administrator (currently UnitedHealthcare) and AT&T. Programming and scripting changes to The Empire Plan's consolidated phone line takes 4-6 weeks. In addition, the Contractor is also required to provide twenty-four (24) hours a Day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to call center service as required by this Section of the RFP;

(3) Maintaining a Dedicated Call Center for the MHSA Program located in the United States (preferably in New York State) that:

(a) Provides direct access to trained Clinicians who direct members to appropriate Network Providers, provide clinical MHSA information and, if requested by the caller, assist in scheduling appointments on behalf of the member, twenty-four (24) hours a Day, 365 Days a year;

(b) Provides access to fully trained customer service representatives and supervisors a minimum of thirty (30) days prior to the Implementation Date and through and including four (4) months after termination of the Agreement between the hours of 8:00AM to 5:00PM, Monday through Friday, except for Business Holidays; and

(c) Meets the Contractor's proposed call center telephone guarantees set forth in Section IV.B.4.b.(8) of this RFP.

(4) Customer service staff must use an integrated system to log and track all Enrollee calls. The system must create a record of the Enrollee contacting the call center, the call type, and all customer service actions and resolutions;

(5) Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries, including but not limited to: Transition of Care; MHSA Program benefits levels; status of pre-certification requests; eligibility and claim status; and be able to identify calls requiring transfer to a Clinician;

(6) Maintaining a designated backup customer service staff located in the United States with MHSA Program-specific training to handle any overflow when the Dedicated Call Center is unable to meet the Contractor's proposed customer service performance guarantees. This back-up system would also be utilized in the event the Dedicated Call Center becomes unavailable;

(7) Maintaining and timely updating a secure online Empire Plan specific customized website accessible by Enrollees a minimum of thirty (30) days prior to the Implementation Date, which is available twenty-four (24) hours a Day, 365 Days a year, except for regularly scheduled maintenance, which will provide, at a minimum access to information regarding: MHSA Program benefits: Network Provider locations; eligibility; Copayment information; pre-authorization information; claim status; and clinically-based educational material. The website may not contain any links to the Contractor's standard website used for other customers. The website Provider search may only contain Provider types that are covered under The Empire Plan. The Department shall be notified of all regularly scheduled maintenance at least one (1) Business Day prior to such maintenance being performed. The Contractor must establish a dedicated link to the customized website for the MHSA Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the MHSA Program. Links bringing a viewer back to the Department website must be provided. No other links are permitted without the written approval of the Department. Access to the online Network Provider locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the MHSA Program shall be borne solely by the Contractor. Also, the Contractor shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the

efficiencies of the customized website including development of an integrated Enrollee portal; and

(8) ***Call Center Telephone Guarantees*:** The Contractor must meet or exceed the following four (4) measures of service on the toll-free customer service telephone line:

(a) ***Call Center Availability*:** The MHSA Program's service level standard requires that the Contractor's telephone line will be operational and available to Enrollees, Dependents and providers at least ninety-nine and five-tenths percent *(*99.5%) of the Contractor's Call Center Hours. The call center availability shall be reported monthly and calculated annually;

(b) ***Call Center Telephone Response Time:*** The MHSA Program's service level standard requires that, at the least, ninety percent (90%) of the incoming calls to the Contractor's telephone line will be answered by a customer service representative within thirty (30) seconds. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a customer service representative or a Clinical Manager, if after hours. The call center telephone response time shall be reported weekly for the first month of the Agreement and then monthly for the remainder of the Agreement and calculated annually;

(c) ***Telephone Abandonment Rate:*** The MHSA Program's service level standard requires that the percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative or Clinical Manager, if after hours will not exceed three percent (3%). The telephone abandonment rate shall be reported weekly for the first month of the Agreement and then monthly for the remainder of the Agreement and calculated annually.

(d) ***Telephone Blockage Rate:*** The MHSA Program's service level standard requires that the Contractor guarantee that not more than zero percent (0%) of incoming calls to the Contractor's telephone line be blocked by a busy signal. The telephone blockage rate shall be reported weekly for the first month of the

Agreement and then monthly for the remainder of the Agreement and calculated annually.

b. <u>Required Submission</u>

(1) Confirm that you will provide Enrollees access to the Clinical Referral Line and MHSA Program information through a consolidated toll-free number 24 hours a day 365 Days a year, as described above.

(2) Confirm you will enter into a shared service agreement with The Empire Plan medical carrier/ third party administrator, or other party designated by the Department, and AT&T. Confirm you will provide 24 hours a day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability.

(3) Confirm you maintain a Dedicated Call Center for the MHSA Program located in the United States, employing a staff of Clinicians and a staff of fully trained customer service representatives (CSR's) and supervisors. Confirm that customer service representatives will be available, for the MHSA Program a minimum of thirty (30) days prior to the Implementation Date and through and including four (4) months after termination of the Agreement between the hours of 8:00AM to 5:00PM, Monday through Friday except for Business holidays. If additional hours are proposed, please state. Confirm that access to Clinical Managers through the Clinical Referral Line will be 24 hours a Day, 365 Days a year.

(4) Describe the information, resources and system capabilities that are available for the customer service representatives to address and resolve member inquiries. Include:

(a) Whether any Interactive Voice Response (IVR) system is proposed;

(b) A sample of the IVR script and a description of customizable options, if any, you propose for the MHSA Program;

(c) A description of the management reports and information available from the system including the key statistics you propose to report; and

(d) A description of the capabilities of your phone system to record calls, and track call types, reasons and resolutions;

(5) Describe the training that is provided to CSR and Clinical Referral Line staff before they go "live" on the phone with Enrollees. Include:

(a) A description of the internal reviews that are performed to ensure quality service is being provided to Enrollees;

(b) The first call resolution rate for the proposed Dedicated Call Center;

(c) The turnover rate for customer service and Clinical Referral Line employees;

(d) Ratio of management and supervisory staff to customer service representatives; and

(e) Proposed staffing levels including the logic used to arrive at the proposed staffing levels;

(6) Describe the back-up system for your primary telephone system which would be used in the event the primary telephone system fails, is unavailable or at maximum capacity. If a back-up system is needed, explain how, and in what order, calls from Enrollees will be handled. Confirm that back-up staff will have MHSA Program-specific training. Indicate the number of times the back-up system has been utilized over the past two (2) years. Confirm that calls will be handled exclusively by your Dedicated Call Center and that the back-up call center would only be used in case of system failure or call overflow;

(7) Describe the information and capabilities your website provides to members and describe the process you will utilize to develop it. Confirm that you will develop an Empire Plan specific customized website for the MHSA Program that will be complete a minimum of thirty (30) days prior to the Implementation Date. Also, confirm that the following information, at a minimum, will be available on the

website: MHSA Program benefits; Network Provider locations; eligibility; Copayment information Pre-authorization information; claim status and clinically-based educational material. Provide the URL of your main website and provide a dummy ID and password so that the Department may view the capabilities and user-friendliness of your website; and

(8) ***Call Center Telephone Guarantees*:** For each of the four (4) Call Center Telephone Guarantees above, the Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fees, for failure to meet the Offeror's proposed guarantee;

(a) ***Call Center Availability:*** *The Standard Credit Amount for each .01 to .50% below the standard of ninety-nine and five-tenths percent (99.5%) that the Offeror's telephone is not operational and available to Enrollees, Dependents and Providers during the Offeror's Call Center Hours, calculated on an annual basis, is $100,000 per year. However, Offerors may propose higher or lesser amounts.*

The Offeror's amount to be credited against the Administrative Fee for each .01 to .50% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) that the Offeror's telephone line is not operational and available to Enrollees, Dependents and Providers during the Offeror's Call Center Hours calculated on an annual basis is $___ per year.

(b) ***Call Center Telephone Response Time:*** *The Standard Credit Amount for each .01 to 1.0% below the standard of at the least ninety percent (90%) of incoming calls to the Offeror's telephone line that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, is $25,000 a year. However, Offerors may propose higher or lesser amounts.*

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, calculated on an annual basis, is $_____ per year;

(c) ***Telephone Abandonment Rate:*** *The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service or Clinical Referral Line representative in excess of the standard of three percent (3%), is $25,000 per year. However, Offerors may propose higher or lesser amounts.*

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service or Clinical Referral Line representative in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee), calculated on an annual basis, is $____ per year; and

(d) ***Telephone Blockage Rate:*** *The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of the standard of zero percent (0%), is $25,000 per year. However, Offerors may propose higher or lesser amounts.*

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line that is blocked by a busy signal, in excess of the standard of zero percent (0%) (or the Offeror's proposed guarantee), calculated on an annual basis, is $_____ per year.

5. Enrollee Communication Support

The Department regularly provides information regarding MHSA Program benefits to Enrollees through various publications, the Department's website and attendance at various meetings. The Contractor will be required to assist the Department with the creation, review and presentation of MHSA Program materials that will enhance an Enrollee's understanding of MHSA Program benefits. Please see Exhibit II.J for a summary of MHSA Program presentations that took place in the past twelve (12) month period.

a. **Duties and Responsibilities**

(1) All Enrollee communications developed by the Contractor are subject to the Department's review and prior written approval, including but not limited to any regular standardized direct communication with Enrollees or their MHSA Providers in connection with covered benefits or the processing of Enrollee claims, either through mail, e-mail, fax or telephone. The Department, in its sole discretion, reserves the right to require any customization it deems necessary.

(2) The Contractor will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:

(a) Developing language describing the MHSA Program for inclusion in the NYSHIP General Information Book and Empire Plan SPD, subject to the Department's review and approval;

(b) Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing MHSA Program benefit features and/or highlighting trends in MHSA utilization;

(c) Timely reviewing and commenting on proposed MHSA Program communication material developed by the Department;

(d) Developing timely and accurate Summaries of Benefits Coverage (SBC), which will be consolidated with coverage information from other Program carriers/third party administrators for The Empire Plan, Student Employee Health Plan and Excelsior Plan. The Department will post the SBCs on NYSHIP Online. Upon Enrollee request, the Contractor must direct Enrollees to the NYSHIP Online website to view the SBC or distribute a copy of the SBC to the Enrollee within the federally required time period; and

(e) Paying a portion of the Shared Communication Expenses, the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees. The Empire Plan's medical carrier/third party administrator will bill the Contractor on a quarterly basis for a portion of the Programs' Shared

Communication Expenses. The Department agrees that these costs are not included in Administrative Fees and that the Contractor will be reimbursed for these costs as set forth in Article XIII of Section VII of the RFP.

(3) Upon request, subject to the approval of the Department, on an "as needed" basis, the Contractor agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. **The Contractor agrees that the costs associated with these services are included in the Offeror's Administrative Fee.**

(4) The Contractor must work with the Department to develop appropriate customized forms and letters for the MHSA Program, including but not limited to claim forms, pre-certification forms and letters, explanation of benefits, appeal letters, etc. All such communications must be approved by the Department prior to their distribution.

b. <u>Required Submission</u>

(1) Please describe the organizational resources currently dedicated to Enrollee communications including any changes that would occur if you were awarded the resultant Agreement. Please detail the process that will be utilized to develop Enrollee communications including, but not limited to the role of the Offeror's legal department. Provide several examples of the MHSA Program communications you have developed for Enrollees. Confirm your understanding that all MHSA Program communications developed by the Offeror are subject to the Department's final approval.

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

(3) Confirm that the Offeror will pay the allocated portion of Shared Communication Expenses covering the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees , and will bill the

MHSA Program for reimbursement in accordance with Article XIII of the Agreement.

(4) Confirm that staff will attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States at the request of the Department. Describe the experience and qualifications of staff that will attend these events.

(5) Confirm you will work with the Department to develop appropriate customized forms and letters for the MHSA Program, including but not limited to claim forms, pre-certification forms and letters, explanation of benefits and appeal letters. Provide samples of customized communications you have produced for other large clients.

(6) Confirm that upon Enrollee request, the Offeror will distribute SBCs to Enrollees in a timely manner.

6. Enrollment Management

The MHSA Program requires the Contractor to ensure the timely addition of enrollment data as well as cancellation of benefits in accordance with the Program's eligibility rules. The Department utilizes a web-based enrollment system for the administration of Employee benefits known as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Enrollees and Dependents. Enrollment information is set forth in Exhibits II.A through II.A.4.

Note: The enrollment counts depicted in these exhibits may vary slightly due to timing differences in exhibit generation.

When a person enrolls in The Empire Plan, Excelsior Plan, or SEHP, the Department's card contractor issues an Employee Benefit Card. An Enrollee with individual coverage will receive one card containing the Enrollee's 9-digit alternate identification number and name. An Enrollee with family coverage will receive two cards containing the Enrollee's alternate identification number and name, as well as Dependents' names. This universal card is used

by Enrollees and Dependents for all components of The Empire Plan. An example of The Empire Plan Employee Benefit Card is provided in Exhibit II.E. An example of the Excelsior Plan Employee Benefit Card is provided in Exhibit II.E.3. The Department will not accept an alternative approach to ID cards. It is the responsibility of the Offeror to ensure that the Provider Network accepts The Empire Plan Employee Benefit Card as evidence of coverage and is capable of submitting claims when presented with The Empire Plan Employee Benefit Card. These cards include The Empire Plan consolidated toll free number that providers may use to contact the MHSA Program if they need claim submission assistance. The Contractor should not expect any modification of the current identification card as part of implementation.

The SEHP Employee Benefit Card displays the Enrollee's 9-digit alternate identification number and name and the expiration date of coverage. The SEHP Employee Benefit Cards are issued annually by a Department contractor and have an expiration date of August 31st of each year. An example of this card is provided in Exhibit II.E.2.

a. <u>Duties and Responsibilities</u>

(1) The selected Contractor will be responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department. These enrollment files shall be used by the Contractor to process claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files.

(2) The Contractor must provide enrollment management services including but not limited to:

(a) ***Initial Testing:***

(i) Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department during the MHSA Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)), fixed length ASCII text file, or a custom file format. The determination will be made by the Department;

(ii) Testing to determine if the initial enrollment file and daily enrollment transaction files loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The Contractor shall submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of the MHSA Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department;

(b) Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Contractor shall, on a daily basis, manually review and load any transactions which did not process correctly from the daily ANSI x.12 834 standard 005010x220 file by reviewing the correct enrollment date maintained in the NYBEAS. The Contractor shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the Department, the Contractor shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Contractor in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a twenty-four (24) hour period. The Contractor must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 standard 005010x220 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit II.H. The Contractor must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

(c) Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee data contained in the enrollment file. Any transfers of enrollment data within the Contractor's system or to external parties must be completed via a secured process;

(d) Providing a back-up system or have a process in place where, if enrollment information is unavailable, Enrollees can obtain Clinical Referral Line services without interruption;

(e) Cooperating fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement;

(f) Maintaining a read-only connection to the NYBEAS enrollment system for the purpose of providing the Contractor's staff with access to current MHSA Program enrollment information. Contractor's staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 8:00 am to 5:00 pm, with the exception of NYS holidays as indicated on the Department's website; and

(g) Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Contractor must make payment for covered benefits or reimbursement directly to such party. The Contractor will be required to store this information in its system(s) so that any claim payments or any other plan communication distributed by the Contractor, including access to information on the Contractor's website would go to the person designated in the QMCSO;

b. Required Submission

(1) Describe your testing plan to ensure that the initial enrollment load and daily enrollment transition files for the MHSA Program are accurately updated to your system and that they interface correctly with your claims system.

(a) What quality controls are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system?

(b) How does your system identify transactions that will not load into your enrollment system? What exceptions will cause enrollment transactions to fail to load into your enrollment system? What steps are taken to resolve the exceptions, and what is the turnaround time for the exception records to be added to your enrollment file?

(2) Describe your system capabilities for retrieving and maintaining enrollment information within twenty-four (24) hours of its release by the Department as well as:

(a) How your system maintains a history of enrollment transactions and how long enrollment history is kept online. Is there a limit to the quantity of history transactions that can be kept on-line?

(b) How your system handles retroactive changes and corrections to enrollment data;

(c) Detail how your enrollment system captures the information necessary to produce the reports entitled “Claims and Credits Paid by Agency” and “Quarterly Participating Agency Claims” required in the Reporting Section of this RFP;

(d) Confirm your enrollment and claims processing system has the capacity to administer a social security number, Employee identification number and an alternate identification number assigned by the Department. Does your system have any special requirements to accommodate these three identification numbers? Explain how Dependents are linked to the Enrollee in the enrollment system and claims processing system; and

(e) Confirm you will, on a daily basis, manually review and load any transactions which did not process correctly from the daily 834 file.

(3) Describe how your enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

(4) Describe the back-up system, process or policy that will be used to ensure that Enrollees receive Clinical Referral Line services in the event that enrollment information is not available.

(5) Confirm you will cooperate fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement.

(6) Confirm that you will maintain a read-only connection to the NYBEAS enrollment system, and that Offeror's staff will be available to access enrollment information through NYBEAS during the required hours, Monday through Friday, from 8:00 AM to 5:00 PM with the exception of NYS holidays.

(7) Describe your ability to meet the administrative requirements for National Medical Support Orders and dependents covered by a Qualified Medical Child Support Order (QMCSO), including storing this information in your system so that information about the Dependent is only released to the individual named in the QMCSO.

(8) ***Enrollment Management Guarantee:*** The MHSA Program service level standard requires that one hundred percent (100%) of all MHSA Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the standard.

The Standard Credit Amount for each 24 hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the MHSA Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $5,000. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each twenty-four (24) hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the MHSA Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system, is $_____ .

7. Reporting

Reporting must be structured to provide assurances that member, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with Network Providers and the terms of the Agreement. The Contractor may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames.

In order to fulfill its obligations to enrolled members and ensure contract compliance, the MHSA Program requires that the Contractor provide detailed claims data on a monthly basis, as well as specific summary reports concerning the administration of the MHSA Program in an accurate manner.

All electronic files received by the Department are first validated for compliance with the specified file structure. Files that fail to adhere to this structure are rejected in their entirety.

a. Duties and Responsibilities

The Contractor will be responsible for accurate reporting services including, but not limited to:

(1) Ensuring that all financial reports including claim reports are generated from amounts billed to the MHSA Program, and reconcile to amounts reported in the quarterly and annual financial experience reports;

(2) Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, monitoring and analysis of the MHSA Program. These reports must tie to the amounts billed to the MHSA Program. The final format of reports is subject to the Department review and approval;

(3) Supplying reports in paper format and/or in an electronic format including but not limited to Microsoft, Access, Excel and/or Word as determined by the Department. The reports include, but are not limited to, reports and data files listed in Article XV "Reports and Claim Files" section of this Agreement;

(4) Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by the Department. Information required in the Ad Hoc Reports may include but is not limited to providing;

(a) Forecasting and trend analysis data
(b) Utilization data
(c) Utilization review savings
(d) Benefit design modeling analysis
(e) Reports to meet clinical program review needs
(f) Reports segregating claims experience for specific populations
(g) Reports to monitor Agreement compliance

(5) Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to authorized Department representatives;

(6) ***Management Reports and Claim File Guarantees****:* The Contractor must provide accurate management reports and claim files as specified in Section IV.B.7.a.(7)

of this RFP will be delivered to the Department no later than their respective due dates inclusive of the date of receipt; and

(7) ***Supplying reports in paper format and/or in a***n electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Annual, Quarterly and Monthly Reports and include the time frames for submittal to the Department:

Annual Reports

Annual Financial Experience Report: The Contractor must submit an annual experience report of the MHSA Program's charges and credits no later than seventy-five (75) Days after the end of each Calendar Year. This statement must detail, at minimum, claims paid during the year, projected incurred claims not yet paid, administration costs Shared Communication Expenses, performance credits, audit credits, etc. Such detail must include all charges by the Contractor to the MHSA Program;

Annual Premium Renewal Report: The Contractor must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This report must detail all assumptions utilized to support recommended premium level necessary for the following Plan Year. The report must include, but not be limited to: paid claim amounts; projected incurred claims; trend; Administrative Fees and changes in enrollment;

Annual Summary Reporting: The Contractor must prepare and present to the Department, GOER, Division of Budget and NYS employee unions an annual report that details MHSA Program performance and industry trends. This presentation shall include, at a minimum, comparisons of the MHSA Program to book of business statistics, and other similar plan statistics. Clinical, financial and service issues are to be comprehensively addressed. The annual presentation and report are due each May after the end of each complete Calendar Year with the exception of the May following termination of the Agreement for which only the report is due; and

Annual Report of Claims and Credits Paid by Agency: The Contractor must submit a report with summary level claims and credits paid by agency. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. The report is due thirty (30) Days after the end of the Calendar Year;

Quarterly Reports

Quarterly Financial Summary Reports: The Contractor must submit quarterly financial reports which present the MHSA Program's experience for the most recent quarter (based on a Calendar Year) and the experience from the beginning of the Calendar Year to the end of the quarter being reported. The quarterly reports must also include projections of;

- annual financial performance;
- assessment of MHSA Program costs;
- incurred claim triangles;
- audit recoveries;
- settlement and litigation recoveries;
- administrative expenses;
- trend statistics; and
- such other information as the Department deems necessary.

The reports are due on a quarterly basis, fifteen (15) Days after the end of the reporting period;

Quarterly Performance Guarantee Report: The Contractor must submit quarterly the MHSA Program's Performance Guarantee report that details the Contractor's compliance with all of the Contractor's proposed Performance Guarantees. The report should include the areas of: Implementation, customer service (telephone availability, telephone response time, abandonment rate and blockage rate); enrollment management, reporting, network composition, provider access, provider credentialing, financial and non financial accuracy, turnaround time for processing network and non-network claims, non-network Clinical Referral Line,

emergency care Clinical Referral Line, urgent care Clinical Referral Line outpatient and inpatient Utilization Review; and inpatient and outpatient appeals. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;

Quarterly Utilization Report*:* The Contractor must submit quarterly the MHSA Program's Quarterly Utilization Report that details MHSA care utilization by type of service for both network and non-network authorizations, by type of treatment (inpatient, outpatient, ALOC) Applied Behavioral Analysis, collective bargaining unit, age of the member, type of Dependent, and any other category as requested by the Department. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. The report is due forty-five (45) Days after the end of the quarter;

Quarterly Network Access: The Contractor must submit a measurement of the Network access (using **Exhibit I.Y.3**) based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter;

Quarterly Coordination of Benefit Report: The Contractor must submit a report that details the amount received as a result of coordinating benefits with other health plans including Medicare. The Contractor's report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other health plans or Medicare. The final format of this report will be determined by the Department in consultation with the Contractor. The report is due thirty (30) Days after the end of the quarter;

Quarterly Participating Agency Claims: The Contractor must submit a quarterly report that presents summary level claim information by Participating Agency. The Contractor shall submit this report using the data elements specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the quarter;

Quarterly Website Analytics Report: The Contractor must submit a quarterly report that provides comprehensive performance information for the Contractor's customized MHSA Program website as set forth in Section IV.B.4.a.(7) of this RFP. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the layout and design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter;

Quarterly Provider Audit Report: The Contractor must submit a quarterly audit report to the Department that summarizes audits planned, initiated, in-progress and completed, as well as audit findings, recoveries and any other enforcement action by the Contractor. The report is due thirty (30) Days after the end of the quarters.

Monthly Reports

Monthly Report of Paid Claims by Month of Incurral: The Contractor must submit a monthly report that provides summarized paid claims by month of incurral. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

MHSA Program Customer Service Monthly Reports: Each month, the Contractor must submit a customer service report that measures the Contractor's customer service performance including call center availability, call center telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and claims turnaround. The final format of these reports will be determined by the Department in consultation with the Contractor. The reports are due thirty (30) Days after the end of the month. For the first month of the Agreement, these reports will be due on a weekly basis; and

Detailed Claim File Data: The Contractor must transmit to the Department and/or its Decision Support System (DSS) Vendor, currently Truven Health Analytics, a computerized file via secure transfer, containing detailed claim records using data

elements acceptable to the Department to support the claims processed each reporting period and invoiced to the Department. The Department requires that all claims processed and/or adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the MHSA Program. The Contractor must securely forward the required claims data to the Department and/or its DSS vendor within fifteen (15) Days after the end of each month and submit a summarized report by month utilizing a format acceptable to the Department. The Contractor must continue to send the Detailed Claim File each month after termination of the Agreement until such time as the Department and Contractor mutually agree that the claims run-out is complete.

b. <u>Required Submission</u>

(1) The Offeror must submit examples of the financial and utilization reports that have been listed without a specified format in the reporting requirements above as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the MHSA Program. Provide an overview of your reporting capabilities with the value you believe this will bring to the MHSA Program.

(2) Confirm that you will provide reports in the specified format (paper and/or electronic Microsoft Access, Excel, Word), as determined by the Department;

(3) Confirm that you will provide direct, secure access to your claims system and any online and web-based reporting tools to the Department's offices. Include a copy of the data sharing agreement you propose for Department staff to execute in order to obtain systems access;

(4) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.

(5) ***Management Reports and Claim File Guarantees*:** The MHSA Program's service level standard requires that accurate management reports and claims files

will be delivered to the Department and Decision Support Vendor, as applicable, no later than their respective due dates. For the management reports and claim files listed in Section IV.B.7.a. (7) of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this standard.

The Standard Credit Amount for each management report or claim file that is not received by its respective due date is $1,000 per report per each Business Day. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the MHSA Program's Administrative Fee for each management report or claim file that is not received by its respective due date, is $_____ per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department and Decision Support Vendor, as applicable, inclusive of the date of receipt.

8. Consulting

The Department requires the Contractor to be an expert in the MHSA industry, thus, the Department requires the Contractor to provide the Department with up-to-date developments in the MHSA industry and may be requested by the Department to provide advice and recommendations related to such developments. The Department expects the Contractor to proactively provide advice and recommendations that are related to the clinical quality and cost management of the MHSA Program. Such recommendations must, at a minimum include preliminary analysis of financial, therapeutic and Enrollee impact of proposed and contemplated benefit design and State/Federal legislative changes.

a. Duties and Responsibilities

The Contractor will be responsible for providing advice and recommendations regarding the MHSA Program. Such responsibility shall include, but not be limited to:

(1) Informing the Department in a timely manner concerning such matters as cost containment strategies, technological improvements, Provider best practices and State/Federal legislation (e.g., Federal parity legislation, etc.) that may affect the MHSA Program. The Contractor must also make available to the Department one or more members of the clinical or account management team to discuss the implications of new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and

(2) Assisting the Department with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed MHSA Program modifications and contemplated benefit design changes on Enrollees.

In the event of a design change and should the Offeror request any change in compensation, any such change will be processed in accordance with Section V of this RFP.

b. <u>Required Submission</u>

(1) What resources do you utilize to ensure the MHSA Program is kept abreast of the latest developments in the MHSA field? How do you propose to communicate trends, pending legislation and industry information to the MHSA Program?

(2) Please confirm you will assist the Department with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State.

9. <u>Transition and Termination of Agreement</u>

The Contractor shall ensure that upon termination of the Agreement, any transition to another organization be done in a way that provides Enrollees with uninterrupted access

to their MHSA benefits and associated customer services through the final termination of the Agreement . This includes, but is not limited to: ensuring Enrollees can continue to receive services from Network Providers; the processing of all claims; verification of enrollment; providing sufficient staffing to ensure members continue to receive good customer service and clinical management service even after the termination date of the Agreement; and developing a strategy for addressing the treatment needs of those members in treatment with Providers that are not in the successor contractor's network. It is also imperative that the MHSA Program continue to have dialogue with key personnel of the Contractor's dedicated account team, maintain access to online systems and receive data/reports and other information regarding the MHSA Program after the termination date of the Agreement. In addition, the Contractor and the successor contractor shall fully cooperate with the Department to create and carry-out a Transition Plan in a timely manner.

a. <u>Duties and Responsibilities</u>

(1) The Contractor must commit to fully cooperate with the successor contractor to ensure the timely, receipt of all information necessary to transfer administration of the MHSA Program;

(2) The Contractor must, within one hundred twenty (120) Days prior to the end of the Agreement, or within forty-five (45) Days of notification of termination, if the Agreement is terminated prior to the end of its term, submit to the Department for approval a detailed written Transition Plan, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

(a) Transition of MHSA Program data, including but not limited to a minimum of one year of historical Enrollee claim data including providers' telephone numbers, names, addresses, zip codes licensure types and tax identification numbers, detailed Coordination of Benefits data, High Volume Provider data, report formats, pre-certification/prior authorization approved - through dates, disability determination approved-through dates, any exceptions that have been entered into the adjudication system on behalf of the Enrollee such as a Single Case Agreement, as well as other data the successor Contractor may

request and the Department approves during implementation of the MHSA Program in the format acceptable to the Department. The transition of data files should include but not be limited to the following;

(i) Providing a test file to the successor contractor at least seventy-five (75) days in advance of the Implementation Date to allow the successor contractor to address any potential formatting issues;

(ii) Providing one or more pre-production files at least eight (8) weeks prior to implementation that contains the above MHSA Program data as specified by the Department and working in conjunction with the successor contractor;

(iii) Providing a second production file four (4) weeks prior to implementation; and

(iv) Providing a third production file to the successor contractor by the close of business three (3) days after the Agreement terminates;

(3) Within fifteen (15) Business Days from receipt of the Contractor's proposed Transition Plan, the Department shall either approve the Transition Plan or notify the Contractor, in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department;

(4) Within fifteen (15) Business Days from the Contractor's receipt of the required changes, the Contractor shall incorporate said changes into the Transition Plan and submit such revised Transition Plan to the Department;

(5) The Contractor shall be responsible for transitioning the MHSA Program in accordance with the approved Transition Plan;

(6) To ensure that the transition to a successor contractor provides Enrollees with uninterrupted access to MHSA benefits and associated customer services, and to enable the Department to effectively manage the Agreement, the Contractor must

provide the following obligations and deliverables to the MHSA Program through the final financial settlement of the Agreement, including but not limited to:

(a) Provide all Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims and, manual submit claims including but not limited to: Medicaid; out-of-network claims; foreign claims;Coordination of Benefit claims; Medicare; reimbursing late filed claims if warranted, repaying or recovering monies on behalf of the MHSA Program for Medicare claims, retaining NYBEAS access and continuing to provide updates on pending litigation and settlements that the Contractor or the NYS Attorney General's Office has/may file on behalf of the MHSA Program. In addition, the Contractor must continue to provide the Department access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Department notifies the Contractor that access may be ended at an earlier date;

(b) Complete all reports required in Section IV.B.7.a.(7) of this RFP;

(c) Provide the MHSA Program with sufficient staffing in order to address State audit requests and reports in a timely manner;

(d) Agree to fully cooperate with all Department and/or OSC audits consistent with the requirements of Article XXI of the Agreement and Appendices A and B;

(e) Perform timely reviews and responses to audit findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements set forth in Article XXI "Audit Authority", Section VII, Contract Provisions and Appendices A and B; and

(f) Remit reimbursement due the MHSA Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XXI,

"Audit Authority" and Article – "Payments/credits) to/from the Contractor" of Section VII, Contract Provisions and Appendices A and B.

(7) The Contractor must receive and apply enrollment updates, keep Dedicated Call Center phone lines open with adequate staffing to provide customer service at the same levels provided prior to termination of the Agreement, adjust phone scripts, and transfer calls to the successor contractor's lines during the transition period;

(8) The Contractor must work cooperatively with the successor contractor and the Department to develop an approach to ensure a smooth transition for members who must change Providers to maintain the network level of benefits;

(9) The Contractor must prepare and communicate with the successor Contractor , on a case by case basis, a plan to extend and manage the care of high risk Enrollees who are nearing the end of a course of treatment beyond the transition period;

(10) The Contractor must continue to clinically manage and pay for Covered Services for Enrollees determined to be Totally Disabled on the last day of the Contract, for ninety (90) Days or until the disability ends, whichever occurs first;

(11) The Contractor must continue to manage and pay for Covered Services of Enrollees who are confined as inpatient and in Residential Treatment Centers on or before the Agreement termination date until the earlier of the step down of care or midnight on the 90th day subsequent to the Agreement termination date;

(12) The Contractor must forward to the successor contractor on a weekly basis all mis-directed authorization requests received by the Contractor after the Agreement termination date for a period of ninety (90) days.

(13) The Contractor must agree that, if the Contractor does not meet all the Transition Plan requirements in the time frame stated above, the Contractor **will permanently forfeit 100%** of all Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.

b. Required Submission

(1) Confirm that the Contractor will commit to fully cooperate with the successor contractor to ensure the timely, receipt of all information necessary to transfer administration of the MHSA Program.

(2) Provide an outline of the key elements and tasks that would be included in your Transition Plan to ensure that all the required duties and responsibilities are completed if you were the incumbent contractor transferring duties to a successor contractor. Include a brief explanation on how you would accomplish this with the successor contractor.

(3) Please detail the level of customer service and clinical management that you will provide after the termination date of the Agreement resulting from this RFP.

(4) Confirm the Contractor will, if the Contractor does not meet all the Transition Plan requirements in the timeframes stated above, **permanently forfeit 100%** of all Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.

10. Network Management

Empire Plan Enrollees reside throughout the United States and are guaranteed access to Network Providers under the design of the MHSA Program. The Contractor must have a comprehensive, nationwide Provider Network in place to allow adequate access for Enrollees to obtain all MHSA Covered Services through the Provider Network. Through this RFP, the MHSA Program is seeking a Provider Network that delivers cost-effective, clinically appropriate MHSA Covered Services, while meeting the minimum guarantees for Network Provider access. The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed Masters Level Clinicians (MLC) (in NYS, the MLC must qualify for the "R" designation issued by the State Education Department; elsewhere they must have the highest licensure offered in the state for a MLC), Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts,

Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis). Programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) must be included in the MHSA Provider Network.

Provider Network

The current MHSA Program includes a nationwide Provider Network through which Enrollees can obtain all covered MHSA Program services. The Offeror must propose and the Contractor must provide a MHSA Provider Network that meets or exceeds the MHSA Program's minimum access guarantees at the time of proposal submission that is credentialed and contracted for participation in the MHSA Program's Provider Network commencing on the Implementation Date. The Contractor may choose to enter into MHSA Program-specific Provider contracts that are contingent on award and/or utilize existing Provider agreements that can be made applicable to the MHSA Program to meet the MHSA Program's requirement that the Contractor have executed contracts with all the Network Providers included in the Contractor's proposed provider Network File upon the submission date of their Proposal.

a. Duties and Responsibilities

(1) The Contractor must maintain a credentialed and contracted MHSA Provider Network that meets or exceeds the MHSA Program's minimum access standards (or the Contractor's proposed access standards, if greater) throughout the term of the Agreement.

(2) The MHSA Program requires that the Contractor have available to Enrollees on the Implementation Date its proposed MHSA Provider Network in accordance with the requirements set forth in Section IV.B.3.a.(2)(a) guaranteeing effective implementation of their proposed MHSA Provider Network.

(3) The Contractor shall offer participation in its MHSA Provider Network to any Provider who meets the Contractor's credentialing criteria if the Provider is a high volume provider or upon the Department's request where such inclusion is deemed necessary

by the Department to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees.

(4) In developing its proposed MHSA Provider Network, the Contractor is expected to use its best efforts to substantially maintain the composition of Network Providers included in the MHSA Program's current Provider Network. The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed Masters Level Clinician (MLC) (in NYS, MLCs must qualify for the "R" designation issued by the State Education Department; elsewhere, they must have the highest licensure offered in the state for a MLC), Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts, Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis). Programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) must be included in the MHSA Provider Network. The MHSA Provider Network must include Providers throughout New York State and in areas with high concentrations of active and/or retired employees living outside of New York State such that the network access guarantees established by the terms of the Agreement are fully satisfied;

(5) ***Network Composition Guarantee:*** The Contractor must guarantee that throughout the five-year term of the Agreement and optional eleven (11) month extension period, if exercised at the sole discretion of the Department, that at least ninety percent (90%) of the Providers in each of the Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinicianwho qualifies for the "R" designation in NYS or in other states a Masters Level Clinician with highest licensure, Certified Behavior Analyst Provider,

Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner-Other Prescriber, listed on **Exhibit I.Y.2**; will be maintained. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee. This standard shall be measured annually.

(6) ***Network Provider Access Guarantee:*** The Contractor must guarantee that effective the first day of the month following 90 day implementation period after OSC approves the Contract, and throughout the term of the Agreement:

(a) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Facility within five (5) miles;

(b) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Facility within fifteen (15) miles;

(c) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Facility within forty (40) miles;

(d) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Practitioner within three (3) miles;

(e) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Practitioner within fifteen (15) miles; and,

(f) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Practitioner within forty (40) miles.

Note: In calculating whether the Offeror meets the minimum access guarantees, all Enrollees must be counted; no enrollee may be excluded even if a Provider is not located within the minimum access area.

Offerors should propose a guarantee for each of the three (3) areas (urban, suburban and rural) for each of the following two (2) Provider types: Network Facility (Inpatient, ALOC and Outpatient Clinic Group for Mental Health and Substance Abuse combined) and Network Practitioner types (Psychiatrist; Psychologist;

Masters Level Clinican combined) for a total of six (6) separate guarantees. These guarantees are based on the distance, in miles, from a MHSA Program Enrollee's home address to the nearest MHSA Provider Network Provider location.

Urban, suburban and rural are based on US Census Department classifications, as determined by GeoAccess. Offerors may guarantee better access than the minimums, but the guarantee must follow the same structure as the above minimum (i.e., access guarantees for each two Provider groups for each of the six (6) Provider type/area combinations based on the entire MHSA Program population).

(7) ***Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee:*** The Contractor must propose a guarantee for access to Network Certified Behavioral Analysts and Applied Behavioral Analysis Facilities that will be effective the first day of the month following 90 day implementation period after OSC approves the Contract, and throughout the term of the Agreement:

b. <u>Required Submission</u>

(1) Propose access guarantees for the MHSA Program's Provider Network (excluding all Certified Behavior Analysts, Applied Behavior Analysis Agencies, Mental Health & Substance Abuse Practitioners – Other Prescribers,) that meet or exceed the minimum set forth above. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated above.

% of Enrollees with Access to Network Facilities	Enrollee Location	Access Guarantee – 1 Network Facility at least within
___%	Urban	___miles
___%	Suburban	___miles
___%	Rural	___miles

% of Enrollees with Access to Network Practitioners	Enrollee Location	Access Guarantee – 1 Network Practitioner at least within
___%	Urban	___miles
___%	Suburban	___miles
___%	Rural	___miles

(2) Understanding that Applied Behavioral Analysis is often provided in a home setting and it is most applicable to young children, confirm which of the sixty-two (62) counties within the State of New York are served by Network Certified Behavioral Analysts and Applied Behavioral Analysis Agencies.

(3) Complete **Exhibit I.Y.4**, entitled "Comparison of MHSA Program Providers and the Offeror's Proposed Provider Network." Identify whether each of the MHSA Program's Providers will or will not participate in the Offeror's proposed Provider Network in accordance with the instructions provided in **Exhibit I.Y.4**. The file containing the MHSA Program's Providers can be obtained by meeting the requirements specified in Section III.G of this RFP.

(4) Please confirm that if selected, you will provide updated **Exhibits I.Y.2, I.Y.3** and **I.Y.4** thirty (30) days prior to the Implementation Date confirming that the Offeror's proposed Provider Network will be implemented as required on the first day of the month following a 90 day implementation period after OSC approves the Contract. If necessary, the selected Offeror shall submit a second file affirmatively identifying any deviations from the proposed Provider Network along with a detailed explanation for all deviations.

(5) Describe the types of Providers, inpatient facilities and Alternative Levels Of Care (ALOC) included in your proposed Provider Network. Include a listing of programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) which are included in the Provider Network. Provide a listing of Comprehensive Care Centers for Eating Disorders and continuum of care

providers (as established by Article 27-j of the NYS Public Health law) that are included in the Provider Network.

(6) For the Master Level Clinician category, provide a chart listing the licensure types that you include in your network in each State and indicate which of those licensure types the Offeror considers to be the highest licensure type in each State.

(7) Explain how you determine the highest licensure type in each State.

(8) Describe the approaches you would use to solicit additional Providers to enhance your proposed Provider Network for Facilities, OASAS Programs and Practitioners or to fulfill a request to add a specific Provider.

(9) Describe the criteria the Offeror will use to determine Providers to recruit into the Network to allow Enrollees to continue successful therapy plans with current Network Providers that are not in the Offeror's Networkor who are in an underserved area).

(10) Describe your strategy for maintaining the MHSA Program's Network throughout the term of the Agreement resulting from the RFP.

(11) How do you monitor whether Network Providers are accepting new patients into their practices? Do your proposed access standards take into account Provider availability? If yes, how?

(12) ***Network Composition Guarantee:*** The MHSA Program's service level standard requires that at the least ninety percent (90%) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician (MLC) who qualifies for the"R" designation in NYS or a MLC with highest licensure in other states, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber), listed on Exhibit I.Y.2; will be maintained throughout the five-year term of the Agreement and optional

eleven (11) month extension. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee.

The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the guarantee.

The Standard Credit Amount for each .01 to 1.0% below the MHSA Program's service level standard requiring that at least ninety-percent (90%) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician (MLC) who qualifies for the "R" designation in NYS or a MLC with highest licensure in other states, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber) listed on ***Exhibit I.Y.2*** *will be maintained is $25,000 per year. However, Offerors may propose higher or lesser amounts.*

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician who qualifies for the "R" designation in NYS or MLC with highest licensure level in other states, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber) listed on **Exhibit I.Y.2** as reported quarterly and calculated on an annual basis is $_____. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee.

(13) ***Network Provider Access Guarantees:*** You must guarantee that throughout the term of the Agreement resulting from this RFP, Enrollees living in urban, suburban and rural areas will have access, as proposed by the Offeror, to a Network Provider. The Offeror must propose an access guarantee that meets or exceeds the minimum access guarantees set forth in the "Provider Network" Section of this RFP. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the guarantee.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) Access for Urban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Facility (*Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined)* Access-for Urban Areas Guarantee, is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) Access for Suburban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Facility (*Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined)* Access-for Suburban Areas Guarantee, is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) Access for Rural Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Facility (*Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined)* Access-for Rural Areas Guarantee, is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Network Practitioner (Psychiatrist, Psychologist and Master's Level Clinician, combined) Access for Urban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Practitioner *(Psychiatrist, Psychologist and Master's Level Clinician, combined)* Access-for Urban Areas Guarantee, is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Practitioner (Psychiatrist, Psychologist and Master's Level Clinician, combined) Access for Suburban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the

Network Practitioner *(Psychiatrist, Psychologist and Master's Level Clinician, combined)* Access-for Suburban Areas Guarantee is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Practitioner (Psychiatrist, Psychologist and Master's Level Clinician, combined) Access for Rural Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Practitioner *(Psychiatrist, Psychologist and Master's Level Clinician, combined*)Access-for Rural Areas Guarantee, is not met by the Offeror.

Measurement of compliance with each access guarantee will be based on a "snapshot" of the Provider Network taken on the last day of each quarter within the current Plan Year. The results must be provided in the format contained in **Exhibit I.Y.3**. The report is due thirty (30) Days after the end of each quarter.

(14) ***Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee:*** (The Offeror must quote a performance standard and amount to be credited against the Administrative Fee for access that is below the Offeror's proposed guarantee for any quarter in which the Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee is not met by the Offeror.)

Provider Credentialing

The Contractor must ensure that MHSA Network Providers meet the licensing standards required by the state in which they operate. MHSA Network Providers are also required to meet the credentialing criteria established by the Contractor. These criteria should be designed to ensure quality MHSA care.

a. Duties and Responsibilities

(1) The Contractor must assure its MHSA Provider Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

(2) The Contractor must establish credentialing criteria for Network Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the MHSA Provider Network, including, but not limited to, years of experience, level of education/certification, licensure, quality of care, practice patterns, malpractice insurance coverage, hours of operation and availability of appointments.

(3) The Contractor must credential MHSA Network Providers in a timely manner and shall have an effective process by which to confirm MHSA Network Providers continuing compliance with credentialing standards.

(4) The Contractor must maintain a Provider Relations staff presence within New York State.

(5) The Contractor must maintain credentialing records and make them available for review by the Department upon request.

(6) ***Provider Credentialing Guarantee:*** The Contractor must guarantee that within sixty (60) Days of receipt of a completed MHSA Provider application to join the Program's network, the review, including credentialing, will be completed and the Provider notified of the determination.

b. Required Submission

(1) Confirm that you will utilize a credentialing verification organization or establish credentialing criteria for Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the Network, including, but not limited to, years of experience, level of education/certification, licensure, quality of care, practice patterns, malpractice insurance coverage, hours of operation and availability of appointments.

(2) Describe the Offeror's process to ensure that Network Providers meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information used by your organization to verify this information?

(3) Describe your approach for credentialing Network Providers.

(a) Specify if you utilize an external credentialing verification organization. When was this process last completed? What is your process for confirming continuing compliance with credentialing standards? How often do you conduct a complete review?

(b) What steps do you take between credentialing periods to ensure that Network Providers that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Provider Network as soon as possible? What steps, if any, do you take to advise members when a Provider has been removed from the Provider network? Under what circumstance would you notify the Department of the removal of a Network Provider?

(4) How does Provider Relations staff keep abreast of Provider practices, attitudes, and concerns in New York State and other areas? Do you have Provider Relations staff that is located in NYS? How do you support a strong information infrastructure for your Network Providers?

(5) How do you help your Network Providers achieve patient-centered care? How do you help Network Providers improve their diagnosis and assessment abilities to ensure that the care they provide is based upon the best available scientific knowledge? How do you ensure that your Network Providers collaborate with other clinicians to ensure an appropriate exchange of Enrollee information and coordination of care?

(6) Confirm that you will maintain credentialing records and make them available for review by the Department upon request.

(7) ***Provider Credentialing Guarantee:*** The MHSA Program's service level standard requires that within sixty (60) Days of receipt of a completed Provider application to join the MHSA Program's Network, the review, including credentialing, will be completed and the Practitioner, ALOC Program or Facility notified of the determination. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The Standard Credit Amount for each Provider application to join the MHSA Program's Network where the review, including credentialing, and notification of the determination to the Provider is not completed within sixty (60) Days is $1,500. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $_____for each Provider application to join the MHSA Program's Network where the review, including credentialing, and notification of the determination to the Provider is not completed within sixty (60) Days (or the Offeror's proposed guarantee).

Provider Contracting

Contracts with Providers must be written to utilize the MHSA Program's market strength to obtain competitive reimbursement rates with high quality Providers while also ensuring MHSA Program access guarantees are met. Contracting staff should keep abreast of current market conditions and have the wherewithal to adjust contracts with Providers to reflect the best interests of the MHSA Program. The Contractor must ensure that all Network Providers contractually agree and comply with the MHSA Program's requirements and benefit design. Contracts must be consistent with and support proposed access guarantees to ensure long-term stability of the Provider network. The Contactor may choose to enter into MHSA Program-specific Provider contracts that are contingent on award and/or utilize existing Provider agreements that can be made applicable to the MHSA Program to meet the MHSA Program's requirement that the Contractor have executed contracts with all the Network Providers included in the Contractor's Proposed Provider Network File upon the submission date of its proposal.

a. Duties and Responsibilities

The Contractor will be responsible for providing Provider contracting services including but not limited to:

(1) Negotiating pricing arrangements that utilize the MHSA Program's size to optimize the Provider fee schedule;

(2) Ensuring that all MHSA Network Providers contractually agree to and comply with all of the MHSA Program's requirements and benefit design specifications;

(3) Ensuring that MHSA Network Providers accept as payment-in-full, the Contractor's contractual reimbursement for all claims for covered services, subject to the applicable MHSA Program Copayments;

(4) Notifying the Department in writing within one (1) Business Day of any substantial change to the number, composition or terms of the Provider contracts utilized by the MHSA Program;

(5) Negotiating Single Case Agreements with Non-Network Providers on a case-by-case basis when the Contractor determines that it is clinically appropriate or to address guaranteed access issues;

b. Required Submission

(1) Explain your approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements you have with each type of Provider (e.g., per diems, case rates, hourly rates, all inclusive per diems covering Facility and Practitioner fees, etc.).

(2) Confirm that your agreements with Network Providers require their compliance with all the MHSA Program's requirements and benefit design specifications. Provide a copy of the Offeror's proposed Provider contract for both Facilities and Practitioners.

(3) Confirm that Network Providers accept as payment-in-full, the Contractor's contractual reimbursement for all claims for covered services, subject to the applicable MHSA Program Copayments.

(4) Confirm that you will, without delay, notify the Department in writing of any substantial changes to the number, composition or terms of Provider contracts utilized by the MHSA Program.

(5) Complete the following chart listing reasons for voluntary Provider Network terminations:

Facilities/ALOCs/Practitioners	2013	2012	2011
Voluntary Terminations:			
Dissatisfaction with fees			
Disagreement with clinical decision			
Dissatisfaction with administrative process or paperwork			
Dissatisfaction with contractual terms			
Other (describe)			
Total Voluntary terminations			
Number of Network Providers on December 31st			
Voluntary terminations as a Percent of Network			

(6) Describe the circumstances under which the Offeror will negotiate a single case agreement with a Non-Network Provider. Estimate the frequency with which you would expect to authorize network level benefits for non-network inpatient and outpatient services received under the MHSA Program.

Provider Audit and Quality Assurance

The Contractor must support a high quality and cost-effective MHSA Program. The protection of MHSA Program assets must be a top priority of the Contractor. The Contractor must have a strong audit presence throughout its organization. The Contractor shall be responsible for the oversight and audit of Providers that provide MHSA services to MHSA Program Enrollees.

The Contractor must support and encourage quality MHSA care through the following audit and quality assurance duties and responsibilities:

a. <u>Duties and Responsibilities</u>

(1) The Contractor must have a staffed and trained audit unit employing a comprehensive Provider audit program that includes but is not limited to:

(a) Conducting routine and targeted on-site audits of Network Providers. Providers that deviate significantly from normal patterns in terms of cost, CPT coding or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the Department and/or OSC, or when information is received by the Contractor that indicates a pattern of conduct by a Provider that is not consistent with the MHSA Program's design and objectives. Any modifications to the proposed audit program must receive written prior approval by the State;

(b) Providing reports to the Department detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The Contractor must inform the Department in writing of any allegation or other indication of potential fraud and/or abuse identified within seven (7) Business Days of receipt of such allegations or identification of such potential fraud and/or abuse. The Department must be fully informed of all fraud and/or abuse investigations impacting the MHSA Program upon commencement, regardless of whether the individual fraud and/or abuse investigation has a material financial impact to the State;

(c) Maintaining the capability and contractual right of the Contractor to effectively audit the MHSA Program's Provider Network, including the use of statistical sampling audit techniques and the extrapolation of errors;

(d) Remitting 100% of Provider and Enrollee audit recoveries to the Department as applicable within thirty (30) Days of receipt consistent with the process specified in Article XIV, "Payments/ (credits) to/from the Contractor," of the Agreement resulting from this RFP; and

(e) Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Providers and/or Enrollees.

(2) The Contractor must conduct a comprehensive quality assurance program which includes, but is not limited to:

(a) Monitoring the quality of care provided by Network Providers;

(b) Monitoring technical competency and customer service skills of Network Provider staff;

(c) Network Provider profiling;

(d) Peer review procedures;

(e) Outcome and Quality Measurement analysis; and

(f) Maintaining an ongoing training and education program that will be offered to Network Providers.

b. <u>Required Submission</u>

(1) Describe the Provider audit program you would conduct for the MHSA Program including a description of the criteria you use to select Providers for audit and a description of the policy that you follow when a Provider audit detects possible fraudulent activity by the Provider or an Enrollee. Include all types of audits performed and offered by your organization.

(2) Describe the corrective action and the monitoring that takes place when you find that a Provider is billing incorrectly or otherwise acting against the interests of your clients. Please indicate whether you have a fraud and abuse unit within your

organization and its role in the Provider audit program. In the extreme case of potentially illegal activity, what procedures do you have in place to address illegal or criminal activities by the Provider?

(3) Provide a copy of the audit language and fraud and abuse language that is contained in your standard contract(s) for Network Providers.

(4) Confirm that the Offeror will remit 100% of Provider and Enrollee audit recoveries to the Department within thirty (30) Days of receipt consistent with the process specified in Article XIV, "Payments/ (credits) to/from the Contractor" and Appendix B of Section VII.

(5) Describe the Offeror's proposed auditing tools and performance measures for identifying fraud and abuse by Network Providers and/or Enrollees.

(6) Describe the Offeror's ongoing quality assurance procedures forNetwork Practitioners. With respect to Network Practitioners, do you:

(a) Share practice pattern with the respective Network Practitioners?
(b) Validate patient satisfaction?

(7) Describe the Offeror's ongoing quality assurance procedures for Network Facilities including inpatient, ALOC and other healthcare Facilities. With respect to Network Facilities do you:

(a) Require that treatment protocols be used?
(b) Investigate whether changes to quality controls are made after adverse outcomes?
(c) Monitor readmission rates after inpatient discharge?

Value Based Initiatives

The Offeror will play a key role in promoting and enhancing the value-based services under the Program.

a. Duties and Requirements

(1) The Contractor must establish a tiered MHSA Provider Network and/or incentives including but not limited to financial, administrative and continuing professional education to promote value-based MHSA Services and enhance Provider performance and clinical outcomes.

b. Required Submission

(1) Describe the tiering criteria and/or incentives you propose for the MHSA Program to promote value-based MHSA services.

(2) Describe any experience you currently have with emerging alternative care delivery models (e.g. Accountable Care Organizations – ACOs).

(a) Are you currently working with any Medicare or other ACOs? What are your goals and objectives for working with these groups?

(b) Provide an overview of the general ACO structure, including the breadth of the networks.

(c) What requirements do you have for working with these groups, such as size requirements, for credentialing; for monitoring their care and services; for measuring their quality; and for measuring and managing their cost and utilization?

(d) What are the lengths, start dates, and end dates of your existing ACO contracts?

(e) Do you use different reimbursement models with these groups? Do not include any cost information in the technical proposal.

(f) List all methods of payment utilized for your various ACO relationships.

(g) Describe steps you have taken to further integrate care, such as behavioral health, reducing readmissions and preventing unnecessary emergency room visits.

(h) How do you monitor and measure the ongoing care, quality results, cost results, and outcomes provided by these organizations?

(i) What performance guarantees are offered?

(j) What are your plans for adding ACO delivery in the future?

(k) Describe important outcomes you have achieved as a result of ACOs with which you have been involved. This might include improved health, reduced utilization of expensive services, improved member experience, and reduced costs.

(l) What have you learned from initiatives that have already been implemented, and how has this program evolved from these learnings?

(3) Do you ever incorporate pay-for-performance, shared savings, risk pools, risk sharing, and/or withholds into the payment methodologies for Network Providers? If yes, describe.Describe any potential future plans to develop any of these care delivery models, including a timeline for implemenation.

(4) How do or will your alternative provider contract payment methodologies reflect quality performance (i.e., measured against standard)?

(5) To what extent, if any, would your MHSA Network Practitioners and Facilities be paid under an alternative (non-fee-for-service) provider payment structure

(a) For each year of the proposed contract effective period (2015 through 2019), what proportion of Network Providers will be or is expected to be paid exclusively on an alternative basis, and therefore, not paid according to the schedule shown on Exhibit V.A.2, andExhibit V.A.3?

(b) For each year of the proposed contract effective period (2015 through 2019), what proportion of Network Providers will or is expected to optionally be paid on an alternative basis, and therefore, the State can choose to pay these providers according to the schedule shown on Exhibit V.A.2 and Exhibit V.A.3?

(6) How do your Network Provider contract payments encourage adherence to clinical guidelines?

(7) How will the Network Provider payment structures result in savings to the State and its members, and ensure high quality of care is provided? Do not include cost information in the technical proposal.

(8) Does the Offeror utilize a predictive modeling tool to identify individuals at risk for mental health or substance abuse admissions or re-admissions? Explain how the tool is used, including the type of data utilized.

(9) Describe any emerging provider payment or delivery system pilot initiatives in which the State's population would eligible to participate.

11. <u>Claims Processing</u>

The Contractor must process all claims submitted under the MHSA Program according to the benefit design, including Network Provider claims and manual submit claims including but not limited to Medicaid, out-of-network claims, foreign claims, coordination of benefits and Medicare primary claims. The claims processing system shall include controls to identify questionable claims, prevent inappropriate payments, and ensure accurate reimbursement of claims in accordance with the benefit design MHSA Program provisions and negotiated, agreements with Providers. All MHSA Program provisions for benefit design and other utilization or clinical management programs must be adhered to for all claims.

To be covered, Enrollee Submitted Claims are required to be submitted to the Contractor no later than one hundred twenty (120) Days after the end of the Calendar Year in which the MHSA service was rendered, or one hundred twenty (120) Days after another plan processes the claim, unless it was not reasonably possible for the Enrollee to meet this deadline. The MHSA Program count of claims can be found in Exhibit II.G.3 of this RFP.

a. Duties and Responsibilities

(1) The Contractor must provide all aspects of claims processing. Such responsibility shall include but not be limited to:

(a) Maintaining a claims processing center located in the United States staffed by fully trained claims processors and supervisors;

(b) Verifying that the MHSA Program's benefit design has been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

(c) Accurate and timely processing of all claims submitted under the MHSA Program in accordance with all applicable laws as well as the benefit design applicable to the Enrollee including Copayment, Deductible, Coinsurance, annual maximums and Coinsurance Maximums, at the time the claim was incurred as specified to the Contractor by the Department;

(d) Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed by the Contractor and approved by the Department. The Contractor's system must ensure that payments are made only for authorized services;

(e) Maintaining claims histories for twenty-four (24) months online and archiving older claim histories for the balance of the calendar year in which they were made and for six (6) additional years thereafter, per Appendix A, with procedures to easily retrieve and load claim records;

(f) Maintaining the security of the claim files and ensuring HIPAA compliance;

(g) Adjusting all attributes of claim records processed in error crediting the MHSA Program for the amount of the claim processed in error;

(h) Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other MHSA Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's Decision Support System vendor at no additional cost. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department;

(i) Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

(j) Maintaining a claims processing system capable of integrating and enforcing the various clinical management and utilization review components of the MHSA Program including: pre-certification, prior authorization, concurrent review and benefit maximums;

(k) Developing and securely routing a MHSA daily claims file that reports claims incurred to date which have been applied to the Shared Accumulators between the Empire Plan Hospital Program, Medical Program and MHSA Program;

(l) Loading a daily claims file from the Empire Plan medical carrier/third party administrator and hospital carrier that reports Shared Accumulators;

(m) Participating in Medicare Crossover by entering into an agreement with the Empire Plan medical carrier /third party administrator to accept electronic claims data record files from the medical carrier/third party administrator for Empire Plan Enrollees that have Medicare as their primary coverage. Claims data will only be sent to the Contractor for possible Empire Plan mental health and substance abuse outpatient claims which also involve Medicare coverage. The claims information sent from the medical carrier/third party administrator will include claims filed with the Center for Medicare and Medicaid Services (CMS) that should be considered by the Contractor for secondary coverage. The Empire Plan medical carrier/third party administrator will sort out any

claims for benefits that are for mental health or substance abuse services and electronically forward the claim to the Contractor for consideration;

(n) Pursuing collection of up-to-date coordination of benefit information that is integrated into the claims processing system through a pursue and pay methodology and pursuing collection of any money due the MHSA Program from other payers or Enrollees who have primary MHSA coverage through another carrier;

(o) Analyzing and monitoring claim submissions to promptly identify errors, fraud and/or abuse and reporting to the State such information in a timely fashion in accordance with a State approved process. The Contractor will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Contractor error, without additional administrative charge to the MHSA Program. The Contractor shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, or due to fraud and abuse the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSA Program upon receipt; however, the Contractor is not responsible to credit amounts that are not recovered;

(p) Establishing a process through which Providers can verify eligibility of Enrollees and Dependents during Call Center Hours;

(q) Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. The Department agrees to reimburse the Contractor for claims processed under the Disabled Lives Benefit in accordance with Section Vof this RFP;

(r) Updating the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year;

(s) Mailing Explanation of Benefits to Enrollees for all Non-Network claims and any other claims for which the Enrollee cost share is in excess of the applicable Copayment for the MHSA service.. Explanation of Benefits for all MHSA services must be mailed to the Enrolleeupon request from the Contractor's Dedicated Call Center and available for download by register users of the Contractor's customized website. An annual Explanation of Benefits statement must be mailed to all Enrollees who have submitted claims within thirty (30) days of the end of each Plan Year; and

(t) Following the guidelines for escheatment as outlined on the NYS Office of the State Comptroller's website at: www.osc.state.ny.us/agencies/guide/MyWebHelp/Content/XIV/1.htm

(2) ***Financial Accuracy Guarantee:*** The Offeror must meet or exceed the following performance guarantee. The Program's service level standard requires that the MHSA Program's financial accuracy be maintained for a minimum of ninety-nine percent (99%) of all claims processed and paid each Plan year. Financial accuracy shall be measured by dividing the number of claims paid correctly by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%);

(3) ***Non-Financial Accuracy Guarantee:*** The Offeror must meet or exceed the following performance guarantee. The Program's service level standard requires that the Program's non-financial accuracy be maintained for a minimum of at least ninety-five percent (95%) of all claims processed and paid during the first contract year. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no errors by the total number of claims reviewed. Non-financial errors include, but are not limited to, entry of incorrect: patient name, date of service, Provider name, Provider Identification Number, and remark code,

as well as incorrect application of Deductibles and/or Coinsurance amounts to the Shared Accumulators. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%);

(4) ***Turnaround Time for Network Claims Adjudication Guarantee:*** The Offeror must meet or exceed the following performance guarantee. The MHSA Program's service level standard requires that, at the least, ninety-nine and five-tenths percent (99.5%) of Provider-submitted claims that are received electronically, or in the Offeror's designated post office box, and require no additional information in order to be properly adjudicated, will be turned around within eighteen (18) Business Days or twenty-four (24) Days of receipt. Turnaround time is measured from the date the Provider-submitted claim is received electronically or received in the Offeror's designated post office box to the date the Provider payment is received by the U.S. Post Office or Contractor's mailing agent; and

(5) ***Turnaround Time for Non-Network Claims Adjudication Guarantee:*** The Offeror must meet or exceed the following performance guarantee. The MHSA Program's service level standard requires that, at the least, ninety-nine and five-tenths percent (99.5%) of enrollee-submitted claims that are received in the Offeror's designated post office box, and require no additional information in order to be properly adjudicated, will be turned around within eighteen (18) Business Days or twenty-four (24) Days of receipt. Turnaround time is measured from the date the Enrollee-submitted claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent.

b. <u>Required Submission</u>

(1) Provide a flow chart and step-by-step description of your proposed claims processing methodology for adjudicating Non-Network and Network claims. Provide a description of the comprehensive edits you propose to ensure proper claim adjudication.

(2) Describe your claims processing system platform including any back-up system utilized. Describe your disaster recovery plan and how Enrollee disruption will be kept to a minimum during a system failure.

(3) Confirm that all aspects of claims processing are located only in the United States staffed by fully trained claims processors and supervisors.

(4) Describe the capabilities of your claims processing system to integrate each of the following required MHSA Program components:

(a) Prior authorization for inpatient services, psychological testing and electro-convulsive treatment, Applied Behavioral Analysis, and concurrent review of outpatient services;

(b) Eligibility verification;

(c) Customized edits for variations in benefits required various employee groups;

(d) Historic look up capability for claims and clinical information; and

(e) Multi-level cost sharing (Deductibles, Coinsurance, Copayments).

(5) Confirm that you will develop and securely route a daily claims file of Shared Accumulator amounts to the Empire Plan medical carrier/third party administrator and hospital carrier.

(6) Confirm that you will timely load the daily claims files of Shared Accumulator amounts received from the Empire Plan medical carrier/third party administrator and hospital carrier.

(7) Describe how any changes to the benefit design would be monitored, verified and tested for the MHSA Program, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the MHSA Program.

(8) Confirm that you participate in Medicare Crossover and provide details of your experience with Medicare Crossover.

(9) Describe your pursue and pay procedures for the collection, storage and investigation of coordination of benefit (COB) information other than Medicare. Explain how frequently COB information is updated.

(10) Explain how your claims processing system collects overpayments from your Provider network.

(11) Describe how your adjudication system feeds the reporting systems, including how claims backlogs are captured and reported.

(12) Confirm the Offeror will adjust all attributes of claim records processed in error and credit the MHSA Program for all costs associated with the claim processed in error.

(13) Describe how the Offeror will analyze and monitor claim submissions to promptly identify errors, fraud and abuse and report such information in a timely fashion to the State in accordance with a State approved process. Confirm the MHSA Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses. Confirm the Offeror will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Offeror error. In cases of overpayments resulting from errors only found to be the responsibility of the Department and for fraud and abuse, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Program upon receipt; however the Offeror, is not responsible to credit amounts that are not recovered.

(14) Confirm that the Offeror will update the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.

(15) Confirm that the Offeror will:

(a) mail Explanation of Benefits to Enrollees for all Non-Network claims and any other claims for which the Enrollee cost share is in excess of the applicable Copayment for the MHSA service;

(b) mail Explanation of Benefits for all MHSA services to the Enrollee upon request from the Contractor's Dedicated Call Center;

(c) make available Explanation of Benefits for all MHSA services for download by register users of the Contractor's customized website; and

(d) mail an annual Explanation of Benefits statement to all Enrollees who have submitted claims within thirty (30) days of the end of each Plan Year.

(16) Confirm the Offeror will follow the guidelines for escheatment as outlined on te NYS Office of the State Comptroller's website at: www.osc.state.ny.us/agencies/guide/MyWebHelp/Content/XIV/1.htm

(17) ***Financial Accuracy Guarantee:*** The MHSA Program's service level standard requires that the MHSA Program's financial accuracy be achieved for a minimum of ninety-nine percent (99%) of all claims processed and paid each year. Financial accuracy shall be measured by dividing the number of claims paid correctly by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine percent (99%) the Offeror's financial accuracy rate of all claims processed and paid each year is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) (or the

Offeror's proposed guarantee) that the MHSA Program's financial accuracy isn't achieved as reported quarterly and calculated on an annual basis is $_____.

(18) ***Non-Financial Accuracy Guarantee:*** The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-five percent (95 %) of all claims processed and paid during the first year of the Agreement. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no errors by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95 %) of the Offeror's non-financial accuracy rate of all claims processed and paid during the first contract year is $10,000 per year and for each .01 to 1.0% below ninety-seven percent (97 %) of the Offeror's non-financial accuracy rate of all claims processed and paid during years two through five of the Agreement is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (of the Offeror's proposed guarantee) of all claims processed and paid during the first contract year (ninety-seven percent (97%) (or the Offeror's proposed guarantee) in years two through five of the Agreement) that the MHSA Program's non-financial accuracy isn't achieved, as reported quarterly and calculated on an annual basis is $_____.

(19) ***Turnaround Time for Network Claims Adjudication Guarantee:*** The MHSA Program's service level standard requires that a minimum of ninety-nine and five-tenths percent (99.5%) of Provider-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror be turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received electronically or in the Offeror's designated post office box to the date the Provider payment is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine and five tenths percent (99.5%) of Provider-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received electronically or in the Offeror's designated post office box to the date the Provider payment is received by the mailing agent is $6,000 per each quarter. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five tenths percent (99.5%) (or the Offeror's proposed guarantee) of Provider-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror's designated post office box to the date the Provider payment is received by the mailing agent, as calculated on a quarterly basis, is $_____.

(20) ***Turnaround Time for Non-Network Claims Adjudication Guarantee:*** The MHSA Program's service level standard requires that a minimum of ninety-nine and five -tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror be turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror's designated

post office box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine and five-tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received electronically or in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent is $6,000 per each quarter. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) of enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent, as calculated on a quarterly basis, is $_____.

12. Clinical Management

Quality Clinical Management techniques help to control costs and ensure that Enrollees are receiving safe, effective treatment in the least restrictive setting. The Department requires the Contractor to provide clinical management that is MHSA parity compliant and located in the United States (preferably New York State) through three Utilization Review (UR) methods that are currently used for the medical component of the Empire Plan: Pre-certification, Concurrent review and Retrospective review. The Contractor must, at a minimum, provide UR as described further in this Section; however, Offerors are not prevented from offering other value oriented UR methods, provided that they are parity compliant and implementation is at the sole discretion of the Department.

Both inpatient hospital and MHSA admissions are subject to pre-certification, except in Emergencies, concurrent review and retrospective review.

Currently, under the MHSA Program, outpatient therapy visits may be reviewed prior to the 11th visit, but services may not be denied prior to the 11th visit. Based on the Final Regulations issued in November 2013, the Contractor will be responsible for proposing a Mental Health Parity and Addiction Equity Act (MHPAEA) compliant concurrent review process. Please refer to Exhibit II.L for a listing of how the Plan's medical carrier addresses the Non-Qualitative Treatment Limitations (NQTL) identified in the Final Regulations.

For the period January 1, 2013 through December 31, 2013 clinical management of the MHSA Program resulted in authorization of approximately 1,504,914 outpatient visits and the certification of nearly 6,232 inpatient and Alternate Level of Care admissions.

Pre-Certification of Care

The MHSA Program is designed to strongly encourage members to seek clinical referral prior to receiving MHSA services. This is accomplished through the use of a Clinical Referral Line (CRL). The CRL is staffed by clinicians who determine the medical appropriateness of MHSA care and direct members to the most appropriate Network Provider and level of care. Also, the pre-certification process includes procedures to determine medical necessity in advance of non-emergent inpatient admissions and for out-patient benefits for "recurrent therapy visits." "Recurrent Therapy Visits" are defined as treatment modalities or services that are dependent on the provider and patient interaction during the patient encounter as the major form of treatment, reoccur on a regular basis, and the total number of which are determined by a specific treatment plan based on the patient's clinical presentation. The current Contractor requires pre-certification for inpatient services, electroconvulsive therapy, psychological testing and Applied Behavioral Analysis.

a. Duties and Responsibilities

To ensure that the resources available to the MHSA Program are utilized for appropriate, medically necessary care, the Contractor is required to perform pre-certification of care which includes, at a minimum:

(1) Use of a voluntary Clinical Referral Line (CRL) located in the United States to evaluate Enrollees MHSA care needs and direct Enrollees to the most appropriate, cost-effective Providers and levels of care. The CRL must be structured to facilitate Clinicians' assessments of the callers, MHSA treatment needs and to provide suitable, timely referrals especially in emergency or urgent situations or for care that requires inpatient admission;

(2) Use of alternate procedures to precertify care when the Enrollee fails to call the CRL, as follows:

(a) When an Enrollee contacts a Network Provider directly for treatment without calling the CRL, the Contractor is ultimately responsible for ensuring that Enrollees receive the Network level of benefits and obtaining all necessary authorizations for treatments for Network outpatient services for "Recurrent Therapy Visits" and Network inpatient care, when an Enrollee contacts a Network Provider directly for treatment without calling the CRL;

(b) When an Enrollee contacts a Network Provider directly and the Network Provider is not the appropriate Provider to treat that Enrollee, the Contractor is responsible for ensuring that its Network Providers take responsibility for assisting the member in obtaining an appropriate referral; and

(c) When an Enrollee contacts a Non-Network Facility for treatment and the Contractor is notified in advance of the admission, the Contractor must provide the Enrollee or other HIPAA authorized representative of the Enrollee, with a written determination of medical necessity of care in advance of the inpatient admission, where feasible.

(3) Timely written notification to the Enrollee, or other HIPAA authorized representative of the Enrollee, of the potential financial consequence of remaining in a Non-Network Facility when the initial determination of medical necessity occurs;

(4) Preparing and sending communications to notify Enrollees and/or their Providers of the outcome of their pre-certification or prior authorization request and

notifying them in writing of the date through which MHSA Program services are approved;

(5) Promptly loading into the clinical management and/or claims processing system approved authorizations determined by the Contractor;

(6) Pre-certifying inpatient hospital admissions for alcohol detox, advising the facility to send the claim to the Hospital Program carrier/third party administrator and managing the Enrollee's care if transferred to rehab;

(7) Loading into the Contractor's clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received; and

(8) Clinical Referral Line Guarantees: The Contractor must meet or exceed the following three (3) performance guarantees as follows:

(a) ***Non-Network CRL Guarantee*****:** The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate MHSA Non-Network Provider or program within two (2) Business Days of the call in, a minimum of at least ninety percent (90%) of the cases as calculated annually.

(b) ***Emergency Care CRL Guarantee*****:** The Program's service level standard requires one hundred percent (100%) of Enrollees who call the CRL in need of life-threatening emergency care be referred to the nearest emergency room and be contacted within thirty (30) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non life-threatening emergency care shall be contacted by a Network Provider or re-contacted by the CRL clinician within thirty (30) minutes of the Enrollee's call to the CRL.

(c) ***Urgent Care CRL Guarantee:*** The Program's service level standard requires that, at the least, ninety-nine percent (99%) of Enrollees in need of urgent care be contacted by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the Enrollee's call to the CRL.

b. <u>Required Submission</u>

(1) Describe in detail how you propose to precertify services including;

(a) An overview of your Clinical Referral Line (CRL) and proposed precertification process as well as the criteria you use to identify the services that the Program should consider for pre-certification or prior authorization.

(b) Your proposed Clinical Referral Line staffing and qualifications of each level of clinician rendering authorizations and denials of care. Will clinical management staff be dedicated to the Program or will they service other customers as well?

(c) For the calendar year 2013, the percentage of Enrollees who called the CRL and who received a referral at a different level of care from the one initially requested.

(d) A description of your proposed precertification program including the type of services subject to precertification, staffing levels, the timeline for completion, clinical information requested, and the number of cases reviewed, approved and declined for a client similar to the Program (for the most recent calendar year). Provide a sample of any pre-certification forms used by the Offeror.

(e) A description of the steps that will be taken to meet the needs of Enrollees who require a Provider with subspecialties, especially those who require pediatric, adolescent or geriatric mental health services. How will you meet the ongoing therapy needs of those Enrollees whose first language is not English; who are hearing impaired; or who request a Provider with a particular ethnic background?

(f) An explanation of how urgent and emergency cases will be identified. Who on the Clinical Management team will be responsible for making such determinations? Describe the procedures that will be followed for ensuring that Enrollees receive appropriate care in urgent and emergency situations.

(g) An explanation of the procedures followed in cases where a Network Provider is contacted directly by an Enrollees seeking treatment.

(h) A description of the steps you will take to encourage the use of the toll-free number for the Clinical Referral Line to minimize self-referrals to Providers, as well as steps you will take to encourage the use of Network Providers; (i) Specify the location where Clinical Referral Line and other clinical management services for the Program will be provided. How will you ensure that CRL and clinical management staff are aware of MHSA community resources?

(i) The methods you use to measure the effectiveness and efficiency of the Clinical Referral Line and pre-certification services *(Do not include any reference to specific monetary savings).*

(j) How you will transition Enrollees with existing precertifications with a Network Provider into your system. Confirm you will load one or more files of pre-certifications and Prior Authorizations approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received.

(k) The guidelines you use to determine length of stay. Have these guidelines been peer reviewed?

(2) Confirm that you will prepare and send approved communications to notify Enrollees and/or their Providers of the outcome of their pre-certification and/or prior authorization request.

(3) Confirm that you will promptly load into the clinical management and/or claims processing system approved pre-certification and prior authorizations determined by the Offeror.

(4) Describe the steps the Contractor will take to pre-certify inpatient hospital admissions for alcohol detox and manage the patient's care if transferred to rehab.

(5) Confirm the Contractor will load into the clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received.

(6) ***Non-Network CRL Guarantee:*** The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate Non-Network Provider within two (2) Business Days of the call in at least ninety percent (90%) of cases. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.
The standard credit amount for each .01 to 1.0% below ninety percent (90%) of cases where Enrollees are referred to Non-Network Providers within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) of cases (or the Offeror's proposed guarantee) that an Enrollee is referred to a Non-Network Provider within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available reported quarterly and calculated on an annual basis, is $_____.

(7) ***Emergency CRL Guarantee:*** The MHSA Program's service level standard requires that when one hundred percent (100%) of Enrollees who call the CRL in need of life- threatening emergency care be referred to the nearest emergency room and be contacted within thirty (30) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non-life threatening emergency care shall be contacted within thirty (30) minutes by a Network Provider or the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below one hundred percent (100%) of Enrollees who call the CRL in need of emergency care will be contacted by either the Network Provider or the clinicians within 30 minutes of the Enrollee's call to the Clinical Referral Line, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of one hundred percent (100%) when an Enrollee requires emergency care, contact will be made by either the Network Provider or the Contractor's Clinical Managers within thirty (30) minutes of the Enrollee's call to the Clinical Referral Line reported quarterly and calculated on an annual basis, is $_____.

(8) ***Urgent Care CRL Guarantee:*** The MHSA Program's service level standard requires that at least ninety-nine percent (99%) of Enrollees who call the CRL in need of urgent care will be contacted by the Contractor to ensure that the Network Provider contacted the Enrollee within 48 hours of the call to the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine percent (99%) of cases when an Enrollee calls the CRL and requires urgent care, contact will be made by the Contractor to ensure that the Network Provider contacted the

Enrollee within forty-eight (48) hours of the call to the CRL, is $10,000per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) (or the Offeror's proposed guarantee) when an Enrollee requires urgent care, contact will be made by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL reported quarterly and calculated on an annual basis, is $_____.

Transition of Care

The MHSA Program offers a ninety (90) day Transition of Care benefit to allow Enrollees who are receiving MHSA services from a network Provider in the incumbent contractor's network to continue therapy at the network level of benefits. The Transition of Care benefit will apply to Enrollees who are currently receiving Outpatient or Alternate Level of Care services. Care for Enrollees who are Inpatient or in a Residential Treatment Center will continue to be managed by the incumbent contractor through the end of the ninety (90) day Transition of Care period or until step down of care, whichever occurs first.

a. Duties and Responsibilities

(1) The Contractor must identify members who are receiving MHSA services from the incumbent contractor's network from a Provider who is not in the Contractor's network. The Contractor must send these members a letter notifying them of the Transition of Care benefit 3-4 weeks prior to the Implementation Date.

(2) The Contractor must notify the corresponding Providers of the Transition of Care benefit, including how to submit claims so that the member is responsible only for the applicable Copayment.

b. Required Submission

(1) Confirm that the Offeror will identify appropriate members and mail Transition of Care letters to members and Providers in a timely manner.

(2) Confirm that the Offeror will process Transition of care benefits so that the member is responsible only for the applicable Copayment.

Concurrent Review

The MHSA Program's concurrent utilization review process assists the Provider in identifying MHSA care that is medically necessary and cost effective, without compromise to the quality of care.

a. Duties and Responsibilities

(1) To safeguard Enrollee health and ensure adherance with the MHSA Program's benefit design and requirements on mental health parity, the Contractor must administer a concurrent utilization review program in the United States which:

(a) Enforces the MHSA Program's benefit design features and ensures that Network Providers use the latest MHSA care protocols for Enrollees;

(b) Uses Clinicians to review Provider treatment plans which must detail, at a minimum: past clinical and treatment history; current symptoms, functional impairment; and DSM-IV diagnosis. The Contractor must require that the Network Provider's proposed treatment plan and goals be in writing for outpatient services. The Contractor must review the treatment plan for a member when the member's visits to the Network Provider exceed the expected duration of services for the Enrollee's clinical diagnosis;

(c) Is conducted in a manner which is parity compliant as required by the Mental Health Parity and Addiction Equity Act;

(d) Is performed by the Contractor for outpatient and inpatient care rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider;

(e) For inpatient admissions, recognizes when to utilize more appropriate and less restrictive levels of care, when medically appropriate. The Contractor must

have procedures to identify when transfer to an alternate inpatient or outpatient setting is appropriate and arrange such transfers;

(f) Establishes maximum time frames for inpatient review based upon the level of care provided, and a time frame that allows for discharge planning where the continued stay is not certified;

(g) Employs appropriately skilled clinicians to review treatment plans in a manner that does not disrupt or delay treatment; and

(h) Renders certification decisions on a timely basis and requires that Peer Advisors render non-certification decisions.

(2) For Enrollees admitted to Non-Network Facilities, the Contractor must have procedures to either arrange to transfer the Enrollee to a Network Facility as soon as medically appropriate, or manage the care as if it was a Network Facility, including negotiating discounts with the facility;

(3) The Contractor must perform appropriate discharge planning by identifying when discharge from an inpatient network setting is appropriate and by directing the Enrollee to appropriate outpatient network care following discharge, including scheduling the initial appointment. Discharge planning must include continual review of the progress of aftercare treatment with the Provider by clinical Manager, as follows:

(a) Clinical Managers must obtain and review, as part of the discharge plan, specifics that include, at a minimum: the name of the follow-up Provider; date and time of initial follow-up appointment; and the names of responsible family members; and

(b) Clinical Managers must assist Providers in locating aftercare services. The Contractor must maintain a database of local community resources to assist Providers in locating aftercare services or alternative care in their areas.

(4) The Contractor must provide intensive case management on a voluntary basis for complex cases or cases requiring long-term treatment. The Contractor must

cooperate with the Empire Plan hospital carrier and other Empire Plan carriers in cases of medical/mental health multiple diagnoses in accordance with Mixed Services Protocol (MSP) guidelines established by the Department. Under those MSP guidelines, in cases where there is both a medical and a psychiatric diagnosis, responsibility for case management is determined by the unit (medical or psychiatric) to which the admission is made and the specialty of the attending physician. When those MSP guidelines are insufficient to determine case management responsibility, the Empire Plan hospital carrier and the Contractor must come to an agreement using other factors such as the condition causing the person to remain hospitalized and the proposed treatment plan; the current MSP is presented in Exhibit II.M.

(5) The Contractor must use Clinical Managers or Peer Advisors to manage the care of members;

(6) The Contractor must measure and assess the effects of clinical management and utilization review processes and procedures on the quality of MHSA care and MHSA Program costs;

(7) ***Outpatient Treatment UR Guarantee:*** The Contactor must guarantee that at least ninety percent (90%) of outpatient treatment plans be reviewed and the Provider and Enrollee notified within twelve (12) Business Days of receipt of the report as reported quarterly and calculated on an annual basis; and

(8) ***Inpatient Treatment UR Guarantee:*** The Contractor must guarantee that at least ninety percent (90%) of requests for authorization of inpatient care be reviewed within twenty-four (24) hours from the receipt of the request and the Enrollee and Provider notified within one (1) Business Day of the determination as reported and calculated on an annual basis.

b. <u>Required Submission</u>

(1) Please detail the full scope of the concurrent UR program that you are proposing to utilize for the MHSA Program, including:

(a) The qualifications of the staff responsible for oversight of your concurrent UR program;

(b) Review of outpatient care;

(c) Review of inpatient care;

(d) Discharge planning and follow-care; and

(e) Intensive case management of high risk cases.

(2) Describe the software you will utilize to administer the concurrent UR program and any other technologies that will be used to apply UR.

(3) Completely describe the criteria used to establish medical necessity as defined by the MHSA Program and how medical necessity is determined.

(4) Explain which of the Offeror's staff (and their clinical licensure level) has the authority to deny payment for services rendered.

(5) Describe your utilization review process and confirm that it is parity compliant as required by MHPAEA.

(6) Describe the methods you utilize to measure MHSA Program effectiveness (*Do not include any reference to specific monetary savings).*

(7) Confirm that you will adhere to the Empire Plan Mixed Services Protocol.

(8) Will you be providing the Empire Plan with a dedicated Clinical team including the Medical Director and Clinician Referral Line staff? Please provide an organizational chart that indicates the titles and number of people associated with the Clinical team.

(9) ***Outpatient Treatment UR Guarantee:*** The MHSA Program's service level standard requires that at least ninety percent (90%) of outpatient treatment plans be reviewed and the Provider and Enrollee notified within twelve (12) Business

Day of receipt of the report, calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of outpatient treatment plans that the Offeror reviews and does not notify the Enrollee and Provider within twelve (12) Business Day of receipt of the report is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) of outpatient treatment plans not reviewed and the Enrollee and Provider notified within twelve (12) Business Day of receipt of the report as reported quarterly and calculated on an annual basis, is $_____.

(10) ***Inpatient Treatment UR Guarantee:*** The MHSA Program's service level standard requires that at least ninety percent (90%) of requests for authorization of inpatient care be reviewed and completed within twenty-four (24) hours from the receipt of the request and the Enrollee and Provider be notified within one (1) Business Day of the determination calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request the Enrollee and Provider notified within one (1) Business Day of the determination, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request and the

Enrollee and Provider notified within one (1) Business Day of the determination as reported quarterly and calculated on an annual basis, is $_____.

Disabled Dependent Determinations

During the term of the Agreement, the Contractor shall be responsible for making Disabled Dependent Determinations for dependents with a disability that is Mental Health and Substance Abuse related. Disabled dependents of NYSHIP enrollees are entitled to be covered under the Enrollee's family coverage beyond the normal age-out limits if those dependents are incapable of self support. For The Empire Plan, the medical program contractor determines disability status for those with physical disabilities and the mental health Contractor determines disabled status for mental health and substance abuse related disabilities. An Application for Coverage for your Disabled Dependent Child for Medical, Dental and/or Vision Coverage (form PS-451) , see Exhibit II.is completed by the Enrollee, the Dependent's Physician and, the Enrollee's employer and then evaluated by the Contractor to determine if the Dependent is disabled. All determinations are subject to re-review by the Contractors on a periodic basis. The following guidelines are used for all disabled Dependent reviews:

If improvement of the Dependent's condition is:

- "Expected," the case will be normally reviewed within six to eight months, unless the Contractor determines a need for a more frequent review.

- Possible," the case will be normally reviewed no sooner than three years, unless the Contractor determines a need for a more frequent review.

- "Not expected," the case will normally be reviewed no sooner than seven years, unless the Contractor determines a need for a more frequent review.

a. Duties and Responsibilities

(1) The Contractor must establish a process to perform reviews of the PS-451 form and all additional medical information for mental health and substance abuse-related dependent disabilities. The review must be completed in the United States

(preferably in New York State) and a clinical determination must be completed within ten (10) Business Days of receipt of a complete form.

(2) The Contractor must send a determination letter, approved in advance by the MHSA Program, to the Enrollee and to the Department advising of the determination within three (3) Business Days of the determination.

b. Required Submission

(1) Provide a description of your process when evaluating disabled Dependent status. Confirm that the Offeror will review the PS-451 form and all additional medical information required to make a clinical determination within ten (10) Business Days of receipt of a complete form.

(2) Confirm that the Offeror will send a letter to the Enrollee and to the Department advising of the determination within three (3) Business Days of the determination.

Appeal Process

When UR results in a decision to deny authorization or reduce the level of services authorized, and the denial is based on medically necessary, experimental or investigational treatment, members may appeal to the Contractor any utilization review decisions. The appeals committee shall make a determination within ten (10) Business Days of the receipt of the necessary medical records. The Contractor will comply with the utilization review process requirements and external appeal process found in Article 49 of NYS Insurance Law, as amended.

a. Duties and Responsibilities

The Contractor must:

(1) Perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer;

(2) Administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment, including:

(a) Developing a clinical appeal form and criteria for establishing medical necessity and experimental or investigational treatment;

(b) Reviewing clinical appeals for medical necessity and experimental or investigational treatment and preparing communications to notify Enrollees of the outcome of appeals; and

(c) Integrating the appeal decisions into the clinical management and claims processing systems.

(3) Establish two levels of internal clinical appeals as follows:

(a) A level 1 clinical appeal must be performed by an independent Peer Advisor; and

(b) A level 2 clinical appeal must be conducted by a panel of two board-certified psychiatrists and a Clinical Manager who work for the Contractor. Panel members must not have been involved in the previous determinations of the case.

(c) Clinical Appeals must be completed in a timely manner consistent with NYS and federal laws:

(i) For a second level clinical appeal of a post-service claim, within thirty (30) days of the member's request;

(ii) For a second level clinical appeal of a pre-service request for benefits, within fifteen (15) days of the member's request; and

(iii) For clinical appeals involving urgent situations, in no more than seventy-two (72) hours following receipt of the appeal.

(4) Oversee and enforce the MHSA Program's appeal processes including reporting the results of the administrative, clinical and external appeal processes for the MHSA Program to the Department in the format and frequency required in the "Reporting" section of this RFP;

(5) Respond to all External Appeals on behalf of the Department as requested by the New York State Department of Financial Services through a process that provides an opportunity for Enrollees and Dependents to appeal where denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service.

(6) ***Inpatient Appeal Guarantee:*** The Contractor must guarantee that at least ninety-five percent (95%) of level one appeals for inpatient care shall be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis; and

(7) ***Outpatient and Alternate Level of Care Appeal Guarantee:*** The Contractor must guarantee that at least ninety-five percent (95%) Outpatient Care and Alternative Levels of Care level one appeals shall be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.

b. Required Submission

(1) Confirm the Contractor will perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer.

(2) Confirm the Contractor will administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment.

(3) Describe in detail how you would administer the required appeal processes for the Program, including:

(a) Turnaround time;

(b) Qualifications of the staff that would conduct the reviews for administrative and level 1 and level 2 clinical appeals;

(c) Description of the criteria that would be used to determine whether the care is medically necessary or experimental and/or investigational;

(d) Do you currently administer an appeals process as described above for other MHSA Programs? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the MHSA Program (for the most recent calendar year); and

(e) How is the Enrollee's care handled during the appeal process?

(4) Confirm that you will interface with the New York State Department of Financial Services' External Appeals Process to provide an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service.

(5) ***Inpatient Appeal Guarantee:*** The MHSA Program's service level standard requires that at least ninety-five percent (95%) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of level one appeals for inpatient care that are not be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Offeror's proposed guarantee) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal as reported quarterly and calculated on an annual basis, is $_____.

(6) ***Outpatient and ALOC Appeal Guarantee***: The MHSA Program's service level standard requires that at least ninety-five percent (95%) of Outpatient Care and Alternative Levels of Care level one appeals must be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the

required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Offeror's proposed guarantee) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal, as reported quarterly and calculated on an annual basis is $_____.

13. Other Clinical Management Programs

a. Duties and Responsibilities

(1) The Contractor must provide voluntary opt-in programs for Depression Management, Eating Disorders and Attention Deficit Hyperactivity Disorder (ADHD). The cost of the Depression Management, Eating Disorder and ADHD Programs shall be included in the Administrative Fee. The programs must include:

(a) a method to identify members with depression, eating disorders and ADHD using screening tools, both on-line and by mail;

(b) methods to educate members about the symptoms, effects and treatment of depression, eating disorders and ADHD;

(c) accepting referrals to Network Providers;

(d) telephonic support, coordination with treating providers and referrals to community services; and

(e) a method to establish contact with Empire Plan primary care physicians, and other medical specialists likely to have patients that present with symptoms of depression, eating disorders and ADHD in order to educate medical Providers about the availability of the depression, eating disorder and ADHD programs.

(2) The Offeror may propose other voluntary opt-in programs which are available at no additional cost. The Department reserves the right to decide whether or not to participate in any program offered and the right to opt out of any program at any time.

b. <u>Required Submission</u>

(1) Describe the depression management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

(2) Describe the eating disorder management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

(3) Describe the ADHD management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

(4) Please describe any other voluntary clinical management or utilization review programs that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees.

(5) If you are proposing to receive a data feed from the Empire Plan's Prescription Drug Program to be used as a method to identify members with depression, eating disorders and ADHD, please include a copy of your Non-Disclosure Agreement you have executed with CaremarkPCS Health, LLC.

SECTION V: COST PROPOSAL REQUIREMENTS

A. Introduction

As described in this RFP, the Mental Health and Substance Abuse Program provides health benefits to covered members on a self-funded basis. The costs associated with the MHSA Program include Network Claims Costs, Non-Network Claim Costs, Administrative Fees, Shared Communication Expenses and Assessments made through State or federal legislation. Section V presents the Cost Proposal submission requirements as well as the requirements concerning the financial transactions and other cost/transparency related questions.

B. Cost Proposal components

The following present the Cost Proposal components, associated duties and responsibilities and the Cost Proposal submission requirements.

1. Network Claims

a. Duties and Responsibilities

1) In accordance with Section IV of the RFP, the Contractor must contract with Network Providers. The amount charged to the MHSA Program shall be the contracted Network Provider fee, less any applicable Copayment and after the coordination of benefits when the claim is processed as secondary coverage.
2) Claim Payments are to be made based on the requirements contained in Section IV and Articles 6.11.0 and 12.1.0 of Section VII of this RFP, including but not limited to each group's Copayment as reflected in Exhibit II.B; and Exhibit II.B2 of this RFP as well as the annual maximum for Applied Behavioral Analysis (ABA) services as reflected in the most current Plan Communication materials.
3) Throughout each Plan Year, the selected Contractor shall charge to the Program the incurred claims cost for Network services based on the amounts actually paid by the Contractor to Network Providers.

4) ***Network Pricing Guarantee:*** The Offeror must develop and propose a Guarantee Average Unit Cost (GAUC) for the Network Outpatient Services presented in Exhibit V.A.2 and the Network Inpatient/Alternative Level of Care (ALOC) Services presented in Exhibit V.A.3. The Contractor is required to guarantee that the Actual Average Unit Cost (AAUC) for each category shall not exceed the proposed GAUC.

   a) Based on incurred claims for each Plan Year that are paid as of June 30th of the following year, the Contractor shall calculate the AAUC for the Inpatient Services and Outpatient Services categories. Such Network Services shall include all services/days paid at the Network benefit level including services/days rendered by Non-Network Providers when the Contractor determines that it is appropriate for either access or clinical reasons. Network Services shall not include non-network services where the Contractor had no opportunity to direct the care or Transition of Care services. The calculation of the AAUC shall be equal to the amounts that would be paid by the Contractor to the Network Provider for Plan primary claims only and prior to the application of the Copayment and Bad Debt and Charity assessments.

   b) The Contractor acknowledges that the GAUC for the Inpatient Services set forth in Exhibit V.A.3 may incorporate the inpatient professional service component pertaining to global reimbursement arrangements. Amounts actually paid and reported to the Department for Inpatient Services will include the inpatient professional service component of global arrangements. Any adjustments in the calculation of the AAUC shall be at the sole discretion of the Department and subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.

c) If the AAUC for each category exceeds the GAUC, the Contractor shall forfeit a portion of the Administrative Fee for failure to meet this guarantee, as follows:

For each 1.0% the AAUC exceeds the Outpatient Services GAUC proposed in Exhibit V.A.2, the Contractor shall pay the Department a performance credit equal to 1.5% of the total Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charged to the MHSA Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Outpatient Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

For each 1.0% the AAUC exceeds the Inpatient and ALOC Services GAUC proposed in Exhibit V.A.3, the Contractor shall pay the Department a performance credit equal to 1.5% of the total Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charge to the MHSA Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Inpatient and ALOC Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

d) For the first Plan Year (2015), no change to the proposed GAUC will be allowed, except in the event of circumstances outside the control of the Contractor that may have a significant effect on cost, such as legislation or substantial enrollment risk profile fluctuations. Any proposed change made by the Contractor in the GAUCs for the 2015 Plan year shall be at the sole

discretion of the Department and subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.

e) For each Plan year after 2015, the Contractor may request in writing an increase in the GAUC. The annual increase shall not exceed the percentage increase in CPI-W for Medical Care, as reported by the Bureau of Labor Statistics for the month of July of the preceding calendar year. If the prior increase in the GAUC occurred more than 12 months prior to the effective date of the requested increase, the maximum increase shall not exceed the cumulative CPI-W observed since the implementation of the prior increase. Any increase in the GAUC requires written approval by the Department and amendment of the Agreement, upon documentation by the Contractor to the satisfaction of the Department, that such increase is required to maintain adequate Network access.

f) For purposes of both the development of the GAUC and AAUC, claims processed as secondary to the Plan shall be excluded from the calculations and network pricing guarantees. In addition, the GAUC and AAUC shall not include any fees or assessments set forth in Section V.B.3, V.B.4 and V.B.5 of this RFP

C. Required Submission

1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.1a. above, Section IV of the RFP and Section VII, Articles 6.10.0 and 12.1.0 of the RFP.

2) The Offeror must complete Exhibit V.A.2, Guaranteed Average Unit Cost of Outpatient Services, including ABA services, Exhibit V.A.3, Guaranteed Average Unit Cost of Inpatient Services and ALOC services by Revenue Code in accordance with the instructions contained in Exhibit V.A.1 of the RFP.

2. Non-Network Claims

a. Duties and Responsibilities

1) The Contractor will accurately process Non-Network claims and make payments directly to the Enrollee (or Approved Facility) in a timely manner.

2) The Contractor will process Non-Network claims, as follows:

a. For the Empire Plan and Excelsior Plan: using Reasonable and Customary charges based on the 90th percentile of charges for each service performed, as determined by Fair Health. Reasonable and Customary means the lowest of:

1. The actual charge for services; or
2. The usual charge for services by the Provider for the same or similar service; or
3. The usual charge for services of other Providers in the same or similar geographic area for the same or similar service.

b. For the Student Employee Health Plan: using the Network Provider allowed amount applicable for Downstate New York;

3) The claim payments are to be made based on the requirements contained in Section IV of the RFP, including but not limited to each group's Co-insurance and Deductible as reflected in Exhibit II.B; and Exhibit II.B.2 as well as the annual maximum for ABA services.

4) Where a Network Provider is not available because of clinical or access considerations, the Contractor must negotiate a Single Case Agreement with a Non-Network Provider in a manner consistent with what is typically allowed for a Network Provider in the same discipline for the same service. The Contractor must pay the claim and charge the MHSA Program as if the services were

incurred in-network and include these charges in the calculations of the annual AAUC.

5) The Contractor will update its database with Fair Health's Reasonable and Customary amounts in a timely manner, at a minimum of twice a year.

b. Required Submission

1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.2.a. above, Section IV of the RFP and Section VII, Article 12.2.0 of the RFP.

2) Does the Offeror establish a different allowed amount for Non-Network Provider charges based on licensure type or some other clinical criteria for the same CPT code? Please describe the Offeror's methodology in developing the allowed amount for each CPT code if it varies based on licensure type or some other clinical criteria.

3. Administrative Fee

The Administrative Fee is the fee quoted by the Offeror representing the charge to the MHSA Program to cover all of the administrative services provided by the Contractor, with the exception of Shared Communication Expenses. Do not include amounts for the Patient-Centered Outcomes Research Institute (PCORI) fee as that will be paid directly by the Plan.

a. Duties and Responsibilities

The Contractor is required to:

1) Be bound by its quoted Administrative Fee, as proposed in the Contractor's Cost Proposal for the entire term of the Agreement, unless amended in writing;

2) Manage all MHSA Program Enrollees based on the Contractor's Administrative Fee, as proposed by the Contractor in its Cost Proposal;

3) Implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 days of notice;

4) Implement all benefit designs as required by the Department with or without final resolution of any request for an Administrative Fee adjustment. Refusal to implement benefit design changes will constitute a material breach of the Agreement and the Department will seek compensation for all damages resulting;

5) Agree not to request a higher Administrative Fee, and the Department will not consider any increase to the Administrative Fee that is not based on a material change to the MHSA Program requiring the Contractor to incur additional costs. The determination of what constitutes a material change will be at the sole discretion of the Department;

6) Submit detailed documentation of additional administrative/clinical costs, over and above existing administrative/clinical costs, with any request for an increase in the Administrative Fee resulting from a material change in the benefit structure of the MHSA Program. The Department reserves the right to request and the Contractor agrees to provide any additional information and documentation the Department deems necessary to verify that the request for an increase to the Administrative Fee is warranted. The Department's decision to modify the Administrative Fee to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the Department, subject to the approval of a formal amendment to the Agreement by the New York State Attorney General and New York State Office of State Comptroller;

7) Agree that the Administrative Fee shall be calculated based on the number of covered MHSA Program Enrollees as reported by NYBEAS on the first Thursday of each month. The Department shall furnish to the Contractor a written statement for each month showing the number of Enrollee contracts then in force.

8) Claims incurred during the coverage period of the contract but processed/paid after the last day of coverage, as well as applicable Disabled Lives claims incurred after the last day of coverage of the agreement will be administered by the Contractor selected in response to this RFP. An Administrative Fee will not be payable/due beyond the date the last day of coverage; therefore, Offerors should take this into consideration in developing their proposed Administrative Fee.

b. Required Submission

1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.3.a. above.

2) The Offeror is required to provide the Offeror's Administrative Fee quote in Exhibit V.B.

4. Assessments

In accordance with the Health Care Reform Act of 1996, two assessments/surcharges are chargeable to applicable health plans, including the Empire Plan: 1) Graduate Medical Expense (GME) and 2) Bad Debt and Charity (BDC) Assessment. The GME component of the Empire Plan is assessed on the Hospital component of the Empire Plan and therefore not chargeable under the MHSA Program. The BDC is applicable to the MHSA Program.

In addition, other fees and assessments as stipulated by State or federal law may be applicable over the term of the Agreement resulting from this RFP. Such amounts shall be paid by the MHSA Program either through the Contractor or directly to the authorized agency after a determination is made by the Department in consultation with the Contractor regarding the applicability of each fee/assessment to the MHSA Program.

a. Duties and Responsibilities

1) The Contractor shall calculate the applicable BDC each month from the applicable paid claims and may charge the MHSA Program at the time this assessment is paid to the regulatory agency/intermediary by the Contractor.

2) The Contractor shall advise the Department of any new applicable assessments in a timely manner.

3) The Contractor shall bill the MHSA Program for any new assessments within thirty (30) days after the amounts are paid to the regulating entity.

b. Required Submission

1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities in Section V.B.4.a. above.

2) Disclose other applicable assessments, if any, including the amount and basis of the assessment, made by other states/federal government that are applicable to the MHSA Program. Advise whether these assessments can be paid by the Offeror on behalf of the MHSA Program or if they would be directly paid by the Department.

5. Shared Communication Expense

The cost of Empire Plan communication expenses, including Empire Plan reports, At-A-Glance summaries and general information books are allocated among the four Empire Plan Program components. The MHSA Program allocation of shared communication expenses was $532,000 in 2014 and $456,000 in 2013.

a. Duties and Responsibilities

1) The Contractor will pay the medical carrier/third party administrator on a quarterly basis an amount billed for Shared Communication Expenses. The Contractor will be notified prior to the beginning of each Plan Year the amount of Shared Communication Expenses that will be billed.

2) The Contractor shall seek reimbursement of the Shared Communications Expense from the Department by including the amount with the voucher for the payment of the next Administrative Fee to be paid.

b. Required Submission

1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities in Section V.B.5.a. above.

C. Payments/ (Credits) to/ from the Contractor

This Section presents information regarding the financial structure and timing of financial transactions related to the Agreement and the specific items Offerors must submit with their Cost Proposal and questions related to those requirements.

The following information is presented for use by Offerors in developing their Cost Proposal. As of January 2014, there were 233,912 individual contracts and 288,551 family contracts with Empire Plan Mental Health and Substance Abuse coverage. In addition to the Empire Plan contracts, there are 112 individual contracts and 105 family contracts with the Excelsior Plan and 4,837 individual contracts and 804 family contracts with the Student Employee Health Plan (SEHP) benefits. The contract totals include Empire Plan and Medicare primary enrollees. The enrollment mix and benefit characteristics are presented in Exhibit II.A through Exhibit II.A.4; Exhibit II.C; Exhibit II.C.2; and Exhibit II.D. of this RFP. However, the Department cannot guarantee that, during the term of the Agreement, the same enrollment mix and benefit characteristics as those set forth in Exhibit II.A through Exhibit II.A.4; Exhibit II.C; Exhibit II.C.2; and Exhibit II.D will exist.

a. Duties and Responsibilities

1) The Contractor will bill the Department periodically, as proposed, by the Contractor, after claims have been processed. The Department shall pay the Contractor by "wire transfer" within seven days have receiving a bill of the claims processed by the

Contractor. The Department may consider comparable alternatives to this approach during implementation.

2) The Plan will pay an Administrative Fee on a monthly basis within thirty (30) Days after receipt of an accurate invoice. Any credit amounts due from the Contractor to the Department for failure to meet the performance guarantees set forth in the Agreement shall be applied as a credit against the Administrative Fee charged to the MHSA Program. Alternatively, the Department may request and receive payment of any performance guarantee amount directly from the Contractor, as opposed to a credit against the Administrative Fee payable to the Contractor.

3) The Contractor will be billed the MHSA Program's portion of the Shared Communications Expense by the medical carrier/third party administrator in 2015 and each Plan Year thereafter in four (4) equal installments. The Contractor will pay the medical carrier/third party administrator the amount billed and may seek reimbursement from the MHSA Program. Subsequent years' amounts will be calculated by the Department and communicated to the Contractor during the annual rate renewal process. Upon receipt of each Shared Communications Expense bill, the Contractor may bill and the Plan will pay the Contractor an identical amount within thirty (30) Days.

4) Upon final audit determination by the Department, any audit liability amount assessed by the Department shall be paid/credited to the MHSA Programs within thirty (30) Days of the date of the Department's final determination, or within thirty (30) Days of receipt of recoveries related to fraud or abuse or Department errors.

5) The Contractor shall analyze and monitor claim submissions to promptly identify errors, fraud and/or abuse and report to the State such information in a timely fashion in accordance with a State approved process. The Contractor will credit the MHSA Program the amount of any overpayment made by the Contractor regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Contractor error. The Contractor shall

report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, or due to fraud and abuse, the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSA Program within thirty (30) Days of receipt of such recoveries; however, the Contractor is not responsible to credit amounts that are not recovered.

6) Litigation recoveries and settlements shall be paid/credited to the MHSA Program within fifteen (15) Days of receipt by the Contractor.

7) The Agreement resulting from this RFP is not subject to Article XI-A of NYS Finance Law. The Contractor agrees that MHSA Program Services provided under the Agreement shall continue in full force and effect for a minimum of at least thirty (30) days beyond the payment due dates as set forth in Article XV of the Agreement. If after the thirty-fifth (35) calendar day after receipt of an accurate invoice, as set forth in Article XV of the Agreement, the Contractor has not yet received payment from the State for said invoice, the Contractor may proceed under the Dispute Resolution provision in Appendix B and the Agreement shall remain in full force and effect until such final decision is made, unless the Parties can come to a mutual agreement, in which case, the Agreement shall also remain in full force and effect.

b. Required Submission

1) The Offeror is required to confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.C.a above.

2) Describe, in detail, the Offeror's proposed claim invoicing process, if any, including the timing for invoice preparation and supporting detail claims files at the end of each payment period, required payment timeframes and whether this structure is in effect for any other self-funded customers.

D. Cost/Transparency Related Questions

1. Network Provider Questions

a. Describe fully the nature of your reimbursement arrangements with Network Facilities. Distinguish between per diems, case rates, percent of charges versus other types of reimbursement arrangements. Also, distinguish between how your reimbursement arrangements are structured in NYS versus other states that have a high concentration of Empire Plan members, such as New Jersey and Florida.

b. Is there an escalator clause in your Network Facilities contracts to increase fees periodically or are any increases negotiated on a case by case basis? What is your Facility contracting cycle? When were the Network Facility fees last increased?

c. What is your current average Network Facility reimbursement as a percentage of covered charges for your book of business in NYS?

d. Is there an escalator clause in your Network Practitioner contracts to increase fees periodically or are any increases negotiated on a case by case basis? What is your Network Practitioners contracting cycle? When were Network Practitioner fees last increased?

e. What is your current average Network Practitioner reimbursement as: 1) a percentage of covered charges for your book of business in NYS; and 2) a percentage of the Fair Health 90th percentile reasonable and customary charges? Does Network Practitioner reimbursement vary based on licensure of some other credentialing criteria? If so, please describe methodology.

f. Some Offerors negotiate global reimbursement arrangements with Network Facilities to cover certain services such as professional inpatient visits that are normally billed by Practitioners. With respect to global reimbursement, please respond to the following:

   1) Do you reimburse Network Facilities globally for any Practitioners' services?

   2) If yes, describe completely the types of services that are globally reimbursed and the prevalence of such reimbursement both within and outside NYS. What

percent of your Network Facility claim dollars do you estimate are attributable to global reimbursement?

g. Confirm your willingness to provide the Department with information pertaining to specific fee arrangements made with Network Providers, if requested, both during the procurement process and throughout the term of the Agreement resulting from this RFP.

h. Is the Offeror's Proposed Network a standard Network or has it been specifically contracted to administer the Empire Plan MHSA Program? Are the proposed Network Provider fees included in this RFP response currently in place in NYS?

i. Does the Offeror have a single standard contract with Network Providers with consistent terms applied to all of the Offeror's clients? If no, please describe the basis and reasons for the differences.

j. In addition to negotiating agreements with Network Providers on behalf of clients, does the Offeror or any of its Affiliates or any Key Subcontractor's Affiliates have other business arrangements with Network Providers from which the Offeror or any of its Affiliates or any Key Subcontractor's Affiliates have derived revenues? If the Offeror and/or any of its Affiliates or any Key Subcontractor's Affiliates derive revenue or obtain other consideration or compensation from agreements with Network Providers, please identify the recipient(s) of such Network Provider revenue and explain the business relationship from which the revenue is derived. Please detail how the Offeror's business model ensures that these relationships do not create a real or perceived conflict with the clinical and financial interests of the MHSA Program.

k. Are the Offeror's Network fee schedules incorporated in formally adopted corporate policies and procedures? Please explain.

l. Does the Offeror maintain more than one Network fee schedule for purposes of reimbursing Network Providers? Or, does the Offeror have multiple reimbursement

agreements with individual Network Providers that are assigned and utilized based on client and/or different Offeror network products?

m. Describe how Alternative Level of Care (ALOC) services are billed by providers and reimbursed by the Offeror. Are these services billed on a per service or per diem basis?

n. Describe how outpatient alcohol treatment center services are billed by providers and reimbursed by the Offeror. Are these services billed on a per service or per diem basis?

2. Transparency of Financial Interests - Post Contract Award Requirements

The Contractor must agree to be open and forthright in all matters related to the clinical management and cost management of the MHSA Program. The State has strict standard audit provisions, subject to confidentiality requirements. Disclosure obligations include, but are not limited to:

a. Providing full access to all Key Subcontractor and Network Provider agreements related to the MHSA Program under strict confidentiality provisions;

b. Agreeing to the standard audit provisions set forth in Contract Provisions, Section VII of this RFP (see Article XXIII entitled “Audit Authority”), and Appendices A and B; and

c. Agreeing that the Contractor will disclose all agreements related to the provision, servicing and administration of MHSA Program services in effect during the term of the Agreement resulting from this RFP. This includes all relationships between or among the Contractor, and relevant third parties including but not limited to the Contractor, Providers and any other entity from which the Contractor, the Key Subcontractor, or Affiliate receives any form of compensation or any other consideration as a consequence of managing and reimbursing for services under the MHSA Program.

3. Transparency during the Procurement Process. Contractor must provide all information the Department deems necessary to support the Cost Proposal. This includes but is not limited to submitting adequate information to support the Offeror's Proposal regarding alignment with the financial interests of the MHSA Program as well as other information the Department determines is necessary to address any perceived or actual conflicts between the Contractor's business model and the financial interests of the MHSA Program. Please confirm.

4. Explain the contractual and financial relationships among or between the Contractor, Key Subcontractor or Affiliate, if any, and key Network Providers. Please describe how the Offeror's proposed business model eliminates any real or potential conflicts with the clinical and financial interests of the MHSA Program.

5. The Department recognizes that the Offerors' business model may present potential conflicts between the financial interests of the MHSA Program and the Offeror. Please describe any protections or processes the Offeror proposes to mitigate any conflicts of interest.

SECTION VI: EVALUATION AND SELECTION CRITERIA

Proposals determined by the Department to satisfy the submission requirements set forth in Section II and the Minimum Mandatory Requirements set forth in Section III of this RFP will be evaluated by an evaluation team composed of staff of the Department, the Governor's Office of Employee Relations (GOER) and the Division of the Budget (DOB), assisted by any person(s), other than one associated with a competing Offeror, designated by the Department. Proposals will be made available to representatives of NYS employee unions for review and comment. An Offeror's Proposal shall be removed from the evaluation process and not be considered for award should it be determined that the Offeror did not satisfy the Minimum Mandatory Requirements as specified in Section III, despite any attestation made regarding the Minimum Mandatory Requirements.

During the evaluation process, the Department may require clarifying information from an Offeror(s) for the purpose of assuring a full understanding of the Offeror's responsiveness to the RFP requirements and the duties and responsibilities set forth therein. This clarifying information must be submitted in writing in accordance with the formats set forth in Section II of this RFP and, if accepted, shall be included as a formal part of the Offeror's Proposal. Failure to provide the required information by the due date set forth in the Department's request for clarification may result in rejection of the Offeror's Proposal. Nothing in the foregoing shall mean or imply that the Department is obligated to seek or allow clarifications provided for herein. The Department may, at its discretion, elect to perform site visits of Offerors' facilities and have Offerors provide oral presentations pertaining to their Technical Proposal and Cost Proposal. If scheduled, representatives of NYS employee unions may also participate in site visits, Offeror oral presentations, and such other activities applicable to the evaluation of Proposals. The Procurement Manager will coordinate the necessary scheduling arrangements with the Offeror(s).

The Department will consider for evaluation and selection purposes only those Proposals: 1) determined to have met the Minimum Mandatory Requirements specified in Section III of this RFP; and 2) determined to be responsive to the duties and responsibilities set forth in the RFP. The Department's desire is to select a single Offeror to administer the MHSA Program for The

Empire Plan, the Excelsior Plan and the Student Employee Health Plan. To this end, the Department intends to select that responsive and responsible Offeror whose Proposal offers the "Best Value" to the Department as specified in the following evaluation criteria for the purpose of entering into negotiations for a contract.

The Technical Proposal and Cost Proposal components of the evaluation process shall be based on 1,000 available points; with 700 points available to the Technical Proposal and 300 points available to the Cost Proposal (i.e., 70% allocated to the Technical Proposal and 30% allocated to the Cost Proposal).

The Technical Proposal and Cost Proposal will be evaluated separately as described below.

A. Technical Evaluation

Each Offeror's ability and willingness to deliver the MHSA Program Services described in this RFP will be evaluated and scored based on a weighted point system. The evaluation of the Offeror's Technical Proposal will be based on that Offeror's written Technical Proposal; responses to clarifying questions, if any; information obtained through reference checks, including specific reference checks made with the Directors' of Employee Benefits at the Department and GOER for any Offeror, including any proposed Key Subcontractor(s) or Affiliate(s) who performed services under a contract with the Department and, as deemed necessary by the Department, oral presentation(s) and/or site visits conducted to amplify and/or clarify that Offeror's proposed Technical Proposal.

1. Technical Score Ratings

Each Offeror's Technical Proposals will be evaluated based on the following rating scale and criteria as applied to each Required Submission response as required in Section IV of the RFP. A rating of "excellent" equates to a score of 5 for each evaluated Required Submission response. Each reduction in the ratings results in a one point reduction in the score such that a rating of "poor" equates to a score of 1.

a. Excellent (5)

The Offeror far exceeds the criteria. The services described indicate that the Offeror will provide very high quality services and is very pro-active and innovative.

b. Good (4)

The Offeror exceeds the criteria. The services described indicate that the Offeror will exceed the MHSA Program's needs. The Offeror demonstrates some innovative features not shown in typical proposals.

c. Meets Criteria (3)

The Offeror meets but does not exceed the criteria. The services described indicate that the Offeror will meet the MHSA Program's needs.

d. Fair (2)

The Offeror's answer is minimal; or the answer is very general and does not fully address the question; or the Offeror meets only some of the criteria.

e. Poor (1)

The Offeror misinterpreted or misunderstood the question; or the Offeror does not answer the question/criteria in a clear manner or the Offeror does not answer the question; or the Offeror does not meet the criteria.

The Offeror's commitment to meet the levels of standards it outlines in its proposal will be verified by reviewing responses to related performance guarantee questions and reviewing the Offeror's proposed credit to the administrative fee (credit amount) for its failure to meet each of its proposed performance guarantees.

2. Performance Guarantee Ratings

A rating of "excellent" equates to a score of 5 for each evaluated service level standard. Each reduction in the ratings results in a one point reduction in the score such that a rating of "poor" equates to a score of 1. Offerors may propose performance guarantees that exceed the MHSA Program's service level standards presented in this RFP. Proposed performance guarantees are contained within the respective technical areas and will be evaluated using the following criteria:

a. Excellent (5)

(1) The Offeror's proposed performance guarantee exceeds the MHSA Program's service level standard contained within this RFP; and

(2) The Offeror's proposed credit amount is one hundred and twenty-five percent (125%) or more of the standard credit amount stated within this RFP.

b. Good (4)

(1) The Offeror's proposed performance guarantee equals the MHSA Program's service level standard contained within this RFP, and the Offeror's proposed credit amount is one hundred and twenty-five percent (125%) or more of the standard credit amount stated within this RFP; or

(2) The Offeror's proposed performance guarantee exceeds the MHSA Program's service level standard contained within this RFP; and the Offeror's proposed credit amount is greater than one hundred percent (100%) but less than one hundred and twenty-five percent (125%) of the standard credit amount stated within this RFP.

c. Meets Criteria (3)

(1) The Offeror's proposed performance guarantee equals or exceeds the MHSA Program's service level standard contained within this RFP; and

(2) The Offeror's proposed credit amount equals the standard credit amount stated within this RFP.

d. Fair (2)

(1) The Offeror's proposed performance guarantee equals or exceeds the MHSA Program's service level standard contained within this RFP; and

(2) The Offeror's proposed credit amount is greater than fifty percent (50%) but less than one hundred percent (100%) of the standard credit amount stated within this RFP.

e. Poor (1)

(1) The Offeror's proposed performance guarantee is below the MHSA Program's service level standard contained within this RFP regardless of the credit amount proposed by the Offeror; or

(2) The Offeror's proposed credit amount is fifty percent (50%) or less of the standard credit amount stated within this RFP regardless of the level of performance the Offeror pledges.

3. Performance Guarantee Standard Credit Amounts

The MHSA Program's standard credit amount for each Offeror's proposed performance guarantee is as follows:

a. Implementation and Start-Up (Section IV.B.3.b.(2)): Fifty percent (50%) of the Administrative Fee(s) (minimum mandatory requirement);

b. Call Center Availability (Section IV.B.4.b (8.a)): $100,000 per year;

c. Telephone Response Time (Section IV.B.4.b (8.b)): $25,000 per year;

d. Telephone Abandonment Rate (Section IV.B.4.b.(8.c)): $25,000 per year;

e. Telephone Blockage Rate (Section IV.B.4.b.(8.d)) : $25,000 per year;

f. Enrollment Management (Section IV.B.6.b(8)): $5,000 for each 24 hour period beyond 24 hours from the release of the MHSA Program enrollment records;

g. Reporting (Section IV.B.7.b.(6)): $1,000 per report per Business Day between the due date and the date the report is received by the Department inclusive of the day the report is received;

h. Network Composition (Section IV.B.10.b.(12)under the subheading "Provider Network"): $25,000 per year;

i. Network Provider Access (Section IV.B.10.b.(13)under the subheading "Provider Network"): $6,000 per each quarter for each performance guarantee in each of the two (2) Provider types in each of the three (3) areas in which the performance guarantee is not met;

j. Network Provider Access (Section IV.B.10.b.(14) under the subheading "Provider Network"): $1,000 for each quarter that the Offeror's proposed performance guarantee for access to Applied Behavioral Analysis services is not met;

k. Provider Credentialing (Section IV.B.10.b.(7)), under the subheading "Provider Credentialing: $1,500 per instance;

l. Financial Accuracy (Section IV.B.11.b.(17)): $10,000 per year;

m. Non-Financial Accuracy (Section IV.B.11.b (18)): $10,000 per year;

n. Turnaround Time for Network Claims (Section IV.B.11.b.(19)): $6,000 per each quarter;

o. Turnaround Time for Non-Network Claims (Section IV.B.11.b.(20)): $6,000 per each quarter;

p. Non-Network Referrals (Section IV.B.12.b.(6)): $10,000 per year;

q. Emergency Care Follow-up (Section IV.B.12.b.(7)): $10,000 per year;

r. Urgent Care Follow-up (Section IV.B.12.b.(8)): $10,000 per year;

s. Outpatient Treatment Utilization Review (Section IV.B.12.b. (9)), under subheading "Concurrent Review": $10,000 per year;

t. Inpatient Treatment Utilization Review (Section IV.B.12.b.(10)), under subheading "Concurrent Review": $10,000 per year;

u. Inpatient Appeals (Section IV.B.12.b.(5)), under subheading "Appeals Process": $10,000 per year; and

v. Outpatient & ALOC Appeals (Section IV.B.12.b.(6)), under subheading "Appeals Process": $10,000 per year.

4. Technical Scoring

Qualifying Proposals will be evaluated independently by multiple evaluators based on pre-established Evaluation Criteria. The average score for each evaluated response shall be applied to the points associated with each question such that an average score of "Excellent" for each evaluated response will result in a maximum available score of 1,000. All Offerors whose Technical Proposal is evaluated will receive a score in this manner. The technical score will then be converted to points for each Offeror such that the Offeror with the highest technical score will receive 700 points. As calculated by the Procurement Manager, all other Offerors are awarded points at a reduced level with 0.01 points being the lowest possible point value that may be assigned. The awarded points are calculated to the hundredth decimal place. The reduction in points shall be calculated in accordance with a pre-determined formula.

B. Cost Evaluation Component

The Cost Proposal of any Offeror that meets the Minimum Mandatory Requirements will be evaluated by the Department, and others deemed appropriate by the Department. The Department reserves the right to conduct Cost Proposal oral interviews and/or seek written

responses from Offerors to clarify any aspect of the Offeror's cost Proposal. The Department will then calculate a Cost Score for each Offeror.

1. Cost Evaluation

The following components will be utilized to determine the Evaluated Projected MHSA Program Cost:

a. Claim Costs:

i. Projected Cost of Network Claims: The projected cost of Network claims shall be calculated by the Department by multiplying the Guaranteed Average Unit Cost (GAUC) for Network Outpatient Services as presented by the Offeror in response to Exhibit V.A.2 of this RFP, and the GAUC for Network Inpatient Services as presented by the Offeror in response to Exhibit V.A.3 of this RFP, by the number of units of Network service pertaining to plan primary services as projected and normalized by the Department; plus,

ii. Projected Cost of Non-Network Claims: The projected cost of Non-Network claims pertaining to plan primary services as calculated and normalized by the Department; plus,

iii. Projected Bad Debt and Charity (BDC) Assessment: The projected BDC assessment shall be calculated by multiplying a fixed BDC percentage by the Network and Non-Network claim amounts calculated in i and ii above.

The sum of paragraphs i, ii and iii shall represent the evaluated claims cost.

b. Administrative Fee(s): The Department shall multiply the Administrative Fee quoted in Exhibit V.B of this RFP by the number of covered Enrollees, multiplied by twelve (12 months).

c. The Department reserves the right to Analyze and/or Normalize: The Department reserves the right to make other cost calculation adjustments as necessary to

determine the evaluated cost of the Offeror's Proposal. Any such adjustments shall be made with the intent to evaluate Offeror's Proposals on a fair and consistent basis, without prejudice. These normalization adjustments may include but are not limited to unforeseen circumstances whereby the normalization of specific factors among Offerors shall result in a more accurate and fair comparison of the Offerors' Cost Proposals as applied to the normalized claim base.

d. The Department shall then calculate each Offeror's Evaluated MHSA Program cost as the sum of paragraphs VI.B.1a and b, above.

2. Cost Score

The Offeror's Proposal with the lowest calculated cost will be awarded three hundred (300) points. The points awarded to all other Offerors shall be based on a scale representing a 1 point reduction for each $50,000 the Offeror's calculated cost is higher than the calculated cost of the lowest Cost Proposal. The point value calculated and assigned shall be proportional within each $50,000 increment and calculated to the hundredth decimal place.

C. Total Combined Score of Technical and Cost

The Total Combined Score assigned for each Offeror shall be calculated by adding the Offeror's Technical Score and Cost Score.

D. Best Value Determination

It is the Department's desire and intent, if deemed in the best interest of the Department, to select, and enter into negotiations for the purpose of executing a contract, that Offeror that has accumulated the highest Total Combined Score ultimately determined by the Department to be responsible. (Note: If an Offeror's Total Combined Score is equal to or less than 1 point below the highest Total Combined Score, the Offeror's Proposal will be determined to be substantially equivalent to the Offeror holding the highest score. Among any Offeror's Proposals deemed substantially equivalent, the Department shall select the Offeror that has the highest Cost Score calculated pursuant to Section VI.B.1 of this RFP). Contract award

shall be deemed made when notice of proposed contingent award is issued by the Department to the selected Offeror.

By submitting a Proposal in response to this RFP, the Offeror agrees that, if selected, the Offeror will enter into a contract that substantially includes the terms set forth in Section VII of this RFP, Contract Provisions, and Appendices A,B,C and D.

Please note that the terms in Appendix A, "Standard Clauses for All New York State Contracts"; Appendix B, "Standard Clauses for all Department Contracts"; Appendix C, "Third Party Connection and Data Exchange Agreement"; and Appendix D, "Participation by Minority Group Members and Women with Respect to State contracts: Requirements and Procedures," are not subject to negotiation.

If the Department determines that contract negotiations between the Department and the selected Offeror are unsuccessful because of material differences in key provision(s) as determined by the Department, the contract award shall be withdrawn. The Department may invite the Offeror with the next highest Total Combined Score to enter into negotiations for purposes of executing a contract. Scores will not be recalculated for any remaining Offerors, should contract negotiations between the Department and the selected Offeror be unsuccessful, except in a case where the reason for such failure is based on a determination, made subsequent to contract award, that the Offeror is non-responsive or non-responsible.

If an Offeror is eliminated any time prior to contract award, and that Offeror had the highest Technical score and/or Cost score, the Department shall recalculate the applicable Cost and/or Technical Scores for each remaining Offeror in accordance with the methodologies set forth herein.

AGREEMENT NO. C000XXX

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

and

INSERT Contractor NAME

THIS Agreement is entered into by and between New York State Department of Civil Service ("Department" or "DCS"), having its principal office at Empire State Plaza, Agency Building #1, Albany, NY, 12239 and _____ ("Contractor"), a corporation authorized to do business in the State of New York with a principal place of business located at _____, and collectively referred to as "the Parties."

WITNESSETH

WHEREAS, Civil Service Law Article XI authorizes and directs the President of the State Civil Service Commission and New York State Department of Civil Service ("President") to establish a health benefit plan for the benefit of State Employees, Retirees, and their Dependents, and for the benefit of Participating Employers' Employees, Retirees, and their Dependents; and

WHEREAS, Civil Service Law Article XI authorizes and directs the President to purchase a contract or contracts to provide the benefits under the plan of health benefit; and

WHEREAS, The Empire Plan Mental Health and Substance Abuse Program ("Program") provides those mental health and substance abuse health benefits, purchased by the President, for the benefit of those stated above and shall be administered in accordance with New York State laws and regulations including the Civil Service Law, the State Finance Law Article XI, and their respective implementing regulations, including but not limited to the Regulations of the Department of Civil Service (President's Regulations); and

WHEREAS, on March 13, 2014, the Department of Civil Service issued a Request for Proposal (RFP) entitled "Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and Student Health Plan" to secure the services of a qualified organization to provide Program Services as defined in the RFP; and

WHEREAS, after thorough review and evaluation by the State of Proposals received in response to the RFP, the Contractor's Proposal was selected as representing the best value to the State; and

WHEREAS, the Department, in reliance upon the expertise of the Contractor, desires to engage the Contractor to deliver the Program Services, pursuant to the terms and conditions set forth in this Agreement;

THEREFORE, the Parties agree as follows:

ARTICLE I: DEFINITION OF TERMS

1.1.0 **Actual Average Unit Cost (AAUC)** means the average unit cost for Network Coverage/Services paid during the Plan Year. The calculation of the AAUC shall be equal to the amounts that would be paid by the Contractor to Network Providers for Network Outpatient Services and Network Inpatient/ALOC Services for Plan primary claims only and prior to the application of Copayment and Bad Debt and Charity assessments.

1.2.0 **Administrative Fee** means the monthly fee that the Contractor charges the MHSA Program for all administrative services exclusive of the Shared Communication Expense as calculated on a per Enrollee per Month basis.

1.3.0 **Affiliate** means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent.

1.4.0 **Alternate Level of Care (ALOC)** means residential treatment centers, halfway houses, group homes, partial hospitalization programs or continuing day treatment programs which satisfy the requirements of an Approved Facility.

1.5.0 **Applied Behavioral Analysis (ABA)** means a behavioral health service for teaching children with Autism Spectrum Disorder through intensive skill training.

1.6.0 **Approved Facility** means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Law of New York State. If located outside New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug abuse treatment. Partial Hospitalization, Intensive Outpatient Program, Day Treatment, 23 Hour Extended Bed and 72 Hour Crisis Bed will be considered approved facilities if they satisfy the foregoing requirements. In all cases other than an emergency, the facility must also be approved by the Contractor. Residential treatment centers, halfway houses and group homes will be considered approved facilities, if they satisfy the requirements above and admission is certified by the Contractor.

1.7.0 **Business Day(s)** means every Monday through Friday, except for days designated as Business Holidays.

1.8.0 **Business Holiday(s)** means legal holidays observed by the State and any days designated by the Contractor as a holiday and approved as such by the State prior to January 1 of each Calendar Year.

1.9.0 **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.

1.10.0 **Call Center Hours** means 24 hours a Day, 365 Days a year.

1.11.0 **Certification or Certified** means a determination by the Contractor that mental health care or substance abuse care or proposed care is a Medically Necessary, Covered Service in accordance with the terms of the Agreement.

1.12.0 **Child(ren)** means children under 26 years of age, including natural children, legally adopted children, children in a waiting period prior to finalization of adoption, Enrollee stepchildren and children of the Enrollee's domestic partner. Other children who reside permanently with the Enrollee in the Enrollee's household and are chiefly dependent on the Enrollee are also eligible, subject to a statement of dependence and documentation.

1.13.0 **Clinical Manager** means licensed Ph.D.; clinical psychologist, licensed professional registered nurse, or licensed master's level certified social worker with a minimum of three to five years of previous position-related clinical experience in mental health and/or substance abuse treatment or other licensed, qualified individual as approved by the MHSA Program.

1.14.0 **Clinical Referral Line** means the clinical resource and referral service called prior to receiving any Covered Services to obtain network referrals or benefit information. Available 24 hours a Day, 365 Days a year.

1.15.0 **Coinsurance** means, for Non-Network Approved Facility services, the difference between the billed charge and the percentage covered; and, for non-network Practitioner services, the difference between the Reasonable and Customary charge and the percentage covered. The Plan's Coinsurance Maximum is shared between Basic Medical, the Hospital Program and the Mental Health and Substance Abuse Program. Copayments paid to a Network Practitioner count toward meeting the Plan's Coinsurance Maximum.

1.16.0 **Coinsurance Maximum** means the sum of coinsurance costs incurred under the Basic Medical Program and Non -Network Coverage under the Hospital Program and Mental Health and Substance Abuse Program. After the combined annual Coinsurance Maximum is reached, benefits are paid at 100 percent of Reasonable and Customary charges for Covered Services.

1.17.0 **Contractor** means **(TBD)**, the successful Contractor selected as a result of the evaluation of Offerors' Proposals submitted in response to the RFP and the Contractor who executes an Agreement with the Department to provide Program Services.

1.18.0 **Copayment** means the amount the Enrollee is required to pay per visit for Covered Services as specified by the benefit design of the MHSA Program.

1.19.0 **Cost Sharing** means the Enrollee's financial responsibility for Covered Services including Copayment, Deductible and Coinsurance.

1.20.0 **Covered Services** means Medically Necessary mental health and substance abuse care as defined under the terms of the MHSA Program, except to the extent that such care is otherwise limited or excluded under the MHSA Program.

1.21.0 Crisis Intervention Visits means an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.

1.22.0 Day(s) means calendar days unless otherwise noted.

1.23.0 DCS or Department means the New York State Department of Civil Service.

1.24.0 Dedicated Call Center means a group of customer service representatives trained and capable of responding to a wide range of questions, complaints, and inquiries specific to the MHSA Program. The customer service representatives are dedicated to the MHSA Program and do not work on any other accounts.

1.25.0 Deductible means the amount paid by the Enrollee each Calendar Year for Covered Services under the non-network portion before a Plan payment is made. Plan deductibles are shared between the Medical Program and the Mental Health and Substance Abuse Program. The amount applied toward satisfaction of the deductible will be the lower of the following: the amount actually paid for a Medically Necessary service under the non-network portion of the MHSA Program; or for Practitioner services, the Reasonable and Customary charge; or for Approved Facility services, the billed amount for such service.

1.26.0 Dependent means the spouse, domestic partner, and children under twenty-six (26) years of age of an Enrollee. Young adult dependent children age twenty-six (26) or over are also eligible if they are incapable of supporting themselves due to mental or physical disability acquired before termination of their eligibility for coverage under the New York State Health Insurance Program.

1.27.0 Dependent Survivor means the unremarried spouse, dependent child, or domestic partner who has not acquired another domestic partner, of an Enrollee who died after having had at least ten (10) years of service, who was covered as a dependent of the deceased Enrollee at the time of

the Enrollee's death and who elects to continue coverage under NYSHIP following the three (3) month extended benefits period.

1.28.0 **Disabled Lives Benefit** means the benefits provided to an Enrollee who is Totally Disabled on the date coverage ends. The benefits are provided on the same basis as if coverage had continued with no change until the day the Enrollee is no longer Totally Disabled or for ninety (90) days after the date the coverage ended, whichever is earlier.

1.29.0 **Emergency Care** means care received for an emergency condition. An emergency condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such a person or others in serious jeopardy; serious impairment to such person's bodily functions; serious dysfunction of any bodily organ or part of such person; or serious disfigurement of such person.

1.30.0 **Employee** means "Employee" as defined in 4 NYCRR Part 73, as amended, or as modified by collective bargaining agreement.

1.31.0 **Employer** means "Employer" as defined in 4 NYCRR Part 73, as amended.

1.32.0 **Enrollee** means an "Employee" or "Dependent" enrolled in the MHSA Program with mental health/ substance abuse benefits.

1.33.0 **ET** means prevailing Eastern Time.

1.34.0 **Guaranteed Average Unit Cost (GAUC)** means the amounts as proposed by the Contractor for Network Outpatient Services and Network Inpatient/Alternative Level of Care (ALOC) Services in RFP Exhibits V.A.2 and V.A.3, respectively. The GAUC amounts shall be based on Plan primary claims only and be prior to the application of Copayment and Bad Debt and Charity assessments. The GAUC for Network Inpatient/ALOC Services may incorporate the inpatient professional service component pertaining to global reimbursement arrangements.

1.35.0 HIPAA means Health Insurance Portability and Accountability Act of 1996.

1.36.0 Implementation Date means the first day of the month following a minimum implementation period of 90 days subsequent to the Office of State Comptroller's approval of the Agreement that results from this RFP.

1.37.0 Inpatient Services means those services rendered in an Approved Facility to an Enrollee who has been admitted for an overnight stay and is charged for room and board.

1.38.0 Intensive Outpatient Program (IOP) is a freestanding or hospital-based program that provides medically necessary services more than once weekly. Intensive outpatient programs are used as a step-up from routine outpatient services, or as a step-down from acute inpatient, residential care or a partial hospital program. Intensive outpatient programs can be used to treat mental health conditions or substance abuse disorders, or can specialize in the treatment of co-occurring mental health conditions and substance-use disorders.

1.39.0 Key Subcontractor(s) means those vendors with whom the Contractor subcontracts to provide Program Services and incorporates as a part of the Contractor's Program Team.

1.40.0 Maximum Out-of-Pocket means the maximum out-of-pocket costs incurred by an Enrollee for network Copayments for the Medical, Hospital and Mental Health/Substance Abuse Programs, as required by the Affordable Care Act (ACA) for non-grandfathered Plans.

1.41.0 Medical Necessity/Medically Necessary means a Covered Service which the Contractor has certified to be: medically required; having a strong likelihood of improving the condition; and provided at the lowest appropriate level of care for the specific diagnosed condition, in accordance with both generally accepted mental health and substance abuse practices and the professional and technical standards adopted by the Contractor.

1.42.0 Mental Health Care means Medically Necessary care rendered by a covered Practitioner or Approved Facility and which, in the opinion of the Contractor, is directed predominately at treatable behavioral manifestations of a condition that the Contractor determines: is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and substantially

or materially impairs a person's ability to function in one or more major life activities; and has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

1.43.0 **MHSA Program/Plan** means the New York State Health Insurance Program's Empire Plan Mental Health and Substance Abuse Program, the Excelsior Plan Mental Health and Substance Abuse Program and the Student Employee Health Plan Mental Health and Substance Abuse Program administered by the New York State Department of Civil Service.

1. 44.0 **Mixed Services Protocol** means the methodology for allocating the financial liability for covered MHSA services between the Medical Program contractor, Hospital Program contractor and the MHSA Program contractor.

1.45.0 **Network Coverage / Services** means all Medically Necessary services/days paid at the Network benefit level including Medically Necessary services/days rendered by a Non-Network Provider when the Contractor determines that it is appropriate for either access or clinical reasons. Network Services shall not include non-network services where the Contractor had no opportunity to direct the care or Transition of Care services.

1.46.0 **Network Facility** means an Approved Facility that has entered into a Network Provider agreement with the Contractor as an independent contractor. The records of the Contractor shall be conclusive as to whether a facility has a Network Provider agreement in effect on the date services are obtained. A non-network facility can be considered a network facility on a case-by-case basis when approved by the Contractor.

1.47.0 **Network Practitioner** means a Practitioner who has entered into an agreement with the Contractor as an independent contractor to provide Covered Services. The records of the Contractor shall be conclusive as to whether a person had a Network Provider agreement in effect on the date services are obtained. A Non-Network Practitioner can be considered a Network Practitioner on a case-by-case basis when approved by the Contractor.

1.48.0 **Network Provider** means either a Network Practitioner or a Network Facility.

1.49.0 **Non-Network Coverage** means the level of reimbursement paid by the MHSA Program for Covered Services from a Non-Network Provider in compliance with the MHSA Program requirements outlined in the Agreement.

1.50.0 **Non-Network Facility** means an Approved Facility that has not entered into an agreement with the Contractor as an independent contractor to provide Covered Services.

1.51.0 **Non-Network Practitioner** means a Practitioner who has not entered into an agreement with the Contractor as an independent contractor to provide Covered Services. A Non-Network Practitioner can be considered a Network Practitioner on a case-by-case basis when approved by the Contractor.

1.52.0 **Non-Network Provider** means a Non-Network Practitioner or Non-Network Facility.

1.53.0 **NYS** means New York State.

1.54.0 **NYSHIP** means the New York State Health Insurance Program.

1.55.0 **Outpatient Services** means those services rendered in a Practitioner's office or in the department of an Approved Facility where services are rendered to persons who have not had an overnight stay and are not charged for room and board.

1.56.0 **Partial Hospitalization** means a freestanding or hospital-based program that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for less than 4 hours per day. A partial hospital/day treatment program may be used as a step up from a less intensive level of care or as a step down from a more intensive level of care and does not include an overnight stay.

1.57.0 **Participating Agency (PA)** means any unit of local government such as school districts, special districts and district or municipal corporations which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

1.58.0 **Participating Employer (PE)** means a public authority, public benefit corporation, or other public agency, subdivision, or quasi-public organization of the State which elects, with the

approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

1.59.0 **Pass-through Pricing** means the MHSA Program is charged the same mental health substance abuse services fee paid to the Network Provider.

1.60.0 **Peer Advisor** means a psychiatrist or Ph.D. psychologist with a minimum of five (5) years of clinical experience who renders Medical Necessity decisions.

1.61.0 **Physician** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.). He or she must be legally licensed to practice medicine, without limitations or restrictions.

1.62.0 **Plan Sponsor** means the Council on Employee Health Insurance, which is composed of the President of the Civil Service Commission, Director of the Governor's Office of Employee Relations, and the Director of the Division of Budget.

1.63.0 **Plan Year** means the period from January 1st to December 31st in each year covered by this Agreement, unless specified otherwise by the MHSA Program.

1.64.0 **PPACA or ACA** means Patient Protection and Affordable Care Act of 2010 and it's implementing regulations.

1.65.0 **Practitioner** means:

1.65.1 A psychiatrist; or

1.65.2 A psychologist; or

1.65.3 A licensed clinical social worker with at least six (6) years of post-degree experience who qualifies for the New York State Board for Social Work "R designation". If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body; or

1.65.4 A Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist: Advanced Practice nurses who hold a master's or doctoral degree in a specialized area of psychiatric nursing practice nurse; or

1.65.5 A Registered Nurse Practitioner: a nurse with a master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided. Nurse Practitioners may diagnose, treat, and prescribe for a patient's condition that falls within their specialty area of practice. This must be done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols; or

1.65.6 Applied behavioral analysis provider or Certified Behavioral Analyst (CBA) provider: A licensed provider who is certified as a behavior analyst pursuant to a behavioral analyst certification board; or

1.65.7 Applied behavioral analysis or ABA Agency: An agency providing ABA services under the program oversight and direct supervision of a licensed provider and certified behavioral analyst. An ABA Agency may also employ ABA aides to deliver the treatment protocol of the ABA Provider.

1.66.0 **President** means the President of the Civil Service Commission who is also the Commissioner of the Department of Civil Service.

1.67.0 **Program Services** means all of the services to be provided by the Contractor as set forth in this Agreement.

1.68.0 **Program Team** means the Contractor and those Key Subcontractors and Affiliates, if any, utilized by the Contractor who collectively undertake and perform the Program Services which are the subject of the Agreement. Program Team means, for purposes of the RFP, an Offeror and those Key Subcontractors and Affiliates, if any, the Offeror proposes to utilize to collectively undertake and perform the Program Services which are the subject matter of the RFP.

1.69.0 **Proposal** means the Contractor's Administrative Proposal, Technical Proposal, and Cost Proposal, including all responses to supplemental requests for clarification, information, or documentation, submitted during the course of the Procurement.

1.70.0 **Provider** means a Practitioner or Approved Facility that supplies Covered Services under the MHSA Program.

1.71.0 **Provider Network** means the Contractor's credentialed and contracted network of Network Practitioners and Network Facilities.

1.72.0 **Reasonable and Customary** means the lowest of:

1.72.1 The actual charge for services; or

1.72.2 The usual charge for services by the Provider; or

1.72.3 The usual charge for services of other Providers in the same or similar geographic area for the same or similar service.

1.73.0 **Referral** means the process by which the Contractor's toll-free Clinical Referral Line refers an Enrollee to a Network Provider to obtain Covered Services.

1.74.0 **Regulations of the President of the New York State Civil Service Commission** means those regulations promulgated by the President of the Civil Service Commission under the authority of Civil Service Law Article XI, as amended, and including, but not limited to those regulations to be promulgated as 4 New York Code of Rules and Regulations (NYCRR) Part 73.

1.75.0 **Renewal Date** means January 1, 2016 and annually thereafter up to and including January 1, 2019.

1.76.0 **Retiree** means any person defined as a Retiree pursuant to the terms of 4 NYCRR Part 73, as amended.

1.77.0 **RFP or Procurement** means the Request for Proposals entitled "Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and Student Employee Health Plan, dated March 13, 2014.

1.78.0 **Shared Accumulator** means the Coinsurance, certain Copayment and Deductible amounts shared between the MHSA, Medical and Hospital components of the Empire Plan, Student Employee Health Plan and Excelsior Plan.

1.79.0 **Shared Communication Expense** means the expense that the Contractor will be billed and must pay on a quarterly basis to contribute toward the cost of producing various Empire Plan and NYSHIP publications (i.e. provider directories, Choices Guides, At A Glance publications, etc)

1.80.0 **Single Case Agreement** means a unique agreement that the Contractor negotiates with a Network Provider to provide MHSA Program Network-level services for a specific Enrollee when there is sufficient access to a Network Provider within a certain geographic area or a Non-Network Provider possesses a unique specialty that is not currently possessed by a Network Provider within that geographic area.

1.81.0 **State** means New York State as a whole.

1.82.0 **Structured Outpatient Rehabilitation Program (SOP)** means a program that provides substance abuse care and is an operational component of an Approved Facility that is state licensed. If located in New York State, the program must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York. If the program is located outside New York State, it must be part of an Approved Facility accredited by the Joint Commission on Accreditation of Health Care Organizations as a hospital or as a health care organization that provides psychiatric and/or drug abuse or alcoholism services to adults and/or adolescents. The program must also meet all applicable federal, state and local laws and regulations. A Structured Outpatient Rehabilitation Program is a program, in which the patient participates, on an outpatient basis, in prescribed formalized treatment, including an aftercare component of weekly follow-up. In addition, Structured Outpatient Rehabilitation Programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.

1. 83.0 **Substance Abuse Care** means Medically Necessary care provided by an eligible provider for the illness or condition that the Contractor has determined: is a clinically significant behavioral or psychological syndrome or pattern; and substantially or materially impairs a person's ability to function in one or more major life activities; and is a condition which has been classified as a substance abuse disorder in the current American Psychiatric Association Diagnostic and

Statistical Manual of Mental Disorders, unless such condition is otherwise excluded under this MHSA Program.

1.84.0 **Summary Plan Description(s) (SPD)** means the document(s) issued pursuant to and attached by reference to the Agreement. The SPD is issued to Enrollees and describes Program benefits. The SPD includes the initial SPD and amendments, if any.

1.85.0 **Total Disability and Totally Disabled** means that because of a mental health/substance abuse condition, the Enrollee, cannot perform his/her job or the Dependent cannot perform the normal activities of a person that age.

1.86.0 **Transition of Care** means a benefit that provides Enrollees with the Network level of benefits for a period of 90 days to continue Covered Services that commenced with a Network Provider of the former Program contractor.

1.87.0 **Urgent Care** is care that does not meet the definition of emergency care but which should be provided early in the onset of symptoms in order to alleviate or prevent permanent disability, serious medical complications, loss of life or harm to the patient or others.

1.88.0 **Utilization Review** (UR) means a medical management program which reviews the Medical Necessity of mental health and substance abuse treatment. The review should be conducted by a team of licensed and/or certified psychiatric nurses, licensed clinical social workers ("R" status), board-certified or board-eligible psychiatrists and clinical psychologists, as appropriate, to determine whether proposed services are Medically Necessary for diagnosed condition(s). Utilization review includes pre-certification, prior authorization, concurrent review and discharge planning.

1.89.0 **Vestee** means a former Employee who is entitled to continue benefits under NYSHIP because he/she has met all the requirements for NYSHIP coverage as a Retiree, except for age eligibility for pension, at the time employment terminates.

ARTICLE II: AGREEMENT DURATION AND AMENDMENTS

2.1.0 This Agreement shall be subject to and effective upon the approval of the New York State Attorney General's Office ("AG") and the NYS Office of the State Comptroller ("OSC"). The term of the Agreement shall include a minimum 90-day implementation period followed by five (5) years of Program Services, with up to an 11-month extension, at the sole discretion of the Department. It is the Department's intent that this implementation period shall begin following OSC approval of the Agreement, with all other contractual responsibilities (with the exception of the Contractor's Dedicated Call Center and customized website) to begin on the first day of the month following the 90-day implementation period after OSC approves the Contract and subject to the termination provisions contained herein.

2.2.0 The Agreement is subject to amendment(s) only upon mutual consent of the Parties, reduced to writing and approved by the AG and the OSC.

ARTICLE III: INTEGRATION

3.1.0 This Agreement, including all Exhibits, copies of which are attached hereto and incorporated by reference, constitutes the entire Agreement between the Parties. All prior Agreements, representations, statements, negotiations, and undertakings are superseded hereby.

3.2.0 All statements made by the Department shall be deemed to be representations and not warranties.

ARTICLE IV: DOCUMENT INCORPORATION AND ORDER OF PRECEDENCE

4.1.0 The Agreement consists of:

- **4.1.1** The body of the Agreement (that portion preceding the signatures of the Parties in execution), and any amendments thereto;
- **4.1.2** Appendix A – Standard Clauses for All New York State Contracts;
- **4.1.3** Appendix B – Standard Clauses for All Department Contracts;
- **4.1.4** Appendix C – Third Party Connection and Data Sharing Agreement;
- **4.1.5** Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures;
- **4.1.6** The following Exhibits attached and incorporated by reference to the body of the Agreement:

4.1.6a Exhibit A: which includes: the MacBride Act Statement; and the Non-Collusive Bidding Certification;

4.1.6b Exhibit B: the Request for Proposals entitled "Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and Student Employee Health Plan," dated March 13, 2014and Exhibit B-1, the official Department response to questions raised concerning the RFP, dated **(TBD)**;

4.1.6c Exhibit C: the Contractor's Proposal; and, Exhibit C-1: Written responses to the Management Interview and related materials clarifying the Contractor's Proposal; and

4.1.6d Exhibit D: the Summary Plan Descriptions.

4.1.6e Exhibit E: Guaranteed Average Unit Costs

4.1.7 In the event of any inconsistency in, or conflict among, the document elements of the Agreement identified above, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

4.1.7a First, Appendix A – Standard Clauses for All New York State Contracts;

4.1.7b Second, Appendix B – Standard Clauses for All Department of Civil Service Contracts;

4.1.7c Third, Appendix C –Third Party Data Connection and Data Exchange Agreement;

4.1.7d Fourth, Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures;

4.1.7e Fifth, any Amendments to the body of the Agreement;

4.1.7f Sixth, the body of the Agreement;

4.1.7g Seventh, Exhibit B, the Request for Proposals entitled "Mental Health and Substance Abuse Benefit Services for The Empire Plan, Excelsior Plan and Student Employee Health Plan dated March 13, 2014" and Exhibit B-1, the official Department response to questions raised concerning the RFP, dated **(TBD)**;

4.1.7h Eighth, Exhibit C: the Contractor's Proposal; and, Exhibit C-1: Written responses to the Management Interview and related materials clarifying the Contractor's Proposal; and

4.1.7i Ninth, Exhibit D, the Summary Plan Description and Benefit Summaries

4.1.7j Tenth, Exhibit E, Guaranteed Average Unit Costs

4.2.0 The terms, provisions, representations and warranties contained in the Agreement shall survive performance hereunder.

ARTICLE V: LEGAL AUTHORITY TO PERFORM

5.1.0 The Contractor shall maintain appropriate corporate and/or legal authority, which shall include but is not limited to the maintenance of an administrative organization capable of delivering the Program Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which the Program Services are to be delivered.

5.2.0 Contractor agrees that it shall perform its obligations under this Agreement in accordance with all applicable federal and NYS laws, rules and regulations, policies and/or guidelines now or hereafter in effect, including but not limited to the requirements set forth in Chapter 56 of the Laws of 2010.

5.3.0 The Contractor shall provide the Department with immediate notice in writing of the initiation of any legal action or suit which relates in any way to the Agreement, or which may affect the performance of Contractor's duties under the Agreement.

ARTICLE VI: PROGRAM SERVICES

6.1.0 The Contractor shall provide all of the Program Services as set forth herein this Article VI of the Agreement for the entire term of the Agreement pursuant to the Summary Plan Description(s) incorporated into this Agreement as Exhibit D. All Program Services shall be provided in accordance with the New York State Civil Service Law and its implementing regulations, and other NYS and Federal Law as may be applicable. In addition, the Contractor shall deliver the Program Services in such a manner so as to comply with all provisions of this

Agreement. The Contractor may provide certain services through Key Subcontractors or Affiliates with the prior review and approval of the Department. Each subcontract entered into with a corporate entity separate from the Contractor for the purpose of delivering Program Services must be maintained throughout the term of the Agreement unless such change is approved in writing by the Department. All Key Subcontracts shall expressly name the State of New York, through the Department, as the sole intended beneficiary of any such Key Subcontract. The Contractor must maintain significant financial, legal, and audit oversight of any of its Key Subcontractors or Affiliates. The Contractor remains fully responsible for all services and actions performed under this Agreement. The Contractor shall submit all Key Subcontracts to the Department for its approval. The Contractor shall submit all such Key Subcontracts with no redactions to the Department before execution for its review and approval.

6.1.1 Costs/Fees for all services required under this Agreement shall be included in the Contractor's Administrative Fee.

6.2.0 Account Team

6.2.1 The Contractor must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the MHSA Program during implementation, operation and transition.

6.2.1a The account team must be comprised of qualified and experienced individuals who are acceptable to the Department and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the MHSA Program in an efficient manner;

6.2.1b The Contractor must ensure that there is a process in place for the account team to gain immediate access to appropriate corporate resources and senior management necessary to meet all MHSA Program requirements and to address any issues that may arise during the performance of the Agreement.

6.2.2 The Contractor's dedicated account team must be experienced, accessible (preferably in the New York State Capital Region district) and sufficiently staffed to:

6.2.2a provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department, or other staff on behalf of the Council on Employee Health Insurance or union representatives regarding member-specific claims issues for the duration of the Agreement to the satisfaction of the Department;

6.2.2b immediately notify the Department in writing of actual or anticipated events impacting MHSA Program costs and/or delivery of services to Enrollees such as but not limited to legislation, litigation, and operational issues.

6.2.3 The Contractor's dedicated account team must ensure that the MHSA Program is in compliance with all legislative and statutory requirements. If the Contractor is unable to comply with any legislative or statutory requirements, the Department must be notified in writing immediately. The Contractor must work with the Department to develop accurate Summary Plan Descriptions (SPDs) and MHSA Program material.

6.3.0 **Premium Development Services:** The Contractor will be responsible for assisting and supporting the Department with all aspects of the premium rate development including, but not limited to:

6.3.1 Providing a team of qualified and experienced individuals who are acceptable to the Department and who will assist and support the Department in developing premium rates consistent with the financial interests and goals of the MHSA Program and the State;

6.3.2 Developing projected aggregate claim, trend and Administrative Fee amounts for each MHSA Program Year. Analysis of all MHSA Program components impacting the MHSA Program cost shall be performed including, but not limited to claims, trend factors, Administrative Fees and changes in enrollment; and

6.3.3 Working with the Department and its contracted actuarial consultant through the annual premium renewal process to further document and explain any premium rate

recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.

6.4.0 Implementation

6.4.1 The Contractor must ensure that the MHSA Program is fully functional by the first day of the month following a minimum 90-day implementation period after the Office of the State Comptroller approves the Agreement. The implementation plan must be detailed and comprehensive and demonstrate a firm commitment by Contractor to complete all implementation activities within the 90-day implementation period.

6.4.2 ***Implementation and Start-up Guarantee:*** The Contractor must guarantee that all Implementation and Start-up activities will be the first day of the month following a 90-day implementation period after he Office of the State Comptroller approves the Agreement (Implementation Date) so that Contractor can assume full operational responsibility for the MHSA Program on the designated date. For the purpose of this guarantee, the Contractor must have in place and operational:

6.4.2a A contracted Provider network (including Certified Behavior Analysts) that meets or exceeds the access and density standards set forth in Section IV.B.10 of this RFP;

6.4.2b A fully operational Dedicated Call Center, including a Clinical Referral Line, providing all aspects of customer support and clinical services as set forth in Section IV.B.4 and Section IV.B.12 of this RFP. The Dedicated Call Center must be open and operational a minimum of thirty (30) days prior to Program implementation Date to assist Enrollees with questions concerning Program transition;

6.4.2c A claims processing system that processes claims in accordance with the MHSA Program's plan design and benefits, as set forth in Section IV.B.11 of this RFP;

6.4.2d A claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the Department to correctly pay claims for eligible Enrollees consistent with MHSA Program benefit design and contractual obligations; and

6.4.2e A fully-functional, customized MHSA Program website available a minimum of thirty (30) days prior to Program the Implementation Date, with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section IV. B.4 of this RFP.

6.5.0 Customer Service

6.5.1 The Contractor will be responsible for all customer support and services including, but not limited to:

6.5.1a Providing Enrollees access to information on all MHSA benefits and services related to the MHSA Program through the Empire Plan consolidated toll-free number twenty-four (24) hours a Day, 365 Days a year;

6.5.1b The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's medical carrier/third party administrator and is available to callers twenty-four (24) hours a Day, 365 Days a year. The Contractor must establish and maintain a transfer connection with AT&T (T-1 line), including a back-up system which will transfer calls to the Offeror's line at their Dedicated Call Center service site. The Contractor must sign a shared service agreement with the Empire Plan's medical carrier/third party administrator (currently UnitedHealthcare) and AT&T Programming and scripting changes to the Empire Plan consolidated phone line takes 4-6 weeks. In addition, the Contractor is also required to provide twenty-four (24) hours a Day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The

TTY number must provide the same level of access to call center service as required by this Section of the Agreement;

6.5.1c Maintaining a Dedicated Call Center for the MHSA Program located in the United States (preferably in New York State) that:

6.5.1d Providing direct access to trained Clinicians who direct members to appropriate Network Providers, provide clinical MHSA information and if requested by the caller, assist in scheduling appointments on behalf of the member twenty-four (24) hours a Day, 365 Days a year;

6.5.1e Providing access to fully trained customer service representatives and supervisors a minimum of thirty (30) days prior to the Implementation Date and through and including four (4) months after termination of the Agreement between the hours of 8:00a.m.to 5:00p.m. Monday through Friday, except for Business Holidays; and

6.5.1f Meets the Contractor's proposed call center telephone guarantees set forth in Section 7.3.0 through 7.6.0 of this Agreement.

6.5.2 Customer service staff must use an integrated system to log and track all Enrollee calls. The system must create a record of the Enrollee contacting the call center, the call type, and all customer service actions and resolutions;

6.5.3 Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries, including but not limited to: Transition of Care; MHSA Program benefits levels; status of pre-certification requests; eligibility and claim status; and be able to identify calls requiring transfer to a Clinician;

6.5.4 Maintaining a designated backup customer service staff located in the United States with MHSA Program-specific training to handle any overflow when the Dedicated Call Center is unable to meet the Contractor's proposed customer service performance guarantees. This back-up system would also be utilized in the event the Dedicated Call Center becomes unavailable; and

6.5.5 Maintaining and timely updating a secure online Empire Plan specific customized website accessible by Enrollees a minimum of thirty (30) days prior to the Implementation Date, which is available twenty-four (24) hours a Day, 365 Days a year, except for regularly scheduled maintenance, which will provide, at a minimum access to information regarding: MHSA Program benefits; Network Provider locations; eligibility; Copayment information; pre-authorization information; claim status; and clinically-based educational material. The website may not contain any links to the Contractor's standard website used for other customers. The website Provider search may only contain Provider types that are covered under the Empire Plan. The Department shall be notified of all regularly scheduled maintenance at least one (1) Business Day prior to such maintenance being performed. The Contractor must establish a dedicated link to the customized website for the MHSA Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the MHSA Program. Links bringing a viewer back to the Department's website must be provided. No other links are permitted without the written approval of the Department. Access to the online Network Provider locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the MHSA Program shall be borne solely by the Contractor. Also, the Contractor shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal.

6.6.0 <u>Enrollee Communication Support</u>:

6.6.1 All Enrollee communications developed by the Contractor are subject to the Department's review and prior written approval, including but not limited to any regular standardized direct communication with Enrollees or their MHSA Providers in connection with covered benefits or the processing of Enrollee claims, either through mail, e-mail, fax or telephone. The Department, in its sole discretion, reserves the right to require any customization it deems necessary.

6.6.2 The Contractor will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:

6.6.2a Developing language describing the MHSA Program for inclusion in the NYSHIP General Information Book and Empire Plan SPD, subject to the Department's review and approval;

6.6.2b Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing MHSA Program benefit features and/or highlighting trends in MHSA utilization;

6.6.2c Timely reviewing and commenting on proposed MHSA Program communication material developed by the Department;

6.6.2d Developing timely and accurate Summaries of Benefits Coverage (SBC), which will be consolidated with coverage information from other Program carriers/third party administrators for The Empire Plan, Student Employee Health Plan and Excelsior Plan. The Department will post the SBCs on NYSHIP Online. Upon Enrollee request, the Contractor must direct Enrollees to the NYSHIP Online website to view the SBC or distribute a copy of the SBC to the Enrollee within the federally required time period; and

6.6.2e Paying a portion of the Shared Communication Expenses, the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees. The Empire Plan's medical carrier/third party administrator will bill the Contractor on a quarterly basis for a portion of the Programs' Shared Communication Expenses. The Department agrees that these costs are not included in Administrative Fees and that the Contractor will be reimbursed for these costs as set forth in Article XIII of the Agreement resulting from this RFP.

6.6.3 Upon request, subject to the approval of the Department, on an "as needed" basis, the Contractor agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United

States. The Contractor agrees that the costs associated with these services are included in the Contractor's Administrative Fee.

6.6.4 The Contractor must work with the Department to develop appropriate customized forms and letters for the MHSA Program, including but not limited to claim forms, pre-certification forms and letters, explanation of benefits, appeal letters, etc. All such communications must be approved by the Department prior to their distribution.

6.7.0 <u>Enrollment Management</u>:

6.7.1 The Contractor will be responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department. These enrollment files shall be used by the Contractor to process claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files. Contractor must provide enrollment management services including but not limited to:

6.7.1a ***Initial Testing:*** Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department during MHSA Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)), fixed length ASCII text file, or a custom file format. The determination will be made by the Department; and

6.7.1b Testing to determine if the initial enrollment file and daily enrollment transaction files loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The Contractor shall submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of the MHSA Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department.

6.7.2 Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims

processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Contractor shall, on a daily basis, manually review and load any transactions which did not process correctly from the daily ANSI x.12 834 standard 005010x220 file by reviewing the correct enrollment date maintained in the NYBEAS. The Contractor shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the Department, the Contractor shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Contractor in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a twenty-four (24) hour period. The Contractor must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 standard 005010x220 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit B of the Agreement. The Contractor must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

6.7.3 Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee data contained in the enrollment file. Any transfers of enrollment data within the Contractor's system or to external parties must be completed via a secured process;

6.7.4 Providing a back-up system or have a process in place where, if enrollment information is unavailable, Enrollees can obtain Clinical Referral Line services without interruption;

6.7.5 Cooperating fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement;

6.7.6 Maintaining a read-only connection to the enrollment system for the purpose of providing the Contractor's staff with access to current MHSA Program enrollment information. Contractor's staff must be available to access enrollment information through NYBEAS Monday through Friday, from 8:00 am to 5:00 pm EST, with the exception of NYS holidays as indicated on the Department's website; and

6.7.7 Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Contractor must make payment for covered benefits or reimbursement directly to such party. The Contractor will be required to store this information in its system(s) so that any claim payments or any other plan communication distributed by the Contractor, including access to information on the Contractor's website would go to the person designated in the QMCSO.

6.8.0 **Reporting:** The Contractor is responsible for accurate reporting services including, but not limited to:

6.8.1 Ensuring that all financial reports including claim reports are generated from amounts billed to the MHSA Program, and reconcile to amounts reported in the quarterly and annual financial experience reports;

6.8.2 Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, monitoring and analysis of the MHSA Program. These reports must tie to the amounts billed to the MHSA Program. The final format of reports is subject to the Department review and approval;

6.8.3 Supplying reports in paper format and/or in an electronic format including but not limited to Microsoft, Access, Excel and/or Word as determined by the Department. The

reports include, but are not limited to, reports and data files listed in Article XV "Reports and Claim Files" section of this Agreement;

6.8.4 Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by the Department. Information required in the Ad Hoc Reports may include but is not limited to providing:

6.8.4a Forecasting and trend analysis data

6.8.4b Utilization data

6.8.4c Utilization review savings

6.8.4d Benefit design modeling analysis

6.8.4e Reports to meet clinical program review needs

6.8.4f Reports segregating claims experience for specific populations

6.8.4g Reports to monitor Agreement compliance

6.8.5 Providing direct, secure access to the Contractor's claims system and any online and web based reporting tools to authorize Department representatives.

6.9.0 **Consulting:** The Contractor will be responsible for providing advice and recommendations regarding the MHSA Program. Such responsibility shall include, but not be limited to:

6.9.1 Informing the Department in a timely manner concerning such matters as cost containment strategies, technological improvements, Provider best practices and State/Federal legislation (e.g., Federal parity legislation, etc.) that may affect the MHSA Program. The Contractor must also make available to the Department one or more members of the clinical or account management team to discuss the implications of new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and

6.9.2 Assisting the Department with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all

associated costs, a clinical evaluation, and the anticipated impact of proposed MHSA Program modifications and contemplated benefit design changes on Enrollees. In the event of a design change and should the Contractor requests any change in compensation, any such change will be processed in accordance with Article VIII, Modification of Program Services.

6.10.0 Network Management

6.10.1 Provider Network

6.10.1a The Contractor must maintain a credentialed and contracted MHSA Provider Network that meets or exceeds the Contractor's minimum access standards (or the Contractor's proposed access standards, if greater) throughout the term of the Agreement. The access standards must be provided in terms of actual distance from Enrollees' residences, as follows:

% of Enrollees with Access to Network Facilities	Enrollee Location	Access Guarantee – 1 Network Facility at least within
___%	Urban	___miles
___%	Suburban	___miles
___%	Rural	___miles
% of Enrollees with Access to Network Practitioners	**Enrollee Location**	**Access Guarantee – 1 Network Practitioner at least within**
___%	Urban	___miles
___%	Suburban	___miles
___%	Rural	___miles

6.10.1b The Contractor must meet or exceed the Contractor's proposed access standards for credentialed and contracted Certified Behavior Analysts in the MHSA Program's Provider Network throughout the term of the Agreement, as follows: (TBD by Offeror's proposal)

6.10.1c The MHSA Program requires that the Contractor have available to Enrollees on the Implementation Date its proposed MHSA Provider Network in

accordance with the requirements set forth in Section 6.4.0 of this Agreement guaranteeing effective implementation of their proposed MHSA Provider Network.

6.10.1d The Contractor shall offer participation in its MHSA Provider Network to any Provider who meets the Contractor's credentialing criteria if the Provider is a high volume provider or upon the Department's request where such inclusion is deemed necessary by the Department to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees.

6.10.1e In developing its proposed MHSA Provider Network, the Contractor is expected to use its best efforts to substantially maintain the composition of Network Providers included in the MHSA Program's current Provider Network. The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed and registered Clinical Social Workers (CSW) (in NYS social workers must have an "R" number issued by the State Education Department), Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts, Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis). Programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) must be included in the MHSA Provider Network. The MHSA Provider Network must include Providers throughout New York State and in areas with high concentrations of active and/or retired employees living outside of New York State such that the network access guarantees established by the terms of the Agreement are fully satisfied.

6.10.2 <u>Provider Credentialing</u>

6.10.2a The Contractor must assure its MHSA Provider Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

6.10.2b The Contractor must establish credentialing criteria for Network Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the MHSA Provider Network, including, but not limited to, years of experience, level of education/certification, Licensure, quality of care, practice patterns, malpractice insurance coverage, hours of operation and availability of appointments;

6.10.2c The Contractor must credential MHSA Network Providers in a timely manner and shall have an effective process by which to confirm MHSA Network Providers continuing compliance with credentialing standards.

6.10.2d The Contractor must maintain a Provider Relations staff presence within New York State.

6.10.2e The Contractor must maintain credentialing records and make them available for review by the Department upon request.

6.10.3 Provider Contracting

6.10.3a The Contractor will be responsible for providing Provider contracting services including but not limited to:

6.10.3a(1) Negotiating pricing arrangements that utilize the MHSA Program's size to optimize the Provider fee schedule;

6.10.3a(2) Ensuring that all MHSA Network Providers contractually agree to and comply with all of the MHSA Program's requirements and benefit design specifications;

6.10.3a(3) Ensuring that MHSA Network Providers accept as payment-in-full, the Contractor's contractual reimbursement for all claims for

covered services, subject to the applicable MHSA Program Copayments;

6.10.3a(4) Notifying the Department in writing within one (1) Business Day of any substantial change to the number, composition or terms of the Network Provider contracts utilized by the MHSA Program; and

6.10.3a(5) Negotiating Single Case Agreements with Non-Network Providers on a case- by-case basis when the Contractor determines that it is clinically appropriate or to address guaranteed access issues;

6.10.4 Provider Audit and Quality Assurance

6.10.4a The Contractor must have a staffed and trained audit unit employing a comprehensive Provider audit program that includes but is not limited to:

6.10.4a(1) Conducting routine and targeted on-site audits of Network Providers. Providers that deviate significantly from normal patterns in terms of cost, CPT coding or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the Department and/or OSC, or when information is received by the Contractor that indicates a pattern of conduct by a Provider that is not consistent with the MHSA Program's design and objectives. Any modifications to the proposed audit program must receive prior written approval from the State;

6.10.4a(2) Providing reports to the Department detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The Contractor must inform the Department in writing of any allegation or other indication of potential fraud and abuse identified within seven (7) Business Days of receipt of such allegations or

identification of such potential fraud and/or abuse. The Department must be fully informed of all fraud and/or abuse investigations impacting the MHSA Program upon commencement, regardless of whether the individual fraud and/or abuse investigation has a material financial impact to the State;

6.10.4a(3) Maintaining the capability and contractual right to effectively audit the MHSA Program's Provider Network, including the use of statistical sampling audit techniques and the extrapolation of errors;

6.10.4a(4) Remitting 100% of Provider and Enrollee audit recoveries to the Department as applicable within thirty (30) Days of receipt consistent with the process specified in Article XIV, "Payments/ (credits) to/from the Contractor" of this Agreement; and

6.10.4a(5) Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Providers and/or Enrollees; and,

6.10.4b The Contractor must conduct a comprehensive quality assurance program which includes, but is not limited to:

6.10.4b(1) Monitoring the quality of care provided by Network Providers;

6.10.4b(2) Monitoring technical competency and customer service skills of Network Provider staff;

6.10.4b(3) Network Provider profiling;

6.10.4b(4) Peer review procedures;

6.10.4b(5) Outcome and Quality Measurement analysis; and

6.10.4b(6) Maintaining an ongoing training and education program that will be offered to Network Providers.

6.10.5 Value Based Initiatives

The Contractor must establish a tiered MHSA Provider Network and/or incentives including but not limited to financial, administrative and continuing professional education to promote value-based MHSA Services and enhance Provider performance and clinical outcomes.

6.11.0 Claims Processing

6.11.1 The Contractor must provide all aspects of claims processing. Such responsibility shall include but not be limited to:

6.11.1a Maintaining a claims processing center located in the United States staffed by fully trained claims processors and supervisors;

6.11.1b Verifying that the MHSA Program's benefit design has been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

6.11.1c Accurate and timely processing of all claims submitted under the MHSA Program in accordance with all applicable laws as well as the benefit design applicable to the Enrollee including Copayment, Deductible, Coinsurance and Coinsurance Maximums, at the time the claim was incurred as specified to the Contractor by the Department;

6.11.1d Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed by the Contractor and approved by the Department. The Contractor's system must ensure that payments are made only for authorized services;

6.11.1e Maintaining claims histories for twenty-four (24) months online and archiving older claim histories for the balance of the calendar year in which they were

made and for six (6) additional years thereafter, per Appendix A, with procedures to easily retrieve and load claim records;

6.11.1f Maintaining the security of the claim files and ensuring HIPAA compliance;

6.11.1g Adjusting all attributes of claim records processed in error crediting the MHSA Program for the amount of the claim processed in error;

6.11.1h Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other MHSA Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's Decision Support System vendor at no additional cost. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department;

6.11.1i Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

6.11.1j Maintaining a claims processing system capable of integrating and enforcing the various clinical management and utilization review components of the MHSA Program including: pre-certification, prior authorization, concurrent review and benefit maximums;

6.11.1k Developing and securely routing a MHSA daily claims file that reports claims incurred to date which have been applied to the Shared Accumulators; between the Empire Plan Hospital Program, Medical Program and MHSA Program;

6.11.1l Loading a daily claims file from the Empire Plan medical carrier/third party administrator and hospital carrier that reports Shared Accumulators;

6.11.1m Participating in Medicare Crossover by entering into an agreement with the Empire Plan medical carrier/third party administrator to accept electronic claims data record files from the medical carrier/third party administrator for

Empire Plan Enrollees who have Medicare as their primary coverage. Claims data will only be sent to the Contractor for possible Empire Plan mental health and substance abuse outpatient claims which also involve Medicare coverage. The claims information sent from the medical carrier/third party administrator will include claims filed with the Center for Medicare and Medicaid Services (CMS) that should be considered by the Contractor for secondary coverage. The Empire Plan medical carrier/third party administrator will sort out any claims for benefits that are for mental health or substance abuse services and electronically forward the claim to the Contractor for consideration;

6.11.1n Pursuing collection of up-to-date coordination of benefit information that is integrated into the claims processing system through a pursue and pay methodology and pursuing collection of any money due the MHSA Program from other payers or Enrollees who have primary MHSA coverage through another carrier;

6.11.1o Analyzing and monitoring claim submissions to promptly identify errors, fraud and/or abuse and reporting to the State such information in a timely fashion in accordance with a State approved process. The Contractor will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Contractor error, without additional administrative charge to the MHSA Program. The Contractor shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, or due to fraud and abuse the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSA Programs upon receipt; however, the Contractor is not responsible to credit amounts that are not recovered;

6.11.1p Establishing a process through which Providers can verify eligibility of Enrollees and Dependents during Call Center Hours;

6.11.1q Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. The Department agrees to reimburse the Contractor for claims processed under the Disabled Lives Benefit in accordance with Article XIV Payments/(Credits) to/from the Contractor.

6.11.1r Updating the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year; and

6.11.1s Mailing Explanation of Benefits to Enrollees for Non-Network claims only. Explanation of Benefits for all MHSA Services must be available upon request from the Contractor's and available for download from the Contractor's customized website. An annual statement of network EOBs must be mailed to Enrollees

6.12.0 Clinical Management

6.12.1 Pre-Certification of Care

6.12.1a To ensure that the resources available to the MHSA Program are utilized for appropriate, medically necessary care, the Contractor is required to perform pre-certification of care which includes, at a minimum:

6.12.1a(1) Use of a voluntary Clinical Referral Line (CRL) located in the United States to evaluate Enrollees MHSA care needs and direct Enrollees to the most appropriate, cost-effective Providers and levels of care. The CRL must be structured to facilitate Clinicians' assessments of the callers' MHSA treatment needs and to provide suitable, timely referrals especially in emergency or urgent situations or for care that requires inpatient admission;

6.12.1a(2) Use of alternate procedures to precertify care when the Enrollee fails to call the CRL, as follows:

6.12.1a(2)i When an Enrollee contacts a Network Provider directly for treatment without calling the CRL, the

Contractor is ultimately responsible for ensuring that Enrollees receive the Network level of benefits and obtaining all necessary aurthorizations for treatments for Network outpatient services for "Recurrent Therapy Visits" and Network inpatient care, when an Enrollee contacts a Network Provider directly for treatment without calling the CRL;

6.12.1a(2)ii When an Enrollee contacts a Network Provider directly and the Network Provider is not the appropriate Provider to treat that Enrollee, the Contractor is responsible for ensuring that its Network Providers take responsibility for assisting the member in obtaining an appropriate referral; and

6.12.1a(2)iii When an Enrollee contacts a Non-Network Facility for treatment and the Contractor is notified in advance of the admission, the Contractor must provide the Enrollee or other HIPAA authorized representative of the Enrollee, with a written determination of medical necessity of care in advance of the inpatient admission, where feasible.

6.12.1a(3) Timely written notification to the Enrollee, or other HIPAA authorized representative of the Enrollee, of the potential financial consequence of remaining in a Non-Network Facility when the initial determination of medical necessity occurs;

6.12.1a(4) Preparing and sending communications to notify Enrollees and/or their Providers of the outcome of their pre-certification or prior

authorization request and notifying them in writing of the date through which MHSA Program services are approved;

6.12.1a(5) Promptly loading into the clinical management and/or claims processing system approved authorizations determined by the Contractor;

6.**12.1a(6)** Pre-certifying inpatient hospital admissions for alcohol detox, advising the facility to send the claim to the Hospital Program vendor and managing the patient's care if transferred to rehab: and

6.12.1a(7) Loading into the Contractor's clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, priorto the during the implementation period, once acceptable files are received.

6.12.2 <u>Concurrent Review</u>

6.12.2a To safeguard Enrollee health and ensure adherance with the MHSA Program's benefit design and requirements on mental health parity, the Contractor must administer a concurrent utilization review program in the United States which:

6.12.2a(1) Enforces the MHSA Program's benefit design features and ensures that Network Providers use the latest MHSA care protocols for Enrollees;

6.12.2a(2) Uses Clinicians to review Provider treatment plans which must detail, at a minimum: past clinical and treatment history; current symptoms, functional impairment; and DSM-IV diagnosis. The Contractor must require that the Network Provider's proposed treatment plan and goals be in writing for outpatient services.

The Contractor must review the treatment plan for a member when the member's visits to the Network Provider exceed the expected duration of services for the Enrollee's clinical diagnosis;

6.12.2a(3) Is conducted in a manner which is parity compliant as required by the Mental Health Parity and Addiction Equity Act;

6.12.2a(4) Performed by the Contractor for t outpatient and inpatient care rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider;

6.12.2a(5) For inpatient admissions, recognizes when to utilize more appropriate and less restrictive levels of care when medically appropriate. The Contractor must have procedures for identifying when transfer to an alternate inpatient or outpatient setting is appropriate and for arranging such transfers;

6.12.2a(6) Establishes maximum time frames for inpatient review based upon the level of care provided, and a time frame that allows for discharge planning where the continued stay is not certified;

6.12.2a(7) Employs appropriately skilled clinicians to review treatment plans in a manner that does not disrupt or delay treatment;

6.12.2a(8) Renders certification decisions on a timely basis and requires that Peer Advisors render non-certification decisions;

6.12.2a(9) For Enrollees admitted to Non-Network Facilities, the Contractor must have procedures to either arrange to transfer the Enrollee to a Network Facility as soon as medically appropriate, or manage the care as if it was a Network Facility, including negotiating discounts with the facility;

6.12.2a(10) The Contractor must perform appropriate discharge planning by identifying when discharge from an inpatient network setting is

appropriate and by directing the Enrollee to appropriate outpatient network care following discharge, including scheduling the initial appointment. Discharge planning must include continual review of the progress of aftercare treatment with the Provider by clinical Manager, as follows:

6.12.2a(10)i Clinical Managers must obtain and review, as part of the discharge plan, specifics that include, at a minimum: the name of the follow-up Provider; date and time of initial follow-up appointment; and the names of responsible family members; and

6.12.2a(10)ii Clinical Managers must assist Providers in locating aftercare services. The Contractor must maintain a database of local community resources to assist Providers in locating aftercare services or alternative care in their areas.

6.12.2a(11) The Contractor must provide intensive case management on a voluntary basis for complex cases or cases requiring long-term treatment. The Contractor must cooperate with the Empire Plan hospital carrier and other Empire Plan carriers in cases of medical/mental health multiple diagnoses in accordance with Mixed Services Protocol (MSP) guidelines established by the Department. Under those MSP guidelines, in cases where there is both a medical and a psychiatric diagnosis, responsibility for case management is determined by the unit (medical or psychiatric) to which the admission is made and the specialty of the attending physician. When those MSP guidelines are insufficient to determine case management responsibility, the Empire Plan hospital carrier and the Contractor must come to an agreement using other factors such as the condition causing the person to remain hospitalized and the proposed treatment plan;

6.12.2a(12) The Contractor must use Clinical Managers or Peer Advisors to manage the care of members; and

6.12.2a(13) The Contractor must measure and assess the effects of clinical management and utilization review processes and procedures on the quality of MHSA Program costs and care.

6.12.3 Disabled Dependent Determinations

6.12.3a The Contractor must establish a process to perform reviews of the PS-451 form and all additional medical information for mental health and substance abuse-related dependent disabilities. The review must be completed in the United States (preferably in New York State) and a clinical determination must be completed within ten (10) Business Days of receipt of a complete form.

6.12.3b The Contractor must send a determination letter, approved in advance by the MHSA Program, to the Enrollee and to the Department advising of the determination within three Business Days of determination.

6.12.4 Appeal Process

6.12.4a The Contractor must:

6.12.4a(1) Perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer;

6.12.4a(2) Administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment, including:

6.12.4a(2)a Developing a clinical appeal form and criteria for establishing medical necessity and experimental or investigational treatment;

6.12.4a(2)b Reviewing clinical appeals for medical necessity and experimental or investigational treatment and preparing communications to notify Enrollees of the outcome of appeals; and

6.12.4a(2)c Integrating the appeal decisions into the clinical management and claims processing systems.

6.12.4a(3) Establish two levels of internal clinical appeals as follows:

6.12.4a(3)a A level 1 clinical appeal must be performed by an independent Peer Advisor; and

6.12.4a(3)b A level 2 clinical appeal must be conducted by a panel of two board-certified psychiatrists and a Clinical Manager who work for the Contractor. Panel members must not have been involved in the previous determinations of the case.

6.12.4a(3)c Clinical Appeals must be completed in a timely manner consistent with NYS and federal laws:

6.12.4a(3)c(1) For a second level clinical appeal of a post-service claim, within thirty (30) days of the member's request;

6.12.4a(3)c(2) For a second level clinical appeal of a pre-service request for benefits, within fifteen (15) days of the member's request;

6.12.4a(3)c(3) For appeals involving urgent situations, in no more than seventy-two (72) hours following receipt of the appeal.

6.12.4a(4) Respond to all External Appeals on behalf of the Department as requested by the New York State Department of Financial Services' through a process that provides an opportunity for Enrollees and Dependents to appeal where denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service.

6.12.4a(5) Oversee and enforce the MHSA Program's appeal processes including reporting the results of the administrative, clinical and external appeal processes for the MHSA Program to the Department in the format and frequency required in Article XV: Reports and Claim Files section of this Agreement.

6.12.5 Other Clinical Management Programs

6.12.5a The Contractor must provide voluntary opt-in programs for Depression Management, Eating Disorders and Attention Deficit Hyperactivity Disorder (ADHD). The cost of the Depression Management, Eating Disorder and ADHD Programs shall be included in the Administrative Fee. The Contractor may receive a data feed from the Empire Plan's Prescription Drug Program to be used as a method to identify members with depression, eating disorders and ADHD, The voluntary opt-in programs must minimally include:

6.12.5a(1) a method to identify members with depression, eating disorders and ADHD using screening tools, both on-line and by mail;

6.12.5a(2) methods to educate members about the symptoms, effects and treatment of depression, eating disorders and ADHD;

6.12.5a(3) accepting referrals to Network Providers;

6.12.5a(4) telephonic support, coordination with treating providers and referrals to community services; and

6.12.5a(5) a method to establish contact with Empire Plan primary care physicians, and other medical specialists likely to have patients that present with symptoms of depression, eating disorders and ADHD in order to educate medical Providers about the availability of the depression, eating disorder and ADHD programs.

6.12.5b The Contractor may propose other voluntary opt-in programs which are available at no additional cost. The Department reserves the right to not participate in any program offered and the right to opt out of any program at any time.

6.12.6 Transition of Care

6.12.6a The Contractor must identify members who are receiving MHSA services from the incumbent contractor's network from a Provider who is not in the Contractor's network. The Contractor must send these members a letter notifying them of the Transition of Care benefit 3-4 weeks prior to the Implementation Date.

6.12.6b The Contractor must notify the corresponding Providers of the Transition of Care benefit, including how to submit claims so that the member is responsible only for the applicable Copayment.

ARTICLE VII: PERFORMANCE GUARANTEES

7.1.0 The Parties agree that the following guarantees and the corresponding credit amounts for failure to meet the Contractor Performance Guarantees shall be implemented effective the first day of

the month following a 90 day implementation period after the Office of the State Comptroller approves the Contract. The Contractor acknowledges and agrees that failure to perform the Program Services features in such a manner which either meets or exceeds any, and/or all of the Contractor Performance Guarantee(s) as set forth in this Article VII, and/or fails to make any payment(s) of any such credit amounts for such failure to meet any Performance Guarantee(s) does not relieve the Contractor of the performance of the activities, duties, and obligations as otherwise set forth in the Agreement. Credit amounts are cumulative. Amounts due from the Contractor to the Department for failure to perform and audit credit amounts, as determined pursuant to Article XIV of this Agreement, shall be made in such amounts as determined by the Department to be final. Upon such determination, the Department shall notify the Contractor, in writing, and the Contractor shall apply such amounts as a credit against the Administrative Fee in accordance with Article XIV of this Agreement within thirty (30) Days of receiving such notification by the Department. These amounts must also be applied as a credit against the Administrative Fee and reported in the Annual Financial Report.

7.2.0 <u>Implementation and Start-up Guarantee and Credit Amount:</u>

7.2.1 ***Guarantee:*** The Contractor must guarantee that all Implementation and Start-up activities will be completed the first day of the month following a 90 day implementation period after the Office of State Comptroller approves the Contract so that Contractor can assume full operational responsibility for the MHSA Program on the designated date. For the purpose of this guarantee, the Contractor must, on the designated date, have in place and operational;

7.2.1a A contracted Provider network that meets the access standards set forth in Section 6.10.1 of this Agreement;

7.2.1b A fully operational Dedicated Call Center, including a clinical referral line, providing all aspects of customer support and clinical services as set forth in Section 6.5.0 of this Agreement; The Dedicated Call Center must be open and operational a minimum of thirty days prior to Program Implementation date to assist Enrollees with questions concerning Program transition;

7.2.1c A claims processing system that processes claims in accordance with the MHSA Program's plan design and benefits, as set forth in Section 6.11.0 of this Agreement;

7.2.1d A claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the Department to correctly pay claims for eligible Enrollees consistent with MHSA Program benefit design and contractual obligations; and

7.2.1e A fully functioning customized MHSA Program website available a minimum of 30 days prior to Program implementation date with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section 6.5.5 of this Agreement.

7.2.2 **Credit Amount**: The Contractor's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is **(TBD)** percent (%) of the 2015 Administrative Fee (prorated on a daily basis).

7.3.0 Call Center Availability Guarantee and Credit Amount

7.3.1 ***Guarantee:*** The MHSA Program's service level standard requires that the Contractor's telephone line will be operational and available to Enrollees, Dependents and providers at least ninety-nine and five-tenths percent *(*99.5%) of the Contractor's Call Center Hours. The call center availability shall be reported monthly and calculated annually.

7.3.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to .50% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Contractor's proposed guarantee) that the Contractor's telephone line is not operational and available to Enrollees, Dependents and Providers during the Contractor's Call Center Hours calculated on an annual basis is $___ per year.

7.4.0 Call Center Telephone Response Time Guarantee and Credit Amount

7.4.1 ***Guarantee:*** The MHSA Program's service level standard requires that at least ninety percent (90%) of the incoming calls to the Contractor's telephone line will be answered by a customer service representative within thirty (30) seconds. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a customer service representative or a Clinical Manager, if after hours. The call center telephone response time shall be reported weekly for the first month of the Agreement and then monthly for the remainder of the Agreement and calculated annually.

7.4.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Contractor's telephone line below the standard of ninety percent (90%) (or the Contractor's proposed guarantee) that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, calculated on an annual basis, is $**(TBD)** per year.

7.5.0 Telephone Abandonment Rate Guarantee and Credit Amount

7.5.1 ***Guarantee:*** The MHSA Program's service level standard requires that the percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative or Clinical Manager, if after hours will not exceed three percent (3%). The telephone abandonment rate shall be reported weekly for the first month of the Agreement and then monthly for the remainder of the Agreement and calculated annually.

7.5.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service or Clinical Referral Line representative in excess of the standard of three percent (3%) (or the Contractor's proposed guarantee), calculated on an annual basis, is $**(TBD)** per year.

7.6.0 Telephone Blockage Rate and Credit Amount:

7.6.1 ***Guarantee:*** The MHSA Program's service level standard requires that the Contractor guarantee that not more than zero percent (0%) of incoming calls to the Contractor's telephone line be blocked by a busy signal. The telephone blockage rate shall be reported weekly for the first month of Agreement and then monthly for the remainder of the Agreement and calculated annually.

7.6.2 ***Credit Amount*****:** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Contractor's telephone line that is blocked by a busy signal, in excess of the standard of zero percent (0%) (or the Contractor's proposed guarantee), calculated on an annual basis, is $**(TBD)** per year.

7.7.0 Enrollment Management Guarantee and Credit Amount

7.7.1 ***Guarantee:*** The MHSA Program's service level standard requires that one hundred percent (100%) of all MHSA Program enrollment records that meet the quality standards for loading will be loaded into the Contractor's enrollment system within twenty-four (24) hours of release by the Department.

7.7.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each twenty-four (24) hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the MHSA Program enrollment records that meet the quality standards for loading is not loaded into the Contractor's enrollment system is $**(TBD).**

7.8.0 Management Reports and Claim File Guarantee and Credit Amount

7.8.1 ***Guarantee:*** The MHSA Program's service level standard requires that accurate management reports and claim files as specified in Section 16.1.0 through 16.4.1 of this Agreement will be delivered to the Department and Decision Support Vendor, as applicable no later than their respective due dates.

7.8.2 ***Credit Amount*****:** The Contractor's quoted amount to be credited against the MHSA Program's Administrative Fee for each management report or claim file that is not

received by its respective due date, is $**(TBD)** per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department and Decision Support Vendor, as applicable, inclusive of the date of receipt.

7.9.0 Network Composition Guarantee and Credit Amount

7.9.1 ***Guarantee:*** The Contractor must propose a Network Composition performance guarantee. The MHSA Program's service level standard requires, that throughout the five-year term of the Agreement and optional eleven (11) month extension period, if exercised at the sole discretion of the Department, that at least ninety percent (90%) of the Providers in each of the Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician who qualifies for the "R" designation in NYS or in other states a Masters Level Clinician with highest licensure, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner-Other Prescriber, listed on **Exhibit I.Y.2**; will be maintained. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee. This standard shall be measured annually.

7.9.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee is $___ for each .01 to1.0% below the standard of ninety percent (90%) (or the Contractor's proposed guarantee) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician who qualifies for the "R" designation in NYS or in other states a Masters Level Clinician with highest licensure, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner-Other Prescriber)listed on **Exhibit I.Y.2** as

calculated on an annual basis is $**_(TBD)**. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee.

7.10.0 Network Provider Access Guarantee and Credit Amount:

7.10.1 ***Guarantee****:* The Contractor guarantees that effective the first day of the month following a 90 day implementation period after OSC approves the Contract and throughout the term of the Agreement:

7.10.1a Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Facility within five (5) miles;

7.10.1b Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Facility within fifteen (15) miles;

7.10.1c Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Facility within forty (40) miles;

7.10.1d Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Practitioner within three (3) miles;

7.10.1e Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Practitioner within fifteen (15) miles; and,

7.10.1f Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Practitioner within forty (40) miles.

7.10.2 ***Credit Amounts***:

7.10.2a The Contractor's quoted amount to be credited against the Administrative Fee is $**(TBD)** for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Facility *(Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined)* Access-for Urban Areas Guarantee, is not met by the Contractor.

7.10.2b The Contractor's quoted amount to be credited against the Administrative Fee is $**(TBD)** for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Facility *(Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined)* Access-for Suburban Areas Guarantee, is not met by the Contractor.

7.10.2c The Contractor's quoted amount to be credited against the Administrative Fee is $**(TBD)** for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Facility *(Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined)* Access-for Rural Areas Guarantee, is not met by the Contractor.

7.10.2d The Contractor's quoted amount to be credited against the Administrative Fee is $**(TBD)**for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Practitioner *(Psychiatrist, Psychologist and Master's Level Clinician, combined)* Access-for Urban Areas Guarantee, is not met by the Contractor.

7.10.2e The Contractor's quoted amount to be credited against the Administrative Fee is $**(TBD**)for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Practitioner *(Psychiatrist, Psychologist and Master's Level Clinician, combined)* Access-for Suburban Areas Guarantee is not met by the Contractor.

7.10.2f The Contractor's quoted amount to be credited against the Administrative Fee is $(**TBD**)___ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Practitioner *(Psychiatrist, Psychologist and*

Master's Level Clinician, combined) Access-for Rural Areas Guarantee, is not met by the Contractor.

7.10.2.g (The Contractor's quoted amount to be credited against the Administrative Fee is $(**TBD**)___ for access that is below the Offeror's proposed guarantee for any quarter in which the Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee is not met by the Offeror.)

7.10.3 Measurement of compliance with each access guarantee will be based on a "snapshot" of the Provider Network taken on the last day of each quarter within the current plan year. The results must be provided in the format contained in Exhibit I.Y.3. The report is due thirty (30) Days after the end of each quarter.

7.11.0 Provider Credentialing Guarantee and Credit Amount

7.11.1 ***Guarantee:*** The Contractor must propose a Provider Credentialing performance guarantee. The MHSA Program's service level standard requires that within sixty (60) Days of receipt of a completed MHSA Provider application to join the MHSA Program's network, the review, including credentialing, will be completed and the Practitioner, ALOC Program or facility notified of the determination.

7.11.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee, on a quarterly basis is $(**TBD**) for each Provider application to join the Program's Network where the review, including credentialing, and notification of the determination to the Provider is not completed within sixty (60) Days (or the Contractor's proposed guarantee).

7.12.0 Financial Accuracy Guarantee and Credit Amount

7.12.1 ***Guarantee:*** The Contractor must propose a financial accuracy performance guarantee. The Program's service level standard requires that the MHSA Program's financial accuracy be maintained for a minimum of ninety-nine percent (99%) of all claims processed and paid each Plan Year. Financial accuracy shall be measured by dividing

the number of claims paid correctly by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). This standard shall be measured on an annual basis;

7.12.2 ***Credit Amount*:** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) (or the Contractor's proposed guarantee) that the MHSA Program's financial accuracy isn't achieved as reported quarterly and calculated on an annual basis is $(**TBD**).

7.13.0 Non-Financial Accuracy Guarantee and Credit Amount

7.13.1 ***Guarantee:*** The Contractor must propose a non-financial accuracy performance guarantee. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of at least ninety-five percent (95%) of all claims processed and paid during the first contract year. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no errors by the total number of claims reviewed. Non-financial errors include, but are not limited to, entry of incorrect: patient name, date of service, Provider name, Provider Identification Number, and remark code, as well as incorrect application of Deductibles and/or Coinsurance amounts to the shared accumulators. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%);

7.13.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (of the Contractor's proposed guarantee) of all claims processed and paid during the first contract year (ninety-seven percent (97%) (or the Contractor's proposed

guarantee) in years two through five of the Agreement) that the MHSA Program's non-financial accuracy rate isn't achieved, as calculated on an annual basis is $(**TBD**).

7.13.3 ***Turnaround Time for Network Claims Adjudication Guarantee:*** The MHSA Program's service level standard requires that at the least, ninety-nine and five-tenths percent (99.5%) of Provider-submitted claims that are received electronically, or in the Offeror's designated post office box, and require no additional information in order to be properly adjudicated, will be turned around within eighteen (18) Business Days or twenty-four (24) Days of receipt. Turnaround time is measured from the date the Provider-submitted claim is received electronically or received in the Offeror's designated post office box to the date the Provider payment is received by the U.S. Post Office or Contractor's mailing agent; and

7.13.4 ***Credit Amount***: The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five tenths percent (99.5%) (or the Contractor's proposed guarantee) of Provider-submitted claims that require no additional information in order to be properly adjudicated that are received by the Contractor and not turned around within eighteen (18) Business Days of twenty-four (24) Days from the date the claim is received in the Contractor's designated post office box to the date the Provider payment is received by the mailing agent, as calculated on a quarterly basis, is $(**TBD**).

7.14.0 Turnaround Time for Non-Network Claims Adjudication Guarantee

7.14.1 ***Guarantee*:** The Contractor must propose a turnaround time for non-network claims adjudication performance guarantee. The MHSA Program's service level standard requires that at least ninety-nine and five-tenths percent (99.5%) of Enrollee-submitted claims that are received in the Contractor's designated post office box, and require no additional information in order to be properly adjudicated, will be turned around within eighteen (18) Business Days or twenty-four (24) Days of receipt. Turnaround time is measured from the date the Enrollee-submitted claim is received in the Contractor's designated post office box to the date the Explanation of Benefits is received by the U.S. Post Office or Contractor's mailing agent.

7.14.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Contractor's proposed guarantee) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Contractor and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Contractor's designated post office box to the date the Explanation of Benefits is received by the mailing agent, as calculated on a quarterly basis, is $(TBD).

7.15.0 Clinical Referral Line Guarantees and Credit Amounts

7.15.1 ***Non-Network CRL Guarantee:*** The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate Non-Network Provider within two (2) Business Days of the call in at least ninety percent (90%) of the cases as calculated annually.

7.15.2 ***Non-Network CRL Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) of cases (or the Contractor's proposed guarantee) when an Enrollee is referred to a Non-Network Provider within two (2) Business Days (in non-emergency or non-emergency or non-urgent situations) because a Network Provider is not available, reported quarterly as calculated annually, is $(**TBD**).

7.15.3 ***Emergency Care CRL Guarantee:*** The MHSA Program's service level standard requires that one hundred percent (100%) of Enrollees who call the CRL in need of emergency care be contacted by either the Network Provider or the Contractor's clinicians within thirty (30) minutes of the Enrollees call to the CRL to assure their safety.

7.15.4 ***Emergency Care CRL Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of one hundred percent (100%) when an Enrollee requires emergency care, contact will be made by either the Network Provider or the Contractor's Clinical Mangers within thirty (30) minutes of the Enrollee's call to the Clinical Referral Line, reported quarterly as calculated annually, is $(**TBD**)

7.15.5 ***Urgent Care CRL Guarantee:*** The MHSA Program's service level standard requires at least ninety-nine percent (99%) of Enrollees in need of urgent care be contacted by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the Enrollee's call to the CRL.

7.15.6 ***Urgent Care CRL Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) (or the Contractor's proposed guarantee) when an Enrollee requires urgent care, contact will be made by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL, reported quarterly as calculated annually, is $(**TBD**).

7.16.0 Utilization Review Guarantees and Credit Amounts

7.16.1 Outpatient Treatment Utilization Review Guarantee and Credit Amount

7.16.1a ***Guarantee:*** The Contractor must propose an outpatient treatment utilization review performance guarantee. The MHSA Program's service level standard requires that at least ninety percent (90%) of outpatient treatment plans be reviewed and the Provider and Enrollee notified within twelve (12) Business Days of receipt of the report as reported quarterly and calculated on an annual basis.

7.16.1b ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Contractor's proposed guarantee) of outpatient treatment plans

not reviewed and the Enrollee and Provider notified within twelve (12) Business Day of receipt of the report as reported quarterly and calculated on an annual basis, is $(**TBD**).

7.17.0 Inpatient Treatment Utilization Review Guarantee and Credit Amount

7.17.1 ***Guarantee:*** The Contractor must propose an inpatient treatment utilization review performance guarantee. The MHSA Program's service level standard requires that at least ninety percent (90%) of requests for authorization of inpatient care be reviewed and completed within twenty-four (24) hours from the receipt of the request and the Enrollee and Provider notified within one (1) Business Day of the determination as reported and calculated on an annual basis.

7.17.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Contractor's proposed guarantee of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request and the Enrollee and Provider notified within one (1) Business Day of the determination, is $(**TBD**).

7.18.0 Appeal Guarantees and Credit Amounts

7.18.1 Inpatient Appeal Guarantee and Credit Amount

7.18.1a ***Inpatient Appeal Guarantee:*** The Contractor must propose a performance guarantee. The MHSA Program's service level standard requires that at least ninety-five percent (95%) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included

as having met the standard. This standard will be calculated on an annual basis;

7.18.1b ***Inpatient Appeal Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Contractor's proposed guarantee) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal as reported quarterly and calculated on an annual basis, is $(**TBD**).

7.18.1c ***Outpatient and ALOC Appeal Guarantee:*** The Contractor must propose a performance guarantee. The MHSA Program's service level standard requires that at least ninety-five percent (95%) Outpatient Care and Alternative Levels of Care level one appeals must be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.

7.18.1d ***Outpatient and ALOC Appeal Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Contractor's proposed guarantee) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal as reported quarterly and calculated on an annual basis, is $(**TBD**).

ARTICLE VIII: MODIFICATION OF PROGRAM SERVICES

8.1.0 In the event that laws or regulations enacted by the Federal government and/or the State have an impact upon the conduct of this Agreement in such a manner that the Department determines that any design elements or requirements of the Agreement must be revised, the Department shall notify the Contractor of any such revisions and shall provide the Contractor with a reasonable time within which to implement such revisions.

8.2.0 In the event that the NYS and the unions representing State Employees enter into collective bargaining agreements, or the State otherwise requires changes in Plan design elements or requirements of the Agreement, the Department shall notify the Contractor of such changes and shall provide the Contractor with reasonable notice to implement such changes.

8.3.0 To the extent that any of the events as set forth in this Article shall take place and constitute a material and substantial change in the delivery of services that are contemplated in accordance with the terms of the MHSA Program as of the Effective Date and which the Contractor is required to perform or deliver under the Agreement, either Party may submit a written request to initiate review of the fee(s) received by the Contractor for services provided and guarantees made by the Contractor under the terms of the Agreement, accompanied by appropriate documentation. The DCS reserves the right to request, and the Contractor shall agree to provide additional information and documentation the DCS deems necessary to verify that a modification of the fees or guarantees is warranted. The DCS will agree to modify the fee(s) to the extent necessary to compensate the Contractor for documented additional costs determined by DCS to be reasonable and necessary. The Contractor will agree to modify the fee (s) to the extent necessary to relieve the DCS of the obligation to pay for Program services that are no longer required. The DCS will agree to modify guarantees as determined by DCS to be necessary to reflect MHSA Program modifications. Should the Parties agree to modify the fee(s) and/or guarantees, such approval shall be subject to written amendment and approval by OSC and the AG. The Contractor shall implement changes as required by the DCS with or without final resolution of any fee proposal.

ARTICLE IX: DEVELOPMENT OF SUMMARY PLAN DESCRIPTIONS AND BENEFIT SUMMARIES

9.1.0 The Contractor shall present to the Department its recommendations for the development of the necessary Summary Plan Descriptions and Benefit Summaries for the Empire Plan, Excelsior Plan and SEHP Mental Health and Substance Abuse Programs. The Department shall review the Contractor's recommendations and shall make the final determination regarding the manner in which the Summary Plan Descriptions and Benefit Summaries shall be developed and issued by the Contractor.

ARTICLE X: ENROLLMENT INFORMATION AND RECORDS

10.1.0 The Contractor shall maintain records in the United States from which may be determined at all times the names of all Enrollees insured hereunder, and their Dependents, and the benefits in force for each such Enrollee, together with the date when any coverage became effective and the effective date of any change in or termination of benefits.

10.2.0 The Department shall transmit enrollment information provided by the Enrollee to the Contractor for the Department Program in an electronic format consistent with Section 6.7.0 of this Agreement. The eligibility rules and the enrollment reports generated as a result of these eligibility rules shall be the sole means of determining valid enrollment for benefits under the Department Program.

10.3.0 The Department and the Enrollees/Dependents shall furnish to the Contractor all information that the Contractor may reasonably require with regard to any matters pertaining to the enrollment of Enrollees/Dependents under this Agreement. A person will not be entitled to or deprived of benefits under the Agreement due to clerical errors.

10.4.0 The Department agrees to provide the Contractor with reasonable access to records of the Department which may have a bearing on the benefits provided by the Contractor or calculation of the Contractor's Administrative Fee as set forth under Article XIII of this Agreement.

ARTICLE XI: DATA SHARING AND OWNERSHIP

11.1.0 All claims and other data related to the Department Program is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other NYSHIP

carriers Department consultants and the Department's Decision Support System contractor and Department of Health's all payer claims database.

11.2.0 Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the Enrollee/Dependent, the Contractor shall not share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department.

ARTICLE XII: DCS PROGRAM CLAIMS REIMBURSEMENT

12.1.0 Provider Network Claims

12.1.1 The Contractor must contract with Network Providers. The amount charged to the MHSA Program shall be the contracted Network Provider fee, less any applicable Copayment and after the coordination of benefits when the claim is processed as secondary coverage.

12.1.2 Claim Payments are to be made based on the requirements contained in Section IV and Articles 6.11.0 and 12.1.0 of this Agreement, including but not limited to each group's Copayment as reflected in Exhibit II.B; and Exhibit II.B2 of the RFP as well as the annual maximum for Applied Behavioral Analysis (ABA) services as reflected in the most current Plan Communication materials.

12.1.3 Throughout each Plan Year, the selected Contractor shall charge to the Program the incurred claims cost for Network services based on the amounts actually paid by the Contractor to Network Providers.

12.1.4 ***Network Pricing Guarantee:*** The Contractor is required to guarantee that the Actual Average Unit Cost (AAUC) for each category shall not exceed the proposed GAUC.

12.1.4a Based on incurred claims for each Plan Year that are paid as of June 30th of the following year, the Contractor shall calculate the AAUC for the Inpatient

Services and Outpatient Services categories. Such Network Services shall include all services/days paid at the Network benefit level including services/days rendered by Non-Network Providers when the Contractor determines that it is appropriate for either access or clinical reasons. Network Services shall not include non-network services where the Contractor had no opportunity to direct the care or Transition of Care services. The calculation of the AAUC shall be equal to the amounts that would be paid by the Contractor to the Network Provider for Plan primary claims only and prior to the application of the Copayment and Bad Debt and Charity assessments.

12.1.4b The Contractor acknowledges that the GAUC for the Inpatient Services set forth in Exhibit V.A.3 may incorporate the inpatient professional service component pertaining to global reimbursement arrangements. Amounts actually paid and reported to the Department for Inpatient Services will include the inpatient professional service component of global arrangements. Any adjustments in the calculation of the AAUC shall be at the sole discretion of the Department and subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.

12.1.4c If the AAUC for each category exceeds the GAUC, the Contractor shall forfeit a portion of the Administrative Fee for failure to meet this guarantee, as follows:

12.1.4c(1) For each 1.0% the AAUC exceeds the Outpatient Services GAUC proposed in Exhibit V.A.2, the Contractor shall pay the Department a performance credit equal to 1.5% of the total Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charged to the MHSA Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for

the Outpatient Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

12.1.4c(2) For each 1.0% the AAUC exceeds the Inpatient and ALOC Services GAUC proposed in Exhibit V.A.3, the Contractor shall pay the Department a performance credit equal to 1.5% of the total Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charge to the MHSA Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Inpatient and ALOC Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

12.1.4d For the first Plan Year (2015), no change to the proposed GAUC will be allowed, except in the event of circumstances outside the control of the Contractor that may have a significant effect on cost, such as legislation or substantial enrollment risk profile fluctuations. Any proposed change made by the Contractor in the GAUCs for the 2015 Plan year shall be at the sole discretion of the Department and subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.

12.1.4e For each Plan year after 2015, the Contractor may request in writing an increase in the GAUC. The annual increase shall not exceed the percentage increase in CPI-W for Medical Care, as reported by the Bureau of Labor Statistics for the month of July of the preceding calendar year. If the prior increase in the GAUC occurred more than 12 months prior to the effective date of the requested increase, the maximum increase shall not exceed the cumulative CPI-W observed since the implementation of the prior increase. Any increase in the GAUC requires written approval by the Department and

amendment of the Agreement, upon documentation by the Contractor to the satisfaction of the Department, that such increase is required to maintain adequate Network access.

12.1.4f For purposes of both the development of the GAUC and AAUC, claims processed as secondary to the Plan shall be excluded from the calculations and network pricing guarantees. In addition, the GAUC and AAUC shall not include any fees or assessments set forth in Section V.B.3, V.B.4 and V.B.5 of this RFP

12.2.0 Non-Network Claims

12.2.1 The Contractor will accurately process Non-Network claims and make payments directly to the Enrollee (or Approved Facility) in a timely manner.

12.2.2 Payments are to be made based on the requirements contained in Section IV of the RFP, including but not limited to each group's Co-insurance and Deductible as reflected in Exhibit II.B; and Exhibit II.B.2 as well as the annual maximum for ABA services.

12.2.3 The Contractor will process Non-Network claims, as follows:

12.2.3a For the Empire Plan and Excelsior Plan: using Reasonable and Customary charges based on the 90th percentile of charges for each service performed, as determined by Fair Health, Reasonable and Customary means the lowest of:

1. The actual charge for services; or
2. The usual charge for services by the Provider for the same or similar service; or
3. The usual charge for services of other Providers in the same or similar geographic area for the same or similar service.

12.2.3b For the Student Employee Health Plan: using the Network Provider allowed amount applicable for Downstate New York;

12.2.4 Where a Network Provider is not available because of clinical or access considerations, the Contractor must negotiate a Single Case Agreement with a Non-Network Provider in a manner consistent with what is typically allowed for a Network Provider in the same discipline for the same service. The Contractor must pay the claim and charge the MHSA Program as if the services were incurred by a Network Provider and include these charges in the calculations of the annual AAUC.

12.2.5 The Contractor will update its database with FAIR Health, Inc.'s database of Reasonable and Customary amounts in a timely manner, at a minimum of twice a year.

ARTICLE XIII: ADMINISTRATIVE FEE

13.1.0 The Contractor shall:

13.1.1 Agree that the following non-exclusive costs are not allowable and shall not be charged to the MHSA Plan as either a direct or formula expense: commissions, non-Plan advertising costs, capital expenditures for improvement or acquisition of facilities, entertainment costs, including social activities or cost of alcoholic beverages, costs of fund raising, costs for political activities, costs for attendance at conferences or meetings of professional organizations unless attendance is necessary in connection with the MHSA Plan and the Contractor received prior written approval by the Department and any costs related to or associated with the preparation and submission of a competitive proposal, including but not limited to the Contractor's Proposal, Exhibit C;

13.1.2 Agree that the Department shall calculate the total Administrative Fee payable to the Contractor for each month by multiplying the per Administrative Fees of $(TBD), by the number of Enrollees in force each month as reported by the New York State Benefit Eligibility and Accounting System on the first Thursday of each month. The Department shall furnish to the Contractor a written statement for each month showing the number of Plan contacts then in force;

13.1.3 Be bound by its Administrative Fee, as proposed in the Contractor's Proposal, Exhibit C, for the entire term of the Agreement unless amended in writing by the Parties;

13.1.4 Manage all MHSA Program Enrollees based on the Contractor's Administrative Fee, as proposed by the Contractor in its Cost Proposal;

13.1.5 Implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 days of notice;

13.1.6 Agree not to request a higher Administrative Fee, and the Department will not consider any increase to the Administrative Fee, that is not based on a material change to the MHSA Program requiring the Contractor to incur additional costs. The determination of what constitutes a material change will be at the sole discretion of the Department;

13.1.7 Submit detailed documentation of additional administrative/clinical costs, over and above existing administrative/clinical costs, with any request for an increase in the Administrative Fee resulting from a material change in the benefit structure of the MHSA Program. The Department reserves the right to request and the Contractor agrees to provide any additional information and documentation the Department deems necessary to make its determination whether a the Contractor's request for an increase to the Administrative Fee is approved. The Department's decision to modify the Administrative Fee to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the Department, subject to the approval of a formal written amendment to the Agreement, signed by the Parties, and approved by the New York State Attorney General and New York State Office of State Comptroller;

13.1.8 Implement all benefit designs as required by the Department with or without final resolution of any request by the Contractor for a higher Administrative Fee. Refusal to implement benefit design changes will constitute a material breach of this Agreement and the Department shall take any action as may be appropriate and provided for by law, rule or in this Agreement, including, but not limited to, seeking compliance and recovering damages; and

13.1.9 Administrative claims incurred during the coverage period of the contract but processed/paid after the last day of coverage, as well as applicable Disabled Lives claims incurred after the last day of coverage of the Agreement will be administered by the Contractor. An Administrative Fee will not be payable/due beyond the termination date of the Agreement.

ARTICLE XIV: Payments/(Credits) to/from the Contractor

14.1.0 The Contractor agrees to manage such financial transactions in accordance with the following:

14.1.1 The Contractor will bill the Department periodically, as proposed, by the Contractor, after claims have been processed. The Department shall pay the Contractor by "wire transfer" within seven days of having received a bill of the claims processed by the Contractor. The Department may consider comparable alternatives to this approach during implementation.

14.1.2 The Plan will pay an Administrative Fee on a monthly basis within thirty (30) Days after receipt of an accurate invoice. Any credit amounts due from the Contractor to the Department for failure to meet the performance guarantees set forth in the Agreement shall be applied as a credit against the Administrative Fee charged to the MHSA Program. Alternatively, the Department may request and receive payment of any performance guarantee amount directly from the Contractor, as opposed to a credit against the Administrative Fee payable to the Contractor.

14.1.3 Upon final audit determination by the Department, any audit liability amount assessed by the Department shall be paid/credited to the MHSA Programs within thirty (30) Days of the date of the Department's final determination, or within thirty (30) Days of receipt of recoveries related to fraud or abuse or Department errors.

14.1.4 The Contractor shall analyze and monitor claim submissions to promptly identify errors, fraud and/or abuse and report to the State such information in a timely fashion in accordance with a State approved process. The Contractor will credit the MHSA Program the amount of any overpayment made by the Contractor regardless of whether

any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Contractor error. The Contractor shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, or due to fraud and abuse, the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSA Program within thirty (30) Days of receipt of such recoveries; however, the Contractor is not responsible to credit amounts that are not recovered.

14.1.5 Litigation recoveries and settlements shall be paid/credited to the MHSA Program within fifteen (15) Days of receipt by the Contractor.

14.1.6 This Agreement is not subject to Article XI-A of NYS Finance Law. The Contractor agrees that MHSA Program Services provided under the Agreement shall continue in full force and effect for a minimum of at least thirty (30) days beyond the payment due date as set forth in this Article XIV. If after the thirty-fifth (35) calendar day after receipt of an accurate invoice, as set forth in this Article XIV of the Agreement, the Contractor has not yet received payment from the State for said invoice, the Contractor may proceed under the Dispute Resolution provision in Appendix B and the Agreement shall remain in full force and effect until such final decision is made, unless the Parties can come to a mutual agreement, in which case, the Agreement shall also remain in full force and effect.

14.1.7 The Contractor will pay the medical carrier/third party administrator on a quarterly basis an amount billed for Shared Communication Expenses. The Contractor will be notified prior to the beginning of each Plan Year the amount of Shared Communication Expenses that will be billed.

14.1.8 The Contractor shall seek reimbursement of the Shared Communications Expense from the Department by including the amount with the voucher for the payment of the next Administrative Fee to be paid.

14.2.0 The Contractor will be responsible for assessments as follows:

14.2.1 The Contractor shall calculate the applicable BDC each month from the applicable paid claims and may charge the MHSA Program at the time this assessment is paid to the regulatory agency/intermediary by the Contractor.

14.2.2 The Contractor shall advise the Department of any new applicable assessments in a timely manner.

14.2.3 The Contractor shall bill the MHSA Program for any new assessments within thirty (30) days after the amounts are paid to the regulating entity.

ARTICLE XV: REPORTS AND CLAIM FILES

15.1.0 Annual Reports

15.1.1 ***Annual Financial Report*:** The Contractor must submit an annual experience report of the Program's charges and credits no later than seventy-five (75) Days after the end of each Calendar Year. These statements must detail, at minimum, claims paid during the year, projected incurred claims not yet paid, administration costs, performance credits, etc. Such detail must include all charges by the Contractor to the Program.

15.1.2 ***Annual Premium Renewal Report:*** The Contractor must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This report must detail all assumptions utilized to support recommended premium level necessary for the following Plan Year. The report must include, but not be limited to: paid claim amounts, projected incurred claims, trend, Administrative Fees and changes in enrollment.

15.1.3 ***Annual Summary Reporting*:** The Contractor must prepare and present to the Department, GOER, Division of Budget and NYS employee unions an annual report that details MHSA Program performance and industry trends. This presentation shall include, at a minimum, comparisons of the MHSA Program to book of business

statistics, and other similar plan statistics. Clinical, financial and service issues are to be comprehensively addressed. The annual presentation and report is due each May after the end of each complete Calendar Year.

15.1.4 ***Annual Report of Claims and Credits Paid by Agency*:** The Contractor must submit a report with summary level claims and credits paid by agency. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. The report is due thirty (30) Days after the end of the Calendar Year.

15.2.0 Quarterly Reports

15.2.1 ***Quarterly Financial Summary Reports*:** The Contractor must submit quarterly financial reports which present the MHSA Program's experience for the most recent quarter (based on a Calendar Year) and the experience from the beginning of the Calendar Year to the end of the quarter being reported. The quarterly reports must also include projections of:

- annual financial performance;
- assessment of MHSA Program costs;
- incurred claim triangles;
- audit recoveries;
- settlement and litigation recoveries;
- administrative expenses;
- trend statistics; and
- such other information as the Department deems necessary.

The reports are due on a quarterly basis, fifteen (15) Days after the end of the reporting period;

15.2.2 ***Quarterly Performance Guarantee Report:*** The Contractor must submit quarterly the MHSA Program's Performance Guarantee report that details the Contractor's compliance with all of the Contractor's proposed Performance Guarantees. The report should include the areas of: Implementation, customer service (telephone availability,

telephone response time, abandonment rate and blockage rate); enrollment management, reporting, network composition, provider access, provider credentialing, financial and non-financial accuracy, turnaround time for processing network and non-network claims, non-network Clinical Referral Line, emergency care Clinical Referral Line, urgent care Clinical Referral Line outpatient and inpatient Utilization Review; and inpatient and outpatient appeals. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F.. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;

15.2.3 ***Quarterly Utilization Report:*** The Contractor must submit quarterly the MHSA Program's Quarterly Utilization Report that details the MHSA Program's care utilization by type of service for both network and non-network authorizations, by type of treatment (inpatient, outpatient, ALOC) Applied Behavioral Analysis, collective bargaining unit, age of the member, type of Dependent, and any other category as requested by the Department. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. The report is due forty-five (45) Days after the end of each quarter;

15.2.4 ***Quarterly Network Access*****:** The Contractor must submit a measurement of the Network access using Exhibit C of the Agreement based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter;

15.2.5 ***Quarterly Coordination of Benefit Report:*** The Contractor must submit a report that details the amount received as a result of coordinating benefits with other health plans including Medicare. The Contractor's report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The final format of this report will be determined by the Department in consultation with the Contractor. The report is due thirty (30) Days after the end of the quarter;

15.2.6 ***Quarterly Participating Agency Claims:*** The Contractor must submit a quarterly report that presents summary level claim information by Participating Agency. The Contractor shall submit this report using the data elements specified by the Department in Exhibit II.F, unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the quarter; and

15.2.7 ***Quarterly Website Analytics Report:*** The Contractor must submit a quarterly report that provides comprehensive performance information for the Contractor's customized MHSA Program website as set forth in Section 6.5.5 of this Agreement. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the layout and design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter.

15.2.8 ***Quarterly Provider Audit Report***: The Contractor must securely submit a provider audit report to the Department summarizing audits planned, initiated, in progress and completed, as well as audit findings, recoveries and any other enforcement action by the Contractor. The report is due thirty (30) Days after the end of the quarter.

15.3.0 <u>Monthly Reports</u>

15.3.1 ***Monthly Report of Paid Claims by the Month Incurred:*** The Contractor must submit a monthly report that provides summarized paid claims by the month incurred. The Contractor must submit this report using data elements acceptable to the Department. The report is due thirty (30) Days after the end of the month; and,

15.3.2 MHSA ***Program Customer Service Monthly Reports:*** Each month the Contractor must submit a customer service report that measures the Contractor's customer service performance including call center availability, call center telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and claims turnaround. The final format of these reports will be determined by the Department in consultation with the Contractor. The customer service report is due thirty (30) Days after the end of the month. For the first two months of the Agreement, this report will be due on a weekly basis. After two months, the Department will re-

examine the required frequency of this report and establish due dates with the Contractor.

15.4.0 Monthly Periodic Claim File

15.4.1 ***Detailed Claim File Data:*** The Contractor must transmit to the Department and/or its Decision Support System (DSS) Vendor a computerized file via secure transfer, containing detailed claim records using data elements acceptable to the Department to support all claims processed each reporting period and invoiced to the Department. The Department requires that all claims processed and/or adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the MHSA Program. The Contractor must securely forward the required claims data to the Department and/or its DSS vendor within fifteen (15) Days after the end of each month and submit a summarized report by month utilizing a format acceptable to the Department.

ARTICLE XVI: TRANSITION AND TERMINATION OF CONTRACT

16.1.0 The Contractor must commit to fully cooperate with the successor contractor to ensure the timely, receipt of all information necessary to transfer administration of the MHSA Program;

16.1.1 The Contractor must, within one hundred twenty (120) Days prior to the end of the Agreement, or within forty-five (45) Days of notification of termination, if the Agreement is terminated prior to the end of its term, submit to the Department for approval a detailed written Transition Plan, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

16.1.1a Transition of MHSA Program data, including but not limited to a minimum of one year of historical Enrollee claim data including providers' telephone numbers, names, addresses, zip codes licensure types and tax identification numbers, detailed Coordination of Benefits data, High Volume Provider data, report formats, pre-certification/prior authorization approved - through dates, disability determination approved-through dates, any exceptions that have been entered into the adjudication system on behalf of the Enrollee such as a

Single Case Agreement, as well as other data the successor Contractor may request and the Department approves during implementation of the MHSA Program in the format acceptable to the Department. The transition of data files should include but not be limited to the following:

16.1.1a(1) Providing a test file to the successor contractor at least seventy-five (75) days in advance of the Implementation Date to allow the successor contractor to address any potential formatting issues;

16.1.1a(2) Providing one or more pre-production files at least eight (8) weeks prior to implementation that contains the above MHSA Program data as specified by the Department and working in conjunction with the successor contractor;

16.1.1a(3) Providing a second production file four (4) weeks prior to implementation; and

16.1.1a(4) Providing a third production file to the successor contractor by the close of business three (3) days after the Agreement terminates;

16.1.2 Within fifteen (15) Business Days from receipt of the Contractor's proposed Transition Plan, the Department shall either approve the Transition Plan or notify the Contractor, in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department;

16.1.3 Within fifteen (15) Business Days from the Contractor's receipt of the required changes, the Contractor shall incorporate said changes into the Transition Plan and submit such revised Transition Plan to the Department;

16.1.4 The Contractor shall be responsible for transitioning the MHSA Plan in accordance with the approved Transition Plan.

16.1.5 To ensure that the transition to a successor contractor provides Enrollees with uninterrupted access to MHSA benefits and associated customer services, and to enable

the Department to effectively manage the Agreement, the Contractor must provide the following obligations and deliverables to the MHSA Program through the final financial settlement of the Agreement, including but not limited to:

16.1.5a Provide all Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims and, manual submit claims including but not limited to: Medicaid; out-of-network claims; foreign claims;Coordination of Benefit claims; Medicare; reimbursing late filed claims if warranted, repaying or recovering monies on behalf of the MHSA Program for Medicare claims, retaining NYBEAS access and continuing to provide updates on pending litigation and settlements that the Contractor or the NYS Attorney General's Office has/may file on behalf of the MHSA Program. In addition, the Contractor must continue to provide the Department access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Department notifies the Contractor that access may be ended at an earlier date;

16.1.5b Complete all reports required in Section IV.B.7.a.(7) of this RFP;

16.1.5c Provide the MHSA Program with sufficient staffing in order to address State audit requests and reports in a timely manner;

16.1.5d Agree to fully cooperate with all Department and/or OSC audits consistent with the requirements of Article XVII of the Agreement and Appendices A and B;

16.1.5e Perform timely reviews and responses to audit findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements set forth in Article XVII "Audit Authority", Section VII, Contract Provisions and Appendices A and B; and

16.1.5f Remit reimbursement due the MHSA Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XVII,

"Audit Authority" and Article XIV "Payments/credits) to/from the Contractor" of Section VII, Contract Provisions and Appendices A and B.

16.1.6 The Contractor must receive and apply enrollment updates, keep Dedicated Call Center phone lines open with adequate staffing to provide customer service at the same levels provided prior to termination of the Agreement, adjust phone scripts, and transfer calls to the successor contractor's lines during the transition period;

16.1.7 The Contractor must work cooperatively with the successor contractor and the Department to develop an approach to ensure a smooth transition for members who must change Providers to maintain the network level of benefits;

16.1.8 The Contractor must work cooperatively with the successor contractor and the Department to develop an approach to ensure a smooth transition for members who must change Providers to maintain the network level of benefits;

16.1.9 The Contractor must prepare and communicate with the successor Contractor , on a case by case basis, a plan to extend and manage the care of high risk Enrollees who are nearing the end of a course of treatment beyond the transition period;

16.1.10 The Contractor must continue to clinically manage and pay for Covered Services for Enrollees determined to be Totally Disabled on the last day of the Contract, for ninety (90) Days or until the disability ends, whichever occurs first;

16.1.11 The Contractor must continue to manage and pay for Covered Services of Enrollees who are confined as inpatient or in Residential Treatment Centers on the Agreement termination date until the earlier of the step down of care or midnight on the 90th day subsequent to the Agreement termination date;

16.1.12 The Contractor must forward to the successor contractor on a weekly basis all mis-directed authorization requests received by the Contractor after the Agreement termination date for a period of ninety (90) days.

16.1.13 The Contractor must agree that, if the Contractor does not meet all of the Transition Plan requirements in the time frame stated above, the Contractor **will permanently forfeit 100%** of all Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department

ARTICLE XVII: AUDIT AUTHORITY

In addition to the Audit Authority requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

17.1.0 The Contractor acknowledges that the Department has the authority to conduct financial and performance audits of the Contractor's delivery of Program services in accordance with the Agreement and any applicable State and federal statutory and regulatory authorities;

17.2.0 Such audit activity may include, but not necessarily be limited to, the following activities:

17.2.1 Review of the Contractor's activities and records relating to the documentation of its performance under this Agreement in areas such as determination of Enrollee or Dependent eligibility and application of various Department program administrative features (e.g., dependent survivor benefits, reasonable adjudication of disabled dependent status);

17.2.2 Comparison of the information in the Contractor's enrollment file to that on the enrollment reports issued to the Contractor by the Department; and

17.2.3 Assessment of the Contractor's information, utilization and demographic systems to the extent necessary to verify accuracy of data on the reports provided to the Department in accordance with Article XV "Reports and Claim Files" of this Agreement.

17.3.0 The Contractor shall maintain and make available documentary evidence necessary to perform the reviews. Documentation maintained and made available by the Contractor may include, but is not limited to, source documents, books of account, subsidiary records and supporting work papers, claim documentation, pertinent contracts, key subcontracts, provider agreements, and correspondence;

17.4.0 The Contractor shall make available for audit all data in its computerized files that is relevant to and subject to the Agreement. Such data may, at the Department's discretion, be submitted to the Department in machine-readable format, or the data may be extracted by the Department, or by the Contractor under the direction of the Department;

17.5.0 The Contractor shall support audits conducted by the Department, Office of the State Comptroller or any designee of these agencies, as follows, including but not limited to:

17.5.1 Providing ample audit resources including access to the Contractor's online system to the Department and OSC at their respective offices through the date of the final financial settlement of the Agreement;

17.5.2 The capability and contractual right of the State to effectively audit the MHSA Program's Provider Network, including the use of statistical sampling audit techniques and the extrapolation of errors; and

17.5.3 Providing full cooperation with all Department and/or OSC audits consistent with the requirements of Appendices A and B and as set forth in this Agreement including provision of access to protected health information and all other confidential information when required for audit purposes as determined by the Department and/or OSC as appropriate. The Contractor must respond to all State (including OSC) audit requests for information and/or clarification within fifteen (15) Business Days. The Contractor must perform timely reviews and respond in a time period specified by the Department to preliminary findings submitted by the Department or the OSC's audit unit in accordance with the requirements of Article XVII "Audit Authority" in this Agreement. Such audits may include, but are not limited to both electronically submitted and paper claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The Contractor shall facilitate audits of Network Providers, including on-site audits, as requested by the Department and/or OSC.

17.6.0 The Contractor shall, at the Department's request, and in a time period specified by the Department, search its files, retrieve information and records, and provide to the auditors such

documentary evidence as they require. The Contractor shall make sufficient resources available for the efficient performance of audit procedures;

17.7.0 The Contractor shall comment on the contents of any audit report prepared by the Department and transmit such comments in writing to the Department within thirty days of receiving any audit report. The response will specifically address each audit recommendation. If the Contractor agrees with the recommendation, the response will include a work plan and timetable to implement the recommendation. If the Contractor disagrees with an audit recommendation, the response will give all details and reasons for such disagreement. Resolution of any disagreement as to the resolution of an audit recommendation shall be subject to the Dispute Resolution provision set forth in Appendix B of this Agreement;

17.8.0 If the Contractor has an independent audit performed of the records relating to this Agreement, a certified copy of the audit report shall be provided to the Department within ten (10) Days after receipt of such audit report by the Contractor; and

17.9.0 The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the OSC as set forth in either Appendix A of this Agreement, Standard Clauses for All New York State Contracts, or Appendix B, Standard Clauses for All Department Contracts.

ARTICLE XVIII: CONFIDENTIALITY

In addition to the Confidentiality requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

18.1.0 All claims and enrollment records relating to the Agreement are confidential and shall be used by the Contractor solely for the purpose of carrying out its obligations under the Agreement, for measuring the performance of the Contractor in accordance with the performance guarantees set forth in Section VII of this Agreement, and for providing the Department with material and information as may be specified elsewhere in this Agreement;

18.2.0 Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the Enrollee/Dependent, no records may be otherwise used or released to any party other than the

Department by the Contractor, its officers, employees, agents, consultants, Key Subcontractors or Affiliates either during the term of the Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the Department, be grounds for termination of the Agreement;

18.3.0 The Contractor, its officers, employees, agents, consultants and/or any Key Subcontractors or Affiliates agree to comply, during the performance of the Agreement, with all applicable Federal and State privacy, security and confidentiality statutes, including but not limited to the Personal Privacy Protection Law (New York Public Officer's Law Article 6-A, as amended), and its implementing regulations, policies and requirements, for all material and information obtained by the Contractor through its performance under the Agreement, with particular emphasis on such information relating to Enrollees and Dependents;

18.4.0 The Contractor shall be responsible for assuring that any agreement between the Contractor and any of its officers, employees, agents, consultants and/or Key Subcontractors or Affiliates contains a provision that strictly conforms to the various confidentiality provisions of this Agreement; and

18.5.0 The Contractor shall promptly advise the Department of all requests made to the Contractor for information regarding the performance of services under this Agreement, including, but not limited to, requests for any material and information provided by the Department, except as required by Key Subcontractors or Affiliates solely for the purpose of fulfilling the Contractor's obligations under this Agreement or as required by law.

ARTICLE XIX: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

19.1.0 For purposes of this Agreement, the term "Protected Health Information" ("PHI") means any information, including demographic information collected from an individual, that relates to the past, present, or future physical or mental health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual, that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Within

the context of this Agreement, PHI may be received by the Contractor from the Department or may be created or received by the Contractor on behalf of the Department. All PHI received or created by the Contractor as a consequence of its performance under this Agreement is referred to herein collectively as "Department's PHI."

19.2.0 The Contractor acknowledges that the Department administers on behalf of New York State several group health plans as that term is defined in HIPAA's implementing regulations at 45 CFR Parts 160 and 164, and that each of those group health plans consequently is a "covered entity" under HIPAA. These group health plans include NYSHIP, which encompasses the Empire Plan as well as participating health maintenance organizations; the Dental Plan, and the Vision Plan. In this capacity, the Department is responsible for the administration of these "covered entities" under HIPAA. The Contractor further acknowledges that the Department has designated NYSHIP and the Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Contractor further acknowledges that the Contractor is a HIPAA "business associate" of the Department as a consequence of the Contractor's provision of services to and/or on behalf of the Department within the context of the Contractor's performance under this Agreement, and that the Contractor's provision of such services may involve the disclosure to the Contractor of individually identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Contractor's disclosure to the Department of individually identifiable health information as a consequence of the services performed under this Agreement.

19.3.0 ***Permitted Uses and Disclosures of the Department's PHI*:** The Contractor may use and/or disclose the Department's PHI solely in accordance with the terms of this Agreement. In addition, the Contractor may use the Department's PHI to provide data aggregation services relating to the health care operations of the Department. Further, the Contractor may use and disclose the Department's PHI for the proper management and administration of the Contract if such use is necessary for the Contractor's proper management and administration or to carry out the Contractor's legal responsibilities, or if such disclosure is required by law or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it shall be held confidentially and used or further disclosed only as required by law or for

the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware in which the confidentiality of the PHI has been breached.

19.4.0 ***Nondisclosure of the Department's PHI:*** The Contractor shall not use or further disclose the Department's PHI other than as permitted or required by this Agreement or as otherwise required by law. The Contractor shall limit its uses and disclosures of PHI when practical to the information comprising a Limited Data Set and in all other cases to the minimum necessary to accomplish the intended purpose of the PHI's access, use, or disclosure.

19.5.0 ***Safeguards:*** The Contractor shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for by this Agreement. The Contractor shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, to reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that it creates, receives, maintains, or that it transmits on behalf of the Department pursuant to this Agreement.

19.6.0 ***Breach Notification:***

19.6.1 ***Reporting:*** The Contractor shall report to the Department any breach of unsecured PHI, even if the breach is not reportable under HIPAA, including any use or disclosure of the Department's PHI otherwise than as provided for by this Agreement, of which the Contractor becomes aware. Further, the Contractor shall report to the Department any security incident of which it becomes aware. "Security incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in an information system. The Contractor shall notify the Department within five (5) Business Days of the date the Contractor becomes aware of the event.

19.6.2 ***Required Information:*** The Contractor shall provide the following information to the Department within ten (10) Business Days of discovery except when, despite all reasonable efforts by the Contractor to obtain the information required, circumstances

beyond the control of the Contractor necessitate additional time. Under such circumstances, the Contractor shall provide to the Department the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) Days from the date of discovery:

19.6.2a the date of the breach incident;

19.6.2b the date of the discovery of the breach;

19.6.2c a brief description of what happened;

19.6.2d a description of the types of unsecured PHI that were involved;

19.6.2e identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the breach;

19.6.2f A brief description of what the Contractor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

19.6.2g any other details necessary to complete an assessment of the risk of harm to the individual.

19.6.3 The Department will be responsible for providing notification to individuals whose unsecured PHI has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach, as well as the Secretary and the media, as required by 45 CFR Part 164.

19.6.4 The Contractor shall maintain procedures to sufficiently investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the Department upon request.

19.6.5 For purposes of this Agreement, "Unsuccessful Security Incidents" include activity such as pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so

long as no such incident results in unauthorized access, use, or disclosure of electronic PHI.

19.6.6 The Contractor shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Contractor not permitted by this Agreement.

19.7.0 ***Associate's Agents:*** The Contractor shall require all of its agents or Key Subcontractors or Affiliates to whom it provides the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, agree to the same restrictions and conditions on the access, use, and disclosure of PHI that apply to the Contractor with respect to the Department's PHI under this Agreement.

19.8.0 ***Availability of Information to the Department:*** The Contractor shall make available to the Department such information and documentation as the Department may require regarding any disclosures of PHI by the Contractor to fulfill the Department's obligations to provide access to, to provide a copy of, and to account for disclosures of the Department's PHI in accordance with HIPAA and its implementing regulations. The Contractor shall provide such information and documentation within a reasonable amount of time of its receipt of the request from the Department.

19.9.0 ***Amendment of the Department's PHI:*** The Contractor shall make the Department's PHI available to the Department as the Department may require to fulfill the Department's obligations to amend individuals' PHI pursuant to HIPAA and its implementing regulations. The Contractor shall, as directed by the Department, incorporate any amendments to the Department's PHI into copies of the Department's PHI as maintained by the Contractor.

19.10.0*Internal Practices*: The Contractor shall make its internal practices, policies and procedures, books, records, and agreements relating to the use and disclosure of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, available to Department and/or the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the Department and/or the Secretary for purposes of determining the Department's compliance with HIPAA and its implementing regulations.

19.11.0*Termination*:

19.11.1 This Agreement may be terminated by the Department at the Department's discretion if the Department determines that the Contractor, as a business associate, has violated a material term of this Article or of the Agreement with respect to the Contractor's obligations under this Article.

19.11.2 ***Disposition of the Department's PHI:*** At the time this Agreement is terminated, the Contractor shall, if feasible, return or destroy all of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, that the Contractor still maintains in any form and retain no copies of such information. Alternatively, if such return or destruction is not feasible, the Contractor shall extend indefinitely the protections of this Agreement to the information and shall limit further uses and disclosures to those purposes that make the return or destruction of the Department's PHI infeasible.

19.12.0*Indemnification:* The Contractor agrees to indemnify, defend and hold harmless the State, the Department and Department's respective employees, officers, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this Article or from any acts or omissions related to this Article by the Contractor or its employees, officers, Key Subcontractors or Affiliates, agents or other members of its workforce. Accordingly, the Contractor shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Contractor's acts or omissions hereunder. The Contractor's obligation to indemnify any Indemnified Party under this Article shall survive the expiration or termination of this Agreement.

19.13.0Miscellaneous:

19.13.1 ***Amendments*:** This Article may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. The Parties agree to take such action as is necessary to amend this Article from time to time as is necessary to achieve and maintain compliance with the requirements of 45 CFR Parts 160-164.

19.13.2 ***Survival*:** The respective rights and obligations of the Business Associate (Contractor), and Covered Entity under HIPAA as set forth in this Article shall survive termination of this Agreement.

19.13.3 ***Regulatory References*:** Any reference herein to a federal regulatory section within the Code of Federal Regulations shall be a reference to such section as it may be subsequently updated, amended or modified.

19.13.4 ***Interpretation*:** Any ambiguity in this Article shall be resolved to permit covered entities to comply with HIPAA.

ARTICLE XX: NOTICES

20.1.0 All notices permitted or required hereunder shall be in writing and shall be transmitted either:

20.1.1 via certified or registered United States mail, return receipt requested;

20.1.2 by facsimile transmission;

20.1.3 by personal delivery;

20.1.4 by expedited delivery service; or

20.1.5 by e-mail.

Such notices shall be addressed as follows or to such different addresses as the Parties may from time-to-time designate:

State of New York [Agency Name]

Name: (TBD)
Title: Director, Employee Benefits Division
Address:

Telephone Number: (TBD)
Facsimile Number: (TBD)
E-Mail Address: (TBD)

[Contractor Name]

Name: (TBD)
Title: (TBD)
Address: (TBD)
Telephone Number: (TBD)
Facsimile Number: (TBD)
E-Mail Address: (TBD)

20.2.0 Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

20.3.0 The Parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Agreement by giving fifteen (15) days written notice to the other Party sent in accordance herewith. The Parties agree to mutually designate individuals as their respective representatives for the purposes of receiving notices under this Agreement. Additional individuals may be designated in writing by the Parties for purposes of implementation and administration/billing, resolving issues and problems and/or for dispute resolution.

Contractor: (TBD) _____

Contract Number: (TBD) _____

IN WITNESS WHEREOF, the Parties hereto have hereunto signed this Agreement on the day and year appearing opposite their respective signatures.

Agency Certification: "In addition to the acceptance of this Agreement, I also certify that original copies of this signature page shall be attached to all other exact copies of this Agreement."

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

Date: _____ By: _____

Name: _____

Title: _____

CONTRACTOR

Date: _____ By:_____

Name: _____

Title: _____

STATE OF) ss:

COUNTY OF

On the _____ day of _____, _____, before me personally came _____, to me known, and known to me to be the person who executed the above instrument, who, being duly sworn by me, did for her/himself depose and say that (s)he is the _____ of _____ the corporation or organization described in and which executed the above instrument; and that (s)he signed his/her name thereto.

My commission expires: _____ _____
NOTARY PUBLIC

Approved as to Form:
ERIC SCHNEIDERMAN
ATTORNEY GENERAL

By: _____
Date: _____

Approved:
THOMAS P. DINAPOLI
COMPTROLLER

By: _____
Date: _____

Actual Average Unit Cost (AAUC) means the average unit cost for Network Coverage/Services paid during the Plan Year. The calculation of the AAUC shall be equal to the amounts that would be paid by the Contractor to Network Providers for Network Outpatient Services and Network Inpatient/ALOC Services for Plan primary claims only and prior to the application of Copayment and Bad Debt and Charity assessments.

Administrative Fee means the monthly fee that the Contractor charges the MHSA Program for all administrative services exclusive of the Shared Communication Expense, as calculated on a per Enrollee per Month basis.

Affiliate means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent.

Agreement means the contract that results from this RFP between the Department and the Contractor.

Alternate Level of Care (ALOC) means residential treatment centers, halfway houses, group homes, partial hospitalization programs or continuing day treatment programs which satisfy the requirements of an Approved Facility.

Applied Behavioral Analysis (ABA) means a behavioral health service for teaching children with Autism Spectrum Disorder through intensive skill training.

Approved Facility means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Law of New York State. If located outside New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug abuse treatment. Partial Hospitalization, Intensive Outpatient Program, Day Treatment, 23 Hour Extended Bed and 72 Hour Crisis Bed

will be considered approved facilities if they satisfy the foregoing requirements. In all cases other than an emergency, the facility must also be approved by the Contractor. Residential treatment centers, halfway houses and group homes will be considered approved facilities, if they satisfy the requirements above and admission is certified by the Contractor.

Business Day(s) means every Monday through Friday, except for days designated as Business Holidays.

Business Holiday(s) means legal holidays observed by the State and any days designated by the Contractor as a holiday and approved as such by the State prior to January 1 of each Calendar Year.

Calendar Year/Annual means a period of 12 months beginning with January 1 and ending with December 31.

Call Center Hours means 24 hours a Day, 365 Days a year.

Certification or Certified means a determination by the Contractor that mental health care or substance abuse care or proposed care is a Medically Necessary, Covered Service in accordance with the terms of the Agreement.

Child(ren) means children under 26 years of age, including natural children, legally adopted children, children in a waiting period prior to finalization of adoption, Enrollee stepchildren and children of the Enrollee's domestic partner. Other children who reside permanently with the Enrollee in the Enrollee's household and are chiefly dependent on the Enrollee are also eligible, subject to a statement of dependence and documentation.

Clinical Manager means licensed PhD, clinical psychologist, licensed professional registered nurse, or licensed master's level certified social worker with a minimum of three to five years of previous position-related clinical experience in mental health and/or substance abuse treatment or other licensed, qualified individual as approved by the MHSA Program.

Clinical Referral Line means the clinical resource and referral service called prior to receiving any Covered Services to obtain network referrals or benefit information. Available 24 hours a Day, 365 Days a year.

Coinsurance means, for Non-Network Approved Facility services, the difference between the billed charge and the percentage covered; and, for non-network Practitioner services, the difference between the Reasonable and Customary charge and the percentage covered. The Plan's Coinsurance Maximum is shared between Basic Medical, the Hospital Program and the Mental Health and Substance Abuse Program. Copayments paid to a Network Practitioner count toward meeting the Plan's Coinsurance Maximum.

Coinsurance Maximum means the sum of coinsurance costs incurred under the Basic Medical Program and Non -Network Coverage under the Hospital Program and Mental Health and Substance Abuse Program. After the combined annual Coinsurance Maximum is reached, benefits are paid at one hundred percent (100%) percent of Reasonable and Customary charges for Covered Services.

Contractor means (TBD), the successful Offeror selected as a result of the evaluation of Offerors' Proposals submitted in response to this RFP and the Contractor who executes a Contract with the Department to provide Program Services.

Copayment means the amount the Enrollee is required to pay per visit for Covered Services as specified by the benefit design of the MHSA Program.

Cost Sharing means the Enrollee's financial responsibility for Covered Services including Copayment, Deductible and Coinsurance.

Covered Services means Medically Necessary mental health and substance abuse care as defined under the terms of the MHSA Program, except to the extent that such care is otherwise limited or excluded under the MHSA Program.

Crisis Intervention Visits means an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources

to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.

Day(s) means calendar days unless otherwise noted.

DCS or Department means the New York State Department of Civil Service.

Dedicated Call Center means a group of customer service representatives trained and capable of responding to a wide range of questions, complaints, and inquiries specific to the MHSA Program. The customer service representatives are dedicated to the MHSA Program and do not work on any other accounts.

Deductible means the amount paid by the Enrollee each Calendar Year for Covered Services under the non-network portion before a Plan payment is made. Plan deductibles are shared between the Medical Program and the Mental Health and Substance Abuse Program. The amount applied toward satisfaction of the deductible will be the lower of the following: the amount actually paid for a Medically Necessary service under the non-network portion of the MHSA Program; or for Practitioner services, the Reasonable and Customary charge; or for Approved Facility services, the billed amount for such service.

Dependent means the spouse, domestic partner, and children under twenty-six (26) years of age of an Enrollee. Young adult dependent children age twenty-six (26) or over are also eligible if they are incapable of supporting themselves due to mental or physical disability acquired before termination of their eligibility for coverage under the New York State Health Insurance Program.

Dependent Survivor means the unremarried spouse, dependent child, or domestic partner who has not acquired another domestic partner, of an Enrollee who died after having had at least ten (10) years of service, who was covered as a dependent of the deceased Enrollee at the time of the Enrollee's death and who elects to continue coverage under NYSHIP following the three (3) month extended benefits period.

Disabled Lives Benefit means the benefits provided to an Enrollee who is Totally Disabled on the date coverage ends. The benefits are provided on the same basis as if coverage had continued with no change until the day the Enrollee is no longer Totally Disabled or for ninety (90) days after the date the coverage ended, whichever is earlier.

Emergency Care means care received for an emergency condition. An emergency condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such a person or others in serious jeopardy; serious impairment to such person's bodily functions; serious dysfunction of any bodily organ or part of such person; or serious disfigurement of such person.

Employee means "Employee" as defined in 4 NYCRR Part 73, as amended, or as modified by collective bargaining agreement.

Employer means "Employer" as defined in 4 NYCRR Part 73, as amended.

Enrollee means an "Employee" or "Dependent" enrolled in the MHSA Program with mental health/substance abuse benefits.

ET means prevailing Eastern Time.

Guaranteed Average Unit Cost (GAUC) means the amounts as proposed by the Contractor for Network Outpatient Services and Network Inpatient/Alternative Level of Care (ALOC) Services in RFP Exhibits V.A.2 and V.A.3, respectively. The GAUC amounts shall be based on Plan primary claims only and be prior to the application of Copayment and Bad Debt and Charity assessments. The GAUC for Network Inpatient/ALOC Services may incorporate the inpatient professional service component pertaining to global reimbursement arrangements.

Implementation Date means the first day of the month following a minimum implementation period of 90 days subsequent to the Office of State Comptroller's approval of the Agreement that results from this RFP.

Inpatient Services means those services rendered in an Approved Facility to an Enrollee who has been admitted for an overnight stay and is charged for room and board.

Intensive Outpatient Program (IOP) is a freestanding or hospital-based program that provides medically necessary services more than once weekly. Intensive outpatient programs are used as a step-up from routine outpatient services, or as a step-down from acute inpatient, residential care or a partial hospital program. Intensive outpatient programs can be used to treat mental health conditions or substance abuse disorders, or can specialize in the treatment of co-occurring mental health conditions and substance-use disorders.

Key Subcontractor(s) means those vendor(s) with whom the Contractor subcontracts to provide Program Services and incorporates as a part of the Contractor's Program Team.

Medical Necessity/Medically Necessary means a Covered Service which the Contractor has certified to be: medically required; having a strong likelihood of improving the condition; and provided at the lowest appropriate level of care for the specific diagnosed condition, in accordance with both generally accepted mental health and substance abuse practices and the professional and technical standards adopted by the Contractor.

Mental Health Care means Medically Necessary care rendered by a covered Practitioner or Approved Facility and which, in the opinion of the Contractor, is directed predominately at treatable behavioral manifestations of a condition that the Contractor determines: is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and substantially or materially impairs a person's ability to function in one or more major life activities; and has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

MHSA Program/Plan means the New York State Health Insurance Program's Empire Plan Mental Health and Substance Abuse Program, the Excelsior Plan Mental Health and Substance Abuse Program and the Student Employee Health Plan Mental Health and Substance Abuse Program administered by the New York State Department of Civil Service.

Mixed Services Protocol means the methodology for allocating the financial liability for covered MHSA services between the Medical Program contractor, Hospital Program contractor and the MHSA Program contractor.

Network Coverage/ Services means all Medically Necessary services/days paid at the Network benefit level including Medically Necessary services/days rendered by a Non-Network Provider when the Contractor determines that it is appropriate for either access or clinical reasons. Network Services shall not include non-network services where the Contractor had no opportunity to direct the care or Transition of Care services.

Network Facility means an Approved Facility that has entered into a Network Provider agreement with the Contractor as an independent contractor. The records of the Contractor shall be conclusive as to whether a facility has a Network Provider agreement in effect on the date services are obtained. A non-network facility can be considered a network facility on a case-by-case basis when approved by the Contractor.

Network Practitioner means a Practitioner who has entered into an agreement with the Contractor as an independent contractor to provide Covered Services. The records of the Contractor shall be conclusive as to whether a person had a Network Provider agreement in effect on the date services are obtained. A Non-Network Practitioner can be considered a network practitioner on a case-by-case basis when approved by the Contractor.

Network Provider means either a Network Practitioner or a Network Facility.

Non-Network Coverage means the level of reimbursement paid by the MHSA Program for Covered Services from a Non-Network Provider in compliance with the MHSA Program requirements outlined in the Agreement resulting from this RFP.

Non-Network Facility means an Approved Facility that has not entered into an agreement with the Contractor as an independent contractor to provide Covered Services.

Non-Network Practitioner means a Practitioner who has not entered into an agreement with the Contractor as an independent contractor to provide Covered Services. A Non-Network Practitioner can be considered a Network Practitioner on a case-by-case basis when approved by the Contractor.

Non-Network Provider means a Non-Network Practitioner or Non-Network Facility.

NYS means New York State.

NYSHIP means the New York State Health Insurance Program.

Offeror means a person or entity that submits a Proposal in response to this RFP.

Outpatient Services means those services rendered in a Practitioner's office or in the department of an Approved Facility where services are rendered to persons who have not had an overnight stay and are not charged for room and board.

Partial Hospitalization means a freestanding or hospital-based program that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for less than 4 hours per day. A partial hospital/day treatment program may be used as a step up from a less intensive level of care or as a step down from a more intensive level of care and does not include an overnight stay.

Participating Agency (PA) means any unit of local government such as school districts, special districts and district or municipal corporations which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

Participating Employer (PE) means a public authority, public benefit corporation, or other public agency, subdivision, or quasi-public organization of the State which elects, with the approval of

the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

Pass-through Pricing means the MHSA Program is charged the same mental health/substance abuse services fee paid to the Network Provider.

Peer Advisor means a psychiatrist or Ph.D. psychologist with a minimum of five (5) years of clinical experience who renders Medical Necessity decisions.

Physician means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.). He or she must be legally licensed to practice medicine without limitations or restrictions.

Plan Sponsor means the Council on Employee Health Insurance, which is composed of the President of the Civil Service Commission, Director of the Governor's Office of Employee Relations, and the Director of the Division of Budget.

Plan Year means the period from January 1st to December 31st in each year covered by the Agreement, unless specified otherwise by the MHSA Program.

Practitioner means:

1. A psychiatrist; or
2. A psychologist; or
3. A licensed clinical social worker with at least six (6) years of post-degree experience who qualifies for the New York State Board for Social Work "R designation". If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body; or
4. A Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist: Advanced Practice nurses who hold a master's or doctoral degree in a specialized area of psychiatric nursing practice nurse; or
5. A Registered Nurse Practitioner: a nurse with a master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided. Nurse Practitioners may diagnose, treat, and prescribe for a patient's

condition that falls within their specialty area of practice. This must be done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols; or

6. Applied behavioral analysis provider or Certified Behavioral Analyst (CBA) provider: A licensed provider who is certified as a behavior analyst pursuant to a behavioral analyst certification board; or
7. Applied behavioral analysis or ABA Agency: An agency providing ABA services under the program oversight and direct supervision of a licensed provider and certified behavioral analyst. An ABA Agency may also employ ABA aides to deliver the treatment protocol of the ABA Provider.

President means the President of the Civil Service Commission who is also the Commissioner of the Department of Civil Service.

Program Services means all of the services to be provided by the Contractor as set forth in the RFP.

Program Team means, for purposes of the Agreement, the Contractor and those Key Subcontractors and Affiliates, if any, utilized by the Contractor who collectively undertake and perform the Program Services which are the subject of the Agreement. Program Team means, for purposes of the RFP, an Offeror and those Key Subcontractors and Affiliates, if any, the Offeror proposes to utilize to collectively undertake and perform the Program Services which are the subject matter of the RFP.

Proposal means the Contractor's Administrative Proposal, Technical Proposal, and Cost Proposal, including all responses to supplemental requests for clarification, information, or documentation, submitted during the course of the Procurement.

Provider means a Practitioner or Approved Facility that supplies Covered Services under the Mental Health and Substance Abuse Program.

Provider Network means the Contractor's credentialed and contracted network of Network Practitioners and Network Facilities.

Reasonable and Customary means the lowest of:

1. The actual charge for services; or
2. The usual charge for services by the Provider; or
3. The usual charge for services of other Providers in the same or similar geographic area for the same or similar service.

Referral means the process by which the Contractor's toll-free Clinical Referral Line refers an Enrollee to a Network Provider to obtain Covered Services.

Regulations of the President of the New York State Civil Service Commission means those regulations promulgated by the President of the Civil Service Commission under the authority of Civil Service Law, Article XI, as amended, and including, but not limited to those regulations to be promulgated as 4 New York Code of Rules and Regulations (NYCRR) Part 73.

Renewal Date means January 1, 2016 and annually thereafter up to and including January 1, 2019.

Retiree means any person defined as a Retiree pursuant to the terms of 4 NYCRR Part 73, as amended.

RFP or Procurement means the Request for Proposals entitled "Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and Student Employee Health Plan" dated March 13, 2014.

Shared Accumulator means the Coinsurance, certain Copayment and Deductible amounts shared between the MHSA, Medical and Hospital components of the Empire Plan, Student Employee Health Plan and Excelsior Plan.

Shared Communication Expense means the expense that the Contractor will be billed and must pay on a quarterly basis to contribute toward the cost of producing various Empire Plan and NYSHIP publications (i.e. provider directories, Choices Guides, At A Glance publications, etc).

Single Case Agreement means a unique agreement that the Contractor negotiates with a Non-Network Provider to provide MHSA Program Network-level services for a specific Enrollee when there is insufficient access to a Network Provider within a certain geographic area or a

Non-Network Provider possesses a unique specialty that is not currently possessed by a Network Provider within that geographic area.

State means New York State as a whole.

Structured Outpatient Rehabilitation Program (SOP) means a program that provides substance abuse care and is an operational component of an Approved Facility that is state licensed. If located in New York State, the program must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York. If the program is located outside New York State, it must be part of an Approved Facility accredited by the Joint Commission on Accreditation of Health Care Organizations as a hospital or as a health care organization that provides psychiatric and/or drug abuse or alcoholism services to adults and/or adolescents. The program must also meet all applicable federal, state and local laws and regulations. A Structured Outpatient Rehabilitation Program is a program, in which the patient participates, on an outpatient basis, in prescribed formalized treatment, including an aftercare component of weekly follow-up. In addition, Structured Outpatient Rehabilitation Programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.

Substance Abuse Care means Medically Necessary care provided by an eligible provider for the illness or condition that the Contractor has determined: is a clinically significant behavioral or psychological syndrome or pattern; and substantially or materially impairs a person's ability to function in one or more major life activities; and is a condition which has been classified as a substance abuse disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, unless such condition is otherwise excluded under this MHSA Program.

Summary Plan Description(s) (SPD) means the document(s) issued pursuant to an attached by reference to the Agreement resulting from this RFP. The SPD is issued to Enrollees and describes Program benefits. The SPD includes the initial SPD and amendments, if any.

Total Disability and Totally Disabled means that because of a mental health/substance abuse condition, the Enrollee, cannot perform his/her job or the Dependent cannot perform the normal activities of a person that age.

Transition of Care means a benefit that provides Enrollees with the Network level of benefits for a period of 90 days to continue Covered Services that commenced with a Network Provider of the former Program contractor.

Urgent Care is care that does not meet the definition of emergency care but which should be provided early in the onset of symptoms in order to alleviate or prevent permanent disability, serious medical complications, loss of life or harm to the patient or others.

Utilization Review (UR) means a medical management program which reviews the Medical Necessity of mental health and substance abuse treatment. The review should be conducted by a team of licensed and/or certified psychiatric nurses, licensed clinical social workers ("R" status), board-certified or board-eligible psychiatrists and clinical psychologists, as appropriate, to determine whether proposed services are Medically Necessary for diagnosed condition(s). Utilization review includes pre-certification, prior authorization, concurrent review and discharge planning.

Vestee means a former Employee who is entitled to continue benefits under NYSHIP because he/she has met all the requirements for NYSHIP coverage as a Retiree, except for age eligibility for pension, at the time employment terminates.

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

PLEASE RETAIN THIS DOCUMENT
FOR FUTURE REFERENCE.

January 2014

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STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds $50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed $85,000 (State Finance Law Section 163.6-a). However, such pre-approval shall not be required for any contract established as a centralized contract through the Office of General Services or for a purchase order or other transaction issued under such centralized contract.

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex (including gender identity or expression), national origin, sexual orientation, military status, age, disability, predisposing genetic characteristics, marital status or domestic violence victim status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be a condition precedent to payment by the State of

any State approved sums due and owing for work done upon the project.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or (iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, must give the reason or reasons why the payee does not have such number or numbers.

(b) Privacy Notification. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00,

whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
Albany, New York 12245
Telephone: 518-292-5100
Fax: 518-292-5884
email: opa@esd.ny.gov

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
633 Third Avenue
New York, NY 10017
212-803-2414
email: mwbecertification@esd.ny.gov
https://ny.newnycontracts.com/FrontEnd/VendorSearchPublic.asp

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. COMPLIANCE WITH NEW YORK STATE INFORMATION SECURITY BREACH AND NOTIFICATION ACT. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208).

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW. If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded

the contract, the Department of Civil Service and the State Comptroller.

24. PROCUREMENT LOBBYING. To the extent this agreement is a "procurement contract" as defined by State Finance Law Sections 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law Sections 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.
To the extent this agreement is a contract as defined by Tax Law Section 5-a, if the contractor fails to make the certification required by Tax Law Section 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

26. **IRAN DIVESTMENT ACT**. By entering into this Agreement, Contractor certifies in accordance with State Finance Law §165-a that it is not on the "Entities Determined to be Non-Responsive Bidders/Offerers pursuant to the New York State Iran Divestment Act of 2012" ("Prohibited Entities List") posted at:
http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf

Contractor further certifies that it will not utilize on this Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that should it seek to renew or extend this Contract, it must provide the same certification at the time the Contract is renewed or extended. Contractor also agrees that any proposed Assignee of this Contract will be required to certify that it is not on the Prohibited Entities List before the contract assignment will be approved by the State.

During the term of the Contract, should the state agency receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, the state agency will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the state agency shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the Contractor in default.

The state agency reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

APPENDIX B

STANDARD CLAUSES FOR ALL DEPARTMENT CONTRACTS

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1. INTEGRATION

The contract executed between the Department and the Contractor (or Purchase Order issued by the Department) is hereinafter referred to as the Agreement. The Agreement, including all Exhibits and Appendices, including this Appendix B, copies of which are attached thereto, and incorporated therein by reference, constitutes the entire agreement between the Parties for the purpose of the fulfillment of Program Services or Project Services. All prior agreements, representations, statements, negotiations and undertakings are superseded hereby.

All statements made by the Department shall be deemed to be representations and not warranties.

2. EXECUTORY PROVISION

Section 112 of the State Finance Law requires that any contract made by a State department which exceeds fifty thousand dollars ($50,000) in amount be first approved by the Comptroller of the State of New York before becoming effective. The Parties recognize that, if the Agreement is for fifty thousand dollars or more, it is wholly executory until and unless approved by the Comptroller of the State of New York.

3. CHOICE OF LAW

The Parties agree that the Agreement shall be interpreted according to the laws of the State of New York, except where the federal supremacy clause requires otherwise. The Contractor shall be required to bring any legal proceeding against the Department arising from the Agreement in New York State courts located in Albany County.

4. DISPUTE RESOLUTION

Except as otherwise provided in the Agreement, any dispute raised by the Contractor concerning any question of fact or law arising under the Agreement which is not disposed of by mutual agreement of the Parties shall be decided initially by the designee of the President of the Civil Service Commission (President). A copy of the written decision shall be furnished to the Contractor. The Parties shall proceed diligently with the performance of the Agreement and shall comply with the provisions of such decision and continue to comply pending further resolution of any such dispute as provided herein. The decision of the designee of the President shall be final and conclusive unless, within ten (10) Days from the receipt of such decision, the Contractor furnishes the President a written appeal. In the event of an appeal, the President shall promptly review the initial decision, and confirm, annul, or modify it. The decision of the President shall be final and conclusive unless, as determined by a court of competent jurisdiction, it violates one of the provisions of section 7803 of the Civil Practice Law and Rules. Pending final decision of any Article 78 proceeding hereunder, both Parties shall proceed diligently with the performance of the Agreement in accordance with the President's decision.

5. WAIVER OF BREACH

No term or provision of the Agreement shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and signed by the Party claimed to have waived or consented. No consent by a Party to, or waiver of, a breach under the Agreement shall constitute a consent to, a waiver of, or excuse for any other, different or subsequent breach.

6. NEW YORK STATE REQUIREMENTS

The Contractor acknowledges that it is bound by the terms of Appendix A, Standard Clauses For All New York State Contracts, which is attached and incorporated by reference to the Agreement.

7. OUTSIDE OF SCOPE

The Contractor agrees that any and all work performed outside the scope of the Agreement shall be deemed to be gratuitous and not subject to any charge, cost or payment of any kind.

8. NON-ASSIGNABILITY

Neither the rights nor the obligations of the Contractor under the Agreement may be conveyed, assigned, delegated, or otherwise transferred in any manner whatsoever by the Contractor, either in whole or in part, without the prior written approval of the Department.

9. NOTIFICATION

All notices permitted or required by the Agreement to be given by one Party to the other shall be in writing and shall be transmitted either (1) via certified or registered mail, return receipt requested; (2) by facsimile transmission; (3) by personal delivery; (4) by expedited delivery service; or (5) by e-mail.

10. INDEMNIFICATION

The Contractor agrees to indemnify, defend and save harmless the Department, the State, its officers, agents and employees, for any claims or losses the Department, the State or any individuals may suffer when such claims or losses result from the claims of any person or organization for any and all injuries or damages caused by the negligent acts or omissions of the Contractor, its officers, employees, agents, consultants and/or sub-contractors in performance of the Agreement. Furthermore, the Contractor agrees to indemnify, defend and save harmless the Department and the State, its officers, agents, and employees from any and all claims or losses caused by the acts or omissions of any and all contractors, sub-contractors, consultants and any other persons, firms, or corporations furnishing or supplying work, services, materials, or supplies in connection with the performance of the Agreement and from all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of the Agreement, and against any loss, damages or actions, including, but not limited to, costs and expenses, for violation of proprietary rights, copyrights, patents, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any material, information or data furnished under the Agreement, or based on any libelous or otherwise unlawful matter contained in such material, information or data, except as otherwise provided in the Article entitled "Patent Copyright or Proprietary Rights Infringement" of this Appendix B.

The Contractor also shall provide indemnification against all losses, and/or cost expenses (including reasonable counsel fees) that may be incurred by reason of the Contractor's breach of any term, provision, covenant, warranty, or representation contained herein and/or in connection with the enforcement of the Agreement or any provision hereof.

The Department does not agree to any indemnification provisions in any documents attached hereto that require the Department or the State of New York to indemnify or save harmless the Contractor or third parties.

Notwithstanding anything to the contrary in the Agreement, neither the Department nor the Contractor shall be liable to the other for any special, consequential, or punitive damages, or loss of profits or revenues, whether such damages are alleged as a result of tort (including strict liability), contract, warranty, or otherwise, arising out of or relating to either Party's acts or omissions under the Agreement.

11. PATENT, COPYRIGHT OR PROPRIETARY RIGHTS INFRINGEMENT

The Contractor, solely at its expense, shall defend any claim or suit which may be brought against the Department or the State for the infringement of United States patents, copyrights or proprietary rights arising from the Contractor's or the Department's use of any software, equipment, data, materials and/or information of any kind prepared, developed or furnished by the Contractor in connection with performance of the Agreement and, in any such suit, shall satisfy any final judgment for such infringement. The Department shall give the Contractor written notice for such claim or suit and full right and opportunity to conduct the defense thereof, together with full information and all reasonable cooperation.

If principles of governmental or public law are involved, the State of New York may participate in the defense of any action identified under this Article, but no costs or expenses shall be incurred upon the account of the Contractor without the Contractor's written consent.

If, in the Contractor's opinion, any software, equipment, data, materials and/or information prepared, developed or furnished by the Contractor is likely to or does become the subject of a claim of infringement of a United States patent, copyright or proprietary right, then, without diminishing the Contractor's obligation to satisfy any final award, the Contractor may, with the Department's prior written approval, substitute other equally suitable software, equipment, materials, data and/or information. In the event that an action at law or in equity is commenced against the Department arising out of a claim that the Department's use of any software, equipment, materials and/or information under the Agreement infringes on any patent, copyright, or proprietary right, such action shall be forwarded by the Department to the Contractor for defense and indemnification under this Article and to the Office of the Attorney General of the State of New York together with a copy of the Agreement. If upon receipt of such request for defense, or at any time thereafter, the Contractor is of the opinion that the allegations in such action, in whole or in part, are not covered by the defense and indemnification set forth herein, the Contractor shall immediately notify the Department and the Office of the Attorney General of the State of New York, in writing, and shall specify to what extent the Contractor believes it is and is not obligated to defend and indemnify under the terms and conditions of the Agreement. The Contractor shall in such event protect the interests of the State of New York and shall take the steps necessary to secure a continuance to permit the State of New York to appear and defend its interest in cooperation with the Contractor, as is appropriate, including any jurisdictional defenses which the State shall have.

12. DATE/TIME WARRANTY

The Contractor warrants that products furnished pursuant to the Agreement shall be able to accurately process, date/time data (including, but not limited to, calculating, comparing, and sequencing) transitions, including leap year calculations. Where a Contractor proposes or an acquisition requires that specific products and/or services must perform as a package or system, this warranty shall apply to the products and/or services as a system.

Where the Contractor is providing ongoing services, including but not limited to: i) consulting, integration, code or data conversion, ii) maintenance or support services, iii) data entry or processing, or iv) contract administration services (e.g. billing, invoicing, claim processing), the Contractor warrants that services shall be provided in an accurate and timely manner without interruption, failure, or error due to the inaccuracy of the Contractor's business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) various date/time transitions, including leap year calculations. The Contractor shall be responsible for damages resulting from any delays, errors, or untimely performance resulting there from, including but not limited to the failure or untimely performance of such services.

This Date/Time Warranty shall survive beyond termination or expiration of the Agreement through a) ninety (90) days or b) the Contractor's or product manufacturer/developer's stated date/time warranty term, whichever is longer. Nothing in this warranty statement shall be construed to limit any rights or remedies otherwise available under the Agreement for breach of warranty.

13. VIRUS WARRANTY

Product contains no viruses, either known to the Contractor or which reasonably should have been known to the Contractor exercising due diligence. The Contractor is not responsible for viruses introduced at the Department's site.

14. TITLE AND OWNERSHIP WARRANTY

The Contractor warrants, represents and conveys (i) full ownership, clear title free of all liens, or (ii) the right to transfer or deliver perpetual license rights to any Product(s) transferred to the Department under the Agreement. The Contractor shall be solely liable for any costs of acquisition associated therewith. The Department may require the Contractor to furnish appropriate written documentation establishing the above rights and interests as a condition of payment. The Department's request or failure to request such documentation shall not relieve the Contractor of liability under this warranty.

15. USE RESTRICTIONS AND INTELLECTUAL PROPERTY

The Parties agree that all work by the Contractor for the Department is intended as work for hire. The Parties agree that the Contractor's work is specifically ordered and commissioned for use as contributions to a collective work, or is other such work as specified by section 101(2) of the U.S. Copyright Act [17 U.S.C. 101(2)], and is intended to be a work for hire that is made for the use and ownership of the State of New York and the Department. Furthermore, the Department and the Contractor agree that the State of New York and the Department are the owners of all copyrights regarding the work. The Contractor warrants to the State of New York and the Department that the Contractor, and all of its subcontractors and their employees, who have been, or may be used in regard to the Agreement, forfeits all past or future claims of title or ownership to the work produced.

Materials such as forms and publications used by the Contractor in the course of its performance under the Agreement which have been agreed upon by the Parties as generic materials are specifically excluded from this provision.

16. OWNERSHIP/TITLE TO PRODUCT DELIVERABLES

For purposes of this Article, the term "Department" is understood to mean the Department acting on behalf of the State.

(A) Definitions

1. Product(s):
   A deliverable furnished under the Agreement by or through the Contractor, including existing and custom Product(s), including, but not limited to: a) components of the hardware environment; b) printed materials (including but not limited to training manuals, system and user documentation, reports, drawings); c) third party software; d) modifications, customizations, custom programs, program listings, programming tools, data, modules, components; and e) any properties embodied therein, whether in tangible or intangible form (including but not limited to utilities, interfaces, templates, subroutines, algorithms, formulas, source code, object code).

2. Existing Product(s):

Tangible Product(s) and intangible licensed Product(s) which exist prior to the commencement of work under the Agreement. The Contractor retains the burden of proving that a particular product existed before commencement of the Agreement.

3. Custom Product(s):
   Product(s), preliminary, final or otherwise, which are created or developed by the Contractor, or its subcontractors, partners, employees, or agents under the Agreement for the benefit of the Department.

(B) Title to Project Deliverables

The Contractor acknowledges that it is commissioned by the Department to perform services detailed in the Agreement. Unless otherwise specified in writing in the Agreement, the Department shall have ownership and/or license rights as follows:

1. Existing Product(s):
   a) Hardware - Title and ownership of Existing Hardware Product shall pass to Department upon acceptance.

   b) Software - Title and ownership to Existing Software Product(s) delivered by the Contractor under the Agreement which is normally commercially distributed on a license basis by the Contractor or other independent software vendor/proprietary owner ("Existing Licensed Product"), whether or not embedded in, delivered or operating in conjunction with hardware or Custom Products, shall remain with the Contractor or other independent software vendor/proprietary owner ("ISV"). Effective upon acceptance, such Product shall be licensed to the Department in accordance with the Contractor or ISV owner's standard license agreement, provided, however, that such standard license, must, at a minimum: (a) grant the Department a non-exclusive, perpetual license to use, execute, reproduce, display, perform, adapt (unless the Contractor advises the Department as part of the Contractor's bid proposal that adaptation will violate existing agreements or statutes and the Contractor demonstrates such to the Department's satisfaction) and distribute Existing Licensed Product to the Department up to the license capacity stated in the work order with all license rights necessary to fully effect the general business purpose(s) stated in the Agreement and (b) recognize the State of New York as the licensee. Where these rights are not otherwise covered by the ISV's standard license agreement, the Contractor shall be responsible for obtaining these rights at its sole cost and expense. The Department shall reproduce all copyright notices and any other legend of ownership on any copies authorized under this paragraph.

2. Custom Product(s):
   Effective upon creation of Custom Product(s), the Contractor hereby conveys, assigns and transfers to State the sole and exclusive rights, title and interest in Custom Product(s), whether preliminary, final or otherwise, including all trademark and copyrights. The Contractor hereby agrees to take all necessary and appropriate steps to ensure that the Custom Product(s) are protected against unauthorized copying, reproduction and marketing by or through the Contractor, its agents, employees, or subcontractors. Nothing herein shall preclude the Contractor from otherwise using the related or underlying general knowledge, skills, ideas, concepts, techniques and experience developed under the Agreement in the course of the Contractor's business.

   Where payment for Custom Product does not involve Certificates of Participation (COPS) pursuant to Article 5-A of the State Finance Law or other third party

financing, the Department may, by providing written notice thereof to the Contractor, elect in the alternative to take a non-exclusive perpetual license to Custom Products in lieu of State taking exclusive ownership and title to such Products. In such case, the Department shall be granted a non-exclusive perpetual license to use, execute, reproduce, display, perform, adapt and distribute Custom Product as necessary to fully effect the general business purpose(s) as stated herein.

In the event that the Contractor wishes to obtain ownership rights to Custom Product(s), the sale or other transfer shall be at fair market value as determined by the Parties at the time of such sale or other transfer, and must be pursuant to a separate written agreement in a form acceptable to the State which complies with the terms of this paragraph.

3. Documentation, Data & Reports
The Department shall own title to all documentation, drawings, (e.g., engineering drawings, system diagrams, logic/schematics, plans, reports, training, maintenance or operating manuals), including network design, equipment configurations and other documentation prepared or developed pursuant to the Agreement, whether preliminary, final or otherwise. The Contractor shall deliver to the possession of the Department all work-in-progress documentation as it becomes available, but in no case longer than thirty (30) days after creation.

17. FORCE MAJEURE

Neither Party to the Agreement shall be liable or deemed to be in default for any delay or failure in performance under the Agreement resulting directly or indirectly from acts of God, civil or military authority, acts of public enemy, wars, riots, civil disturbances, insurrections, accident, fire, explosions, earthquakes, floods, the elements, acts or omissions of public utilities or strikes, work stoppages, slowdowns or other labor interruptions due to labor/management disputes involving entities other than the Parties to the Agreement, or any other causes not reasonably foreseeable or beyond the control of a Party. The Parties are required to use best efforts to eliminate or minimize the effect of such events during performance of the Agreement and to resume performance of the Agreement upon termination or cessation of such events.

18. TIME OF THE ESSENCE

The Department and the Contractor acknowledge and agree that time is of the essence for the Contractor's performance under the Agreement.

19. RIGHTS AND REMEDIES

The rights, duties and remedies set forth in the Agreement shall be in addition to, and not in limitation of, rights and obligations otherwise available at law.

20. FEDERAL AND STATE COMPLIANCE

The Contractor shall ensure that its employment practices comply with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended.

The Contractor shall ensure compliance with the Americans With Disabilities Act (42 USC §2101 et. seq.) such that programs and services provided during the course of performance of the Agreement shall be accessible under Title II of the Americans With Disabilities Act and as otherwise applicable under the Americans With Disabilities Act.

21. TAXES

It shall be understood that the Department, as an agency of the State of New York, is not liable for the payment of any sales, use, excise, or other form of tax however designated, levied or imposed, and shall agree to reimburse the Contractor for same only if taxes would have been incurred through the Department's normal business operations.

22. INDEPENDENT CONTRACTOR

The Parties agree that the Contractor is an independent contractor, and the Contractor, its officers, employees, agents, consultants and/or sub-contractors in the performance of the Agreement shall act in an independent capacity and not as agents, officers or employees of the State or the Department. Neither the Contractor nor any sub-contractor shall thereby be deemed an agent, officer, or employee of the State. The Contractor agrees, during the term of the Agreement, to maintain at the Contractor's expense those benefits to which its employees would otherwise be entitled by law, including health benefits, and all necessary insurance for its employees, including worker's compensation, disability and unemployment insurance, and to provide the Department with certification of such insurance upon request. The Contractor remains responsible for all applicable federal, State, and local taxes, and all FICA contributions.

23. NO THIRD PARTY BENEFICIARIES

Nothing contained in the Agreement, expressed or implied, is intended to confer upon any person, corporation, other than the Parties hereto and their successors in interest and assigns, any rights or remedies under or by reason of the Agreement.

24. HEADINGS OR CAPTIONS

The headings or captions contained within the Agreement are intended solely for convenience and reference purposes and shall in no way be deemed to define, limit or describe the scope or intent of the Agreement or any provisions thereof.

25. PARTIAL INVALIDITY

Each Party agrees that it shall perform its obligations under the Agreement in accordance with all applicable federal and State laws, rules, and regulations, policies and/or guidelines now or hereafter in effect. If any term or provision of the Agreement shall be found to be illegal or unenforceable, then, notwithstanding such term or provision, the Agreement shall remain in full force and effect, and such term or provision shall be deemed stricken.

26. CONFLICT OF INTEREST

The Contractor shall ensure that its officers, employees, agents, consultants and/or sub-contractors comply with the requirements of the New York State Public Officers Law ("POL"), as amended, including but not limited to sections 73 and 74, as amended, with regard to ethical standards applicable to State employees, and particularly POL sections 73(8)(a)(i) and (ii) regarding post-employment restrictions affecting former State employees. Additionally, the Contractor shall ensure that no violation of these provisions will occur by reason of the Contractor's proposal for or negotiation and execution of the Agreement or in its delivery of services pursuant to the Agreement. If, during the term of the Agreement, the Contractor becomes aware of a relationship, actual or potential, which may be considered a violation of the POL or which may otherwise be considered a conflict of interest, the Contractor shall notify the Department in writing immediately. Should the Department thereafter determine that such employment is inconsistent with State law; the Department shall so advise the Contractor in writing, specifying its basis for so determining, and may require that the contractual or employment relationship be canceled. Failure to comply with these provisions may result in suspension or cancellation of the Agreement and criminal proceedings as may be required by law.

The Contractor is required to make full disclosure of any circumstances that could affect its ability to perform in complete compliance with the POL. Any questions as to the applicability of these provisions should be addressed by the Contractor to the New York State Ethics Commission, 540 Broadway, Albany, NY 12207 (518) 408-3976.

27. AUDIT AUTHORITY

The Contractor acknowledges that the Department and the Office of the State Comptroller have the authority to conduct financial and performance audits of the Contractor's delivery of Program Services (or Project Services) in accordance with the Agreement and any applicable State and federal statutory and regulatory authorities. Such audit activity may include, but not necessarily be limited to, the review of documentary evidence to determine the accuracy and fairness of all items on the Contractor's submission of claims for payment under the Agreement, and the review of any and all activities relating to the Contractor's performance and administration of the Agreement.

The Contractor shall make available documentary evidence necessary to perform such reviews. Documentation made available by the Contractor may include, but is not limited to, source documents, books of account, subsidiary records and supporting work papers, claim documentation and pertinent contracts and correspondence.

The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the Office of the State Comptroller as set forth in Appendix A of the Agreement - Standards Clauses for All New York State Contracts.

28. CONFIDENTIALITY

All records maintained by the Contractor and relating to the Agreement are confidential and shall be used by the Contractor and its officers, employees, and subcontractors or agents solely for the purpose of carrying out its obligations under the Agreement. Except as directed by a court of competent jurisdiction or as may be permitted or required by applicable New York State or federal law or regulations, no such records may be otherwise used or released to any person by the Contractor, its employees, subcontractors or agents, either during the term of the Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the Department, be grounds for termination of the Agreement.

The Contractor shall promptly advise the Department of all requests made to the Contractor for information regarding the performance of services under the Agreement, including any information provided by the Department, except as required by subcontractors or agents solely for the purpose of carrying out obligations under the Agreement or as required by law.

The Contractor shall be responsible for assuring that any agreement between the Contractor and any of its officers, agents and employees or applicable subcontractors contains a provision that conforms strictly to the provisions of this Article.

29. INFORMATION SECURITY REQUIREMENTS

In accordance with the Information Security Breach and Notification Act (ISBNA) (General Business Law §889-aa, State Technology Law §208), Contractor shall be responsible for complying with provisions of the ISBNA and the following terms contained herein with respect to any private information (as defined in ISBNA) received by Contractor under the Agreement (Private Information) that is within the control of the Contractor either on the Department's information security systems or the Contractor's information security system (System). In the event of a breach of the security of the System (as defined by ISBNA),

Contractor shall immediately commence an investigation, in cooperation with the Department, to determine the scope of the breach and restore security of the System to prevent any further breaches. Contractor shall also notify the Department of any breach of the security of the System immediately following discovery of such breach.

Except as otherwise instructed by the Department, Contractor shall, to the fullest extent possible, first consult with and receive authorization from the Department prior to notifying any individuals, the State Office of Cyber Security and Critical Infrastructure Coordination (CSCIC), the State Consumer Protection Board and the Office of the Attorney General (OAG) or any consumer reporting agencies of a breach of the security of the System or concerning any determination to delay notification due to law enforcement investigations. Contractor shall be responsible for providing the notice to all such required recipients and for all the costs associated with providing such notice. Contractor shall be liable for any other costs associated with noncompliance of ISBNA if caused by the Contractor or Contractor's agents, officers, employees, or subcontractors. Nothing herein shall in any way impair the authority of the OAG to bring an action against the Contractor to enforce the provisions of ISBNA or limit Contractor's liability for any violation of the ISBNA. Additional information relative to the law and the notification process is available at:
http://www.cscic.state.ny.us/security/securitybreach

Contemporaneous with the execution of the Agreement, the Contractor and its designees shall execute the Department's Third Party Connection and Data Exchange Agreement and any other protocol required by the Department, and shall ensure its employees, agents and designees complete the related Third Party Acceptable Use Policy and Agreement if applicable, to ensure the security of data transmissions and other information related to the administration of the Agreement. This request may be waived by the Department in its sole discretion.

30. NONDISCLOSURE OF CONFIDENTIAL INFORMATION

Except as may be required by applicable law or a court of competent jurisdiction, the Contractor, its officers, agents, employees, and subcontractors shall maintain strict confidence with respect to any Confidential Information to which the Contractor, its officers, agents, employees, and subcontractors have access in the course of the Contractor's performance under the Agreement. For purposes of the Agreement, all State information of which the Contractor, its officers, agents, employees and subcontractors becomes aware during the course of performing services for the Department shall be deemed to be Confidential Information (oral, visual or written). Notwithstanding the foregoing, information that falls into any of the following categories shall not be considered Confidential Information:

(a) information that is previously rightfully known to the receiving party without restriction on disclosure;
(b) information that becomes, from no act or failure to act on the part of the receiving party, generally known in the relevant industry or is in the public domain; and
(c) information that is independently developed by the Contractor without use of confidential information of the State.

The Contractor shall hold the State and the Department harmless from any loss or damage to the State or the Department resulting from the disclosure by the Contractor, its officers, agents, employees, and subcontractors of such Confidential Information.

The Contractor shall provide for its officers, agents, employees, and subcontractors to acknowledge and execute a nondisclosure agreement containing substantially the terms described in this Article, if requested to do so by the Department or the State.

This representation shall survive termination of the Agreement.

31. FREEDOM OF INFORMATION LAW

Disclosure of information and material provided to the Department by the Contractor in the course of the Contractor's performance under the Agreement shall be permitted consistent with the laws of the State of New York, and specifically the Freedom of Information Law (FOIL), Article 6 of the Public Officers Law. The Department shall take reasonable steps to protect from public disclosure any of the records relating to the Contractor's performance under the Agreement that otherwise are exempt from disclosure under FOIL.

If the Contractor believes that any information or material provided to the Department constitutes trade secret information that should be exempted from FOIL disclosure, the Contractor must, at the time of the materials' submission, request the exemption in writing, specifically identifying the material by page number, line, or other appropriate designation, and provide a particularized explanation as to why the material constitutes trade secret information and how the disclosure of the identified information would cause substantial injury to the Contractor's competitive position. The material sought to be protected from disclosure must be clearly marked in yellow highlighter, on a duplicate copy of the submission and may be provided in hardcopy or on a CD. Generically marking all material as "Confidential" will not be considered adequate for the purpose of this Article.

The Department's receipt of the Contractor's submission of material and the Contractor's request for protection of the material from FOIL disclosure does not constitute a determination that the information is exempt from disclosure under FOIL. In the event any information or material is requested pursuant to FOIL, the Department will address each party's interests fully in accordance with the procedures required by Article 6 of the Public Officers Law.

32. TERMINATION OF AGREEMENT

In addition to any termination provisions specified elsewhere in the Agreement, the following provisions also shall apply:

The Agreement may be terminated by mutual written agreement of the Parties.

The Agreement may be terminated by the Department for cause upon the failure of the Contractor to comply with the terms and conditions of the Agreement, including any exhibits incorporated herein, provided that the Department shall give the Contractor written notice via registered or certified mail, return receipt requested, or hand delivery, such written notice to specify the Contractor's failure and the termination of the Agreement. Termination shall be effective ten (10) Business Days after receipt of such notice unless the Contractor, in the opinion of the Department, has cured such failure. The Contractor agrees to incur no new obligations nor to claim for any expenses made after receipt of the notification of termination. Upon termination for cause, the Department shall have the right to award a new contract to another contractor. Termination for cause shall create a liability upon the Contractor for actual damages incurred and for all reasonable additional costs incurred in reassigning the Agreement.

The Agreement may be terminated if the Department deems that termination would be in the best interest of the State provided that the Department shall give written notice to the Contractor not less than thirty (30) Days prior to the date upon which termination shall become effective, such notice to be made via registered or certified mail, return receipt requested or hand delivered. The date of such notice shall be deemed to be the date of postmark in the case of mail or the date of hand delivery.

The Agreement may be terminated immediately in the event the Department determines that funds are unavailable. The Department agrees to provide notice to the Contractor as soon as it becomes aware that funds are unavailable in the event of termination under this paragraph. If the initial notice is via oral notification, the Department shall provide written notice immediately thereafter. The Department shall be obligated to pay the Contractor only for the expenditures made and obligations incurred by the Contractor until such time as notice of termination or received either orally or in writing by the Contractor from the Department.

In the event of termination for any reason, the Contractor shall not incur new obligations for the terminated portion. The Contractor agrees, after consultation with the Department, to cancel such outstanding obligations as the Contractor deems appropriate in the exercise of sound business judgment.

Upon termination of the Agreement each Party shall, if applicable, return to the other all papers, materials, and other properties of the other Party held by each for purposes of performance under the Agreement. In addition, each Party shall assist the other Party in orderly termination of the Agreement and the transfer of all aspects hereof, tangible, and intangible, as may be necessary to ensure the orderly administration of the State program.

33. CONTRACTOR PERSONNEL

The Contractor shall designate an Account Executive, who shall be the contact person for all matters arising under the Agreement.

The Contractor agrees to be solely responsible for the recruitment, hiring, provision of employment benefits, payment of salaries, and management of its personnel. These functions shall be carried out by the Contractor in accordance with the provisions of the Agreement and with all applicable federal and State laws and regulations.

The Contractor is required to commit key personnel for the administration of all aspects of the Agreement. In the event that any of the key personnel will be or are unavailable for the performance of their duties, the Contractor will designate and propose to the Department an equally qualified alternate with full authority to act for the unavailable key person.

The Contractor shall notify the Department in writing of any changes in the key personnel designated for performance of the Agreement. This shall include any changes in the personnel designated to bind the Contractor.

The Department reserves the right to demand the reassignment or cancellation of assignment to duties under the Agreement of any Contractor personnel so assigned. The Department shall not exercise the authority unreasonably. The Contractor agrees to replace any employees so reassigned or canceled with an employee of equal or better qualifications. If the Department exercises its right under this provision, it agrees to provide written notice to the Contractor setting forth its reasons with specificity.

34. OPERATIONAL CONTACTS

The Contractor shall maintain appropriate corporate and/or legal authority, which shall include, but not be limited to, the maintenance of an organization capable of delivering Program Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which Program Services are to be delivered pursuant to the Agreement. The Contractor also shall maintain operations, financial and legal staff that shall be directly available to the Department's operations, financial and legal staff, respectively. For purposes of the Agreement, maintenance of such staff and staff availability by the Contractor shall in no way create any agency relationship between the Department and the Contractor.

The Contractor acknowledges and agrees that no aspect of the Contractor's performance under the Agreement is contingent upon Department personnel or the availability of Department resources, with the exception of all proposed actions of the Contractor specifically identified in the Agreement as requiring the Department approval. With respect to such approval, the Department shall act promptly and in good faith.

The Contractor must cooperate fully with any other contractors who may be engaged by the Department relative to the the Agreement.

The Contractor must ensure that all contacts by the Contractor personnel with other New York State agencies, external organizations (Federal Agencies, Unions, etc.) which result in any charge, cost or payment of any kind, must receive prior written authorization from the Department's Contract Manager.

35. SUBCONTRACTING

If allowed in the solicitation instrument (e.g., Request for Proposal, Invitation for Bids, etc.) that results in the Agreement, the Contractor may arrange for specified portion(s) of its responsibilities under the Agreement to be subcontracted to a Key Subcontractor(s). A "Key Subcontractor" means that vendor(s) with whom the Contractor subcontracts to provide any portion of Program Services. If the Contractor determines to subcontract a portion(s) of Program Services, the Key Subcontractors must be clearly identified and the nature and extent of its involvement in and/or proposed performance under the Agreement must be fully explained by the Contractor to the Department. The Contractor retains ultimate responsibility for all Program Services performed under the Agreement.

All subcontracts shall be in writing and shall contain provisions, which are functionally identical to, and consistent with, the provisions of the Agreement including, but not be limited to, the body of the Agreement, Appendix A - Standard Clauses For All New York State Contracts, Appendix B - Standard Clauses for All Department Contracts and if applicable as determined by the Department, Appendix C - Third Party Connection and Data Exchange Agreement. Unless waived in writing by the Department, all subcontracts between the Contractor and a Key Subcontractor shall expressly name the State of New York, through the Department, as the sole intended third party beneficiary of such subcontract. The Department reserves the right to review and approve or reject any subcontract with a Key Subcontractor, as well as any amendments to said subcontract(s), and this right shall not make the Department or the State of New York a party to any subcontract or create any right, claim, or interest in the Key Subcontractor or proposed Key Subcontractor against the Department.

The Department reserves the right, at any time during the term of the Agreement, to verify that the written subcontract between the Contractor and Key Subcontractor(s) is in compliance with all of the provision of this Article and any subcontract provisions contained in the Agreement. In addition to other remedies allowed by law, the Department reserves the right to terminate the Agreement for cause if an executed subcontract does not contain all of the provisions/statements stipulated above. If during the term of the Agreement, any executed subcontract between the Contractor and a Key Subcontractor is amended, the Contractor shall, within 30 calendar days of such amendment, provide a copy to the Department.

The Contractor shall give the Department immediate notice in writing of the initiation of any legal action or suit which relates in any way to a subcontract with a Key Subcontractor or which may affect the performance of the Contractor's duties under the Agreement. Any subcontract shall not relieve the Contractor in any way of any responsibility, duty and/or obligation of the Agreement.

36. PUBLICITY AND COMMUNICATIONS

The Contractor shall ensure that all requests for the Contractor's participation in events where the Contractor will be participating on behalf of the Department receive prior written authorization from the Department.

No public discussion or news releases relating to the Agreement shall be made or authorized by the Contractor or the Contractor's agent without the prior written approval of the Department, which written approval shall not be unreasonably withheld or delayed provided, however, that Contractor shall be authorized to provide copies of the Agreement and answer any questions relating thereto to any State or federal regulators or, in connection with its financial activities, to financial institutions for any private or public offering.

37. CONSULTANT DISCLOSURE REQUIREMENTS

Unless directed otherwise by the Department, the Contractor shall demonstrate its compliance with Chapter 10 of the Laws of 2006 throughout the term of the Agreement by submitting to the Department and to the Office of the State Comptroller a "State Consultant Services - Contractor's Annual Employment Report" for each State Fiscal Year. Such report shall be due no later than May 15th of each year following the end of the State Fiscal Year being reported. Such report shall be required of any contract that includes services for analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health and mental health services, accounting, auditing, paralegal, legal, or similar services. Such report shall conform with Bulletin No. G-226 – Form B as issued by the Office of the State Comptroller. The report must be submitted to the Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th floor, Albany, NY 12236, ATTN: Consultant Reporting; and to the Department's Contract Manager.

38. PROCUREMENT LOBBYING RESTRICTIONS UNDER STATE FINANCE LAW SECTIONS 139-j AND 139-k

The Contractor certifies that all information that it has provided or will provide to the Department pursuant to State Finance Law sections 139-j and 139-k is complete, true, and accurate, including but not limited to information regarding prior determinations of non-responsibility within the past four years based upon (i) impermissible contacts of other violations of SFL section 139-j, or (ii) the intentional provision of false or incomplete information to a governmental entity.

The Department reserves the right to terminate the Agreement in the event it is found that the Contractor's certification of its compliance with SFL sections 139-j or 139-k was intentionally false or intentionally incomplete. Upon such finding, the Department may exercise its right to terminate the Agreement by providing written notification to the Contractor in accordance with Article 9 of this Appendix B.

39. VENDOR RESPONSIBILITY

The Contractor is required to provide the Department with an updated Vendor Responsibility Questionnaire when requested to do so by the Department throughout the term of the Agreement. Regardless, the Contractor is required to report to the Department any material changes in the information reported in its initial Vendor Responsibility Questionnaire.

40. TAX LAW SECTION 5-A - CERTIFICATION REGARDING SALES AND COMPENSATING USE TAXES

In the event the value of the Agreement exceeds $100,000, the Contractor must file a properly completed Form ST-220-CA with the Department and a properly completed Form ST-220-TD with the Department of Taxation & Finance before the Agreement may take effect.

In addition, after the Agreement has taken effect, the Contractor must file a properly completed Form ST-220-CA with the Department if the Agreement's term is renewed; further, a new Form ST-220-TD must be filed with the Department of Taxation & Finance if no ST-220-TD has been filed by the Contractor or if a previously filed Form ST-220-TD is no longer correct and complete.

41. CONTRACT PAYMENT

Contractor shall provide complete and accurate billing invoices to the Department in order to receive payment. Billing invoices submitted to the Department must contain all information and supporting documentation required by the Agreement, the Department and the State Comptroller. Payment for invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The Contractor shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by e-mail at epunit@osc.state.ny.us, or by telephone at 518-474-4032. Contractor acknowledges that it will not receive payment on any invoices submitted under the Agreement if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

May 2011

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

THIS AGREEMENT (the "Agreement") by and between the NYS Department of Civil Service ("DCS"), with principal offices in Albany, NY 12239, and

with principal offices at

(hereinafter "Third Party"), is entered into as of the date last written below ("the Effective Date").

This Agreement consists of this signature page and the following attachments incorporated by reference:

1. Attachment 1: Third Party Connection and Data Exchange Agreement Terms and Conditions
2. Attachment 2: Third Party Connection and Data Exchange Request Requirements Document
3. Attachment 3: Third Party Acceptable Use Policy and Agreement
4. Attachment 4: DCS Equipment Loan Agreement (Applicable: ☐Yes ☐No)

This Agreement may only be modified by a written document executed by the parties hereto. Any disputes arising out of or in connection with this Agreement shall be governed by New York State law without regard to choice of law provisions.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed. Each party warrants and represents that its respective signatories whose signatures appear below have been and are on the date of signature duly authorized to execute this Agreement.

Third Party Name:	*NYS Department of Civil Service (DCS)*
Authorized Signature	Authorized Signature
Name *(Print)*	Name *(Print)*
Date	Date

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 1 – SECURITY REQUIREMENTS

1. ***Right to Use Connection***

Third Party may only use the connection and the information obtained from DCS for business purposes as outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2*).*

2. ***Data Exchange***

2.1 Third Party may only use the data obtained for purposes outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2) and the contract or Memoranda of Understanding, if any, that exists between DCS and Third Party for the provision of goods or services or governing conduct between DCS and Third Party with respect to the access to and use of DCS data.

2.2 Data exchange may be conducted only by methods and/or services outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2). Third Party should expect that access to information and services may be limited, as determined or required by DCS.

3. ***Network Security***

3.1 Third Party will allow only its own employees approved in advance by DCS ("Third Party Users") to access the Network Connection or any DCS-owned equipment. Third Party shall be solely responsible for ensuring that Third Party Users are not security risks, and upon DCS' request, Third Party will provide DCS with any information reasonably necessary for DCS to evaluate security issues relating to any Third Party User.

3.2 Third Party will promptly notify DCS whenever any Third Party User leaves Third Party's employ or no longer requires access to the connection or DCS-owned Equipment.

3.3 Each Party will be solely responsible for the selection, implementation, and maintenance of security procedures and policies that are sufficient to ensure that (a) such party's use of the connection (and Third Party's use of DCS-owned Equipment) is secure and is used only for authorized purposes, and (b) such Party's business records and data are protected against improper access, use, loss alteration or destruction.

3.4 The preferred connectivity method is via the Internet to a DCS-approved or DCS-provided Virtual Private Network (VPN) device. If the device is DCS-provided, DCS will loan the Third Party, in accordance with the DCS Equipment Loan Agreement, the required client software for establishing VPN connections with DCS. Normal DCS perimeter security measures will control access to the internal network.

3.5 Extranet – Designated routers are used in combination with firewall rules to allow access to be managed. A second authentication may be required.

3.6 Remote Access - Using the DCS-provided remote access software, Third Party will connect via an Internet browser. The account may be disabled until usage is required and controls are placed and managed by DCS. Third Party will be required to follow procedures to enable the account for each use.

3.7 Third Party Connections will be audited. All remote access user accounts for Third Parties will be given an expiration time. Renewals must be requested by Third Party and approved by the Department Sponsor. Obsolete Third Party connections will be terminated.

3.8 Software versions on all Third Party computers that connect to the DCS network must be versions that are currently supported by the software manufacturer, and all available security updates and hot fixes for that software must be applied in a timely fashion. Software and firmware for all Third Party networking equipment that is part of the connection to the DCS network must be kept up to date, especially with patches that fix security vulnerabilities.

3.9 Anti-virus software and firewalls must be installed and enabled at all times on DCS-owned computers and on Third Party computers that connect to the DCS network. Additionally, virus definition files must be kept up to date.

3.10 In no case may a Third Party Connection to DCS be used as an Internet Connection for Third Party or for a Third Party User.

4. *Notifications*

4.1 Third Party shall notify DCS in writing promptly of any change in its Users for the work performed over the Network Connection or whenever Third Party believes a change in the connection and/or functional requirements of the connection is necessary.

4.2 Any notices required by this Agreement shall be given in hand, sent by first class mail, or via facsimile to the applicable address set forth below.

Third Party Name:	NYS Department of Civil Service Albany, New York 12239
Address:	
Attention:	Attention:

5. ***Citizen Notifications***

If Third Party maintains "identifying personal information" on behalf of the Department and such information is compromised, Third Party shall notify the Department immediately that the information has been compromised, the circumstances under which the information was compromised, and the measures undertaken by Third Party to address those circumstances and to otherwise mitigate the effects of the compromise. If encrypted data is compromised along with the corresponding encryption key and encryption software, the data shall be considered unencrypted and the information will be considered compromised through unauthorized access. If the Department requests Third Party to do so, Third Party shall notify the persons whose identifying information was compromised. Such notification shall be communicated via postal service or email, as directed by the Department, and shall otherwise be executed in accordance with the Department's direction. Notification shall be delayed if a law enforcement agency determines that such notification may impede a criminal investigation. For the purpose of this section, "identifying personal information" shall be any information concerning an individual which, because of name, number, symbol, mark or other identifier in combination with any of the following, is unencrypted: (1) Social Security Number; or (2) driver's license number; or (3) financial account number, credit or debit card number, in combination with any required security code, access code, or password which would permit access to an individual's financial account; or (4) password which would permit access to the individual's account.

6. ***Payment of Costs***

Each Party will be responsible for all costs incurred by that Party under this Agreement, including, without limitation, costs for phone charges, telecommunications equipment and personnel for maintaining the connection.

7. ***Confidentiality***

7.1 Information exchanged for the business purposes outlined in Attachment 2 will be held confidential by the Parties to the maximum extent permitted by law. Each Party may internally use the information received from the other Party hereunder in connection with and as specifically necessary to accomplish the Business Purpose set forth in Attachment 2 and for no other purposes. Each Party may otherwise share such information with other third parties (e.g. consultants, subcontractors, control agencies) as required or permitted by law in order to effect the business purposes outlined in Attachment 2 and for no other purposes, provided that such third parties agree to the confidentiality restrictions set forth herein and as may be required otherwise by State and federal law.

7.2 Third Party must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the sensitive information that it creates, receives, maintains, or transmits on behalf of DCS.

7.3 Unencrypted DCS information must not be transmitted over email.

7.4 Third Party must ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it and report to the DCS Help Desk any security incident of which it becomes aware.

8. ***Third Party Users***

8.1 Third Party must require that each Third Party User executes a Third Party Acceptable Use Policy and Agreement (Attachment 3). Third Party must ensure that DCS is notified by fax or mail when the user base changes, following the specifications in the Third Party Connection & Data Exchange Agreement.

8.2 All aspects of Third Party connections within DCS control may be monitored by the appropriate DCS support group and/or the DCS Information Security Officer. Any unauthorized use or change to devices will be investigated immediately.

8.3 All Third Party Connections will be reviewed on a regular basis and information regarding specific Third Party connection will be updated as necessary. Obsolete Third Party connections will be terminated.

9. ***DCS-owned Equipment***

9.1 DCS may, in DCS' sole discretion, loan to Third Party certain equipment and/or software for use on Third Party premises (the DCS-owned Equipment) under the terms of the DCS Equipment Loan Agreement set forth in Attachment 4. DCS-owned equipment will only be configured for TCP/IP, and will be used solely by Third Party on Third Party's premises or other locations authorized by DCS for the purposes set forth in this Agreement. DCS is responsible for ensuring that it has the right under applicable software licenses to permit third party use.

9.2 Third Party may modify the configuration of the DCS-owned equipment only after notification and approval in writing by authorized DCS personnel.

9.3 Third Party will not change or delete any passwords set on DCS-owned equipment without prior approval by authorized DCS personnel. Promptly upon any such change, Third Party shall provide DCS with such changed password.

10. ***Term, Termination and Survival***

10.1 This Agreement will remain in effect until terminated by either Party, but in no event prior to the termination or expiration of any contract or agreement between the Parties for the purchase of goods or services that provides the business purpose for the exchange of data between the Parties, unless both Parties mutually agree to so terminate this Agreement.

10.2 Upon termination, Third Party shall return all tangible DCS data to DCS within a timeframe specified by DCS for that purpose, and further shall certify in writing to DCS that all other DCS data in whatever form has been destroyed. Additionally, any DCS-owned equipment and/or software shall be promptly returned to DCS at Third Party's expense.

10.3 Notwithstanding the above, the Parties' obligations to safeguard the confidentiality of the data subject to this Agreement shall survive the termination of this Agreement, and shall bind the Parties' employees, subcontractors, agents, heirs, successors and assigns.

11. Severability

If for any reason a court of competent jurisdiction finds any provision or portion of this Agreement to be unenforceable, that provision of the Agreement will be enforced to the maximum extent permissible so as to affect the intent of the Parties, and the remainder of this Agreement will continue in full force and effect.

12. Waiver

The failure of any Party to enforce any of the provisions of this Agreement will not be construed to be a waiver of the right of such Party thereafter to enforce such provisions.

13. Assignment

Third Party may not assign this Agreement, in whole or in part, without the prior written consent from DCS. Any attempt to assign this Agreement, without such consent, will be null and of no effect. Subject to the foregoing, this Agreement is for the benefit of and will be binding upon the parties' respective successors and permitted assigns.

14. *Force Majeure*

Neither Party will be liable for any failure to perform its obligations if such failure results from any act of God or other cause beyond such Party's reasonable control (including, without limitation, any mechanical, electronic or communications failure) which prevents such party from transmitting or receiving any data.

15. *Partial Invalidity*

If this Agreement is entered into as a consequence of Third Party's provision of goods or services to DCS pursuant to a contract or other written agreement, that Agreement supersedes this Agreement to the extent the agreements' provisions may be inconsistent.

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 2 – REQUEST REQUIREMENTS

In accordance with the DCS *Third Party Connection and Data Exchange Policy*, all requests for Third Party connections and data exchanges must be accompanied by this completed requirements document. This document should be completed by the DCS person or group requesting the Third Party connection and/or data exchange. The DCS Department Sponsor must be the Director of the Division whose business requires the Third Party connection and/or data exchange. DCS Divisions are encouraged to work with their IRM Liaison to complete the information in this document.

Part 1 – Business Justification

A. DCS Sponsor *(Division Director)*

Name:
Robert W. DuBois

Division:
Employee Benefits Division

Office Location:
NYS Department of Civil Service
Albany, New York 12239

Phone Number:
518-473-1977

Email Address:
Robert.DuBois@cs.state.ny.us

Back-up Point of Contact: (Data Custodian)

Name:
Barbara Vaughn

Division:
Employee Benefits Division

Office Location:
NYS Department of Civil Service
Albany, New York 12239

Phone Number:
518-549-2328

Email Address:
Barbara.Vaughn@cs.state.ny.us

B. Business Reason for Connection *(To be completed by Sponsor)*

State the purpose of establishing the connection and the purpose of the data transmission. Specify the business needs of the proposed connection. Use additional sheets of paper if needed.

C. Specify the details of the work to be accomplished via the connection. What applications will be used? What information will be used? What transactions will be accomplished?

D. Specify the Third Party Controls to be Implemented for Safeguarding DCS Data:
Access Controls:

Audit Controls:

Working procedures or practices for handling printed material and verbal exchanges:

Method of Disposal of media and paper:

User Account Management, including review of accounts:

Physical Security:

Other:

E. Estimated number of hours of use each week?

☐ 1 – 20 ☐ 21 – 40 ☐ More than 40 hours per week

F. Anticipated normal hours of use?

☐ M – F, 8:00 – 5:00 pm Eastern time ☐ Other (specify):

G. What is the requested installation date? *(Minimum lead-time is 30 days)*

H. Approximately how long will the connection be needed?

☐ Up to 6 months ☐ 6 – 12 months ☐ More than 12 months
☐ Specific time period:

Note: If a connection is needed for more than a year, the Connection Agreement must be renewed annually.

I. Other useful information

J. Third Party Information

Name of Third Party: Main Phone Number:

Main Office Address:

Management Contact

Name: Department:

Address: Email Address:

Phone Number: Manager's Name:

Manager's Phone:

Backup Contact

Name: Department:

Address: Email Address:

Phone Number: Manager's Name:

Manager's Phone:

Technical Contact

Name: Department:

Address: Email Address:

Phone Number:

Manager's Name: Manager's Phone:

Technical Support Hours:

Escalation List:

Domain name(s): Host name(s):

User Names and Contact Information. *(List all employees of the Third Party who will use this access.)*

User 1 *(name, phone, email):*

User 2 *(name, phone, email):*

User 3 *(name, phone, email):*

User 4 *(name, phone, email):*

User 5 *(name, phone, email):*

User 6 *(name, phone, email):*

User 7 *(name, phone, email):*

User 8 *(name, phone, email):*

User 9 *(name, phone, email):*

User 10 *(name, phone, email*):

K. Other information

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 3 – THIRD PARTY ACCEPTABLE USE POLICY AND AGREEMENT

This Policy and Agreement applies to all forms of computer and networking use, including local access at the Department of Civil Service (DCS) premises, remote access via public or private networks, access using DCS equipment, access using individual or group accounts, and access via other methods.

A signed paper copy of this form must be submitted by any individual (1) for whom authorization of a new user account is requested, (2) who will use a shared third party account, and/or (3) who is requesting reauthorization of an existing use. Modifications to the terms and conditions of this agreement will not be accepted by DCS management.

Indicate here if this is a notification that the User named below no longer requires access: ☐

User's Name *(print)*:			
Organization:			
Telephone Number:	Area code	Number	Extension
Office Address:			

The undersigned acknowledges that he or she has read, understands, and agrees to comply with this Third Party Acceptable Use Policy and Agreement governing the use of DCS computing resources.	
User Signature:	Date:

You must sign this signature page and send it to DCS. Retain a copy of the signature page and the attached Policy for your records. This form must be delivered either by fax or mail to:

MAIL: **NYS Department of Civil Service, Albany, NY 12239**
Attention: Help Desk
FAX: **518-485-5588**

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 3 – THIRD PARTY ACCEPTABLE USE POLICY AND AGREEMENT

I. ***Protection of DCS Information***

All records and information maintained in DCS systems accessed by the User are confidential and shall be used by the User solely for the purpose of carrying out the User's official duties. Users may not use any such records and information for any other purpose. No such records or information may otherwise be used or released to any person by the User or by the User's employer or agent, except as may be required by applicable State or federal law or by a court of competent jurisdiction. All accounts and connections will be regularly reviewed.

II. ***DCS Log-on Banner***

All users will follow the guidelines of the DCS Log-on Banner as stated below.

NOTICE * The contents of this banner have been recommended to all State agencies by the Office for Technology in the NYS Preferred Standards and Procedures for Information Security. * This electronic system, which includes hardware, software and network components and all data contained therein (the "system"), is the property of the New York State Department of Civil Service (DCS). * Unauthorized use or attempted unauthorized use of this system is not permitted and may constitute a federal or state crime. Such use may subject you to appropriate disciplinary and/or criminal action. Use of this system is only permitted to the extent authorized by DCS. * Use is limited to conducting official business of DCS. Under the Electronic Communications Privacy Act of 1986 (18 U.S.C. 2510, et seq.), notice is hereby given that there are NO facilities provided by this system for sending or receiving private confidential electronic communication. Any use, whether authorized or not, may be monitored, intercepted, recorded, read, copied, accessed or captured in any manner, and used or disclosed in any manner, by authorized DCS personnel without additional prior notice to users. In this regard, users have no legitimate expectation of privacy during any use of this system or in any data on this system. * Use, whether authorized or unauthorized, constitutes expressed consent for DCS to monitor, intercept, record, read, copy, access or capture and use or disclose such information. * DCS policy regarding this matter can be reviewed on the DCS internal website. Copies can also be obtained from the Office of Human Resources Management. Such policies are subject to revision. This notice is consistent with the Acceptable Use Policy issued to DCS employees regarding acceptable use, June 15, 2005. I have read and understand this notification and department policy.

III. ***Passwords***

The User is not permitted to share his/her password with anyone. Passwords must never be written down. The User must not use the same password for multiple applications. The User must use passwords that are not easily guessed and must not use their email address as their password.

IV. ***Shared Accounts***

All use of shared accounts must be authorized by DCS. Users of shared accounts must be identified to DCS via the completion and signing of this policy/agreement. Third Parties are responsible for notification to DCS when the user base changes. Passwords for shared accounts must not be provided to individuals who have not been identified by Third Party to DCS and who have not completed and signed this policy/agreement.

V. ***Virus Protection***

Anti-virus software must be installed and enabled at all times on DCS-owned computers and on third party computers used to conduct DCS business. Virus definition files must be kept up to date. DCS Information Resource Management (IRM) provides anti-virus software and maintains the configuration of that software for all DCS-owned computers.

VI. ***Acceptable Use***

DCS computers, computing systems and their associated communication systems are provided to support the official business of DCS. All uses inconsistent with DCS' business activities and administrative objectives are considered to be inappropriate use.

Examples of unacceptable behavior include, but are not limited to the following.

- Any illegal activities that could result in legal actions against and/or financial damage to DCS.
- Computer usage that reasonably harasses or offends other employees, users, or outsiders, or results in public embarrassment to DCS.
- Computer usage that is not specifically approved and which consumes significant amounts of computer resources not commensurate with its benefit to DCS' mission or which interferes with the performance of a worker's assigned job responsibilities.
- Use in connection with compensated outside work or unauthorized not-for-profit business activities.
- Use of sniffers, spyware, ad-ware or other related technology.

VII. ***Software Protection***

The User is responsible for complying with copyright, licensing, trademark protection, and fair use restrictions.

VIII. ***Reporting Incidents***

Users are required to report incidents of system errors, data discrepancies, application performance problems, to the DCS Help Desk, at 518-457-5406 phone; 518-485-5588 fax.

IX. *DCS Rights*

Pursuant to the Electronic Communications Privacy Act of 1986 (18 USC 2510 et seq.), notice is hereby given that there are no facilities provided by this system for sending or receiving private or confidential electronic communications. DCS has access to all access attempts, messages created and received, and information created or stored using DCS resources, and will monitor use as necessary to assure efficient performance and appropriate use. Information relating to or in support of illegal activities will be reported to the appropriate authorities.

DCS reserves the right to log and monitor use. DCS reserves the right to remove a user account from the network. DCS assumes no responsibility or liability for files or information deleted.

The DCS will not be responsible for any damages. This includes the loss of data resulting from delays, non-deliveries, or service interruptions caused by negligence, errors or omissions, or caused by the way the user chooses to use DCS computing facilities.

DCS reserves the right to change its policies and rules at any time.

X. *Penalties*

The User shall hold the State and DCS harmless from any loss or damage to the State and/or DCS resulting from the User's inappropriate disclosure of information covered by this User Agreement. Further, the User's non-compliance with this Agreement may result in the revocation of system privileges, termination of employment or contract with DCS, and/or criminal and/or civil penalties.

Name And Address Of Borrower	DCS Business Unit (Loaning Organization)	
	Point Of Contact	
	Work Location	Telephone
Shipping Address (*If different from borrower's)*	Manager's Name	
	Date To Be Loaned	
	Date To Be Returned	

Equipment To Be Loaned

Quantity	Description	Value

Purpose Of Loan

CONDITIONS OF LOAN

1. The Borrower of the above equipment agrees to return same in like condition as received from DCS, normal wear and tear excepted, on or before the above return date, unless the loan period is formally extended.
2. Upon termination of this Agreement, Borrower shall uninstall all DCS software included in this Agreement from Borrower's computer and/or network equipment.
3. The Borrower shall not make **any** copies of DCS software included in this Agreement.
4. In case of loss or damage beyond repair, DCS shall be reimbursed by Borrower at the current price of replacement.
5. The equipment shall not be loaned or transferred to a third party without the written consent of DCS.
6. The right is reserved to cancel the loan or recall the equipment upon _____ days notice.
7. The Borrower shall assume all shipping and/or transportation costs involved.
8. Other conditions:

Agreed (Borrower)	**Approved** (DCS)
Borrowing Organization	Loaning Organization
Signature Of Authorized Official	Signature Of Authorized Official
Title	Title
Date	Date

RECEIPT OF EQUPMENT

Borrower *(Upon initial receipt)*	**DCS Lender** *(Upon termination of Agreement)*
Borrowing Organization	Loaning Organization
Signature Of Authorized Official	Signature Of Authorized Official
Title	Title
Date	Date

CONTRACTOR REQUIREMENTS AND OBLIGATIONS UNDER NEW YORK STATE EXECUTIVE LAW, ARTICLE 15-A (PARTICIPATION BY MINORITY GROUP MEMBERS AND WOMEN WITH RESPECT TO STATE CONTRACTS)

I. General Provisions

A. The Department is required to implement the provisions of New York State Executive Law Article 15-A and 5 NYCRR Parts 142-144 ("MWBE Regulations") for all "State contracts" as defined therein, with a value (1) in excess of $25,000 for labor, services, equipment, materials, or any combination of the foregoing or (2) in excess of $100,000 for real property renovations and construction.

B. Contractor agrees, in addition to any other nondiscrimination provision of the Contract and at no additional cost to the New York State Department (the "Department"), to fully comply and cooperate with the Department in the implementation of New York State Executive Law Article 15-A. These requirements include equal employment opportunities for minority group members and women ("EEO") and contracting opportunities for certified minority and women-owned business enterprises ("MWBEs"). Contractor's demonstration of "good faith efforts" pursuant to 5 NYCRR §142.8 shall be a part of these requirements. These provisions shall be deemed supplementary to, and not in lieu of, the nondiscrimination provisions required by New York State Executive Law Article 15 (the "Human Rights Law") or other applicable federal, state or local laws.

C. Failure to comply with all of the requirements herein may result in a finding of non-responsiveness, non-responsibility and/or a breach of contract, leading to the withholding of funds or such other actions, liquidated damages pursuant to section VII of this Appendix or enforcement proceedings as allowed by the Contract.

II. Contract Goals

A. For purposes of the Contract, the Department established an overall goal of 20% for Minority and Women-Owned Business Enterprises ("MWBE") participation as subcontractors and suppliers, as relates only to the administrative cost component of the overall cost of the Contract.

B. For purposes of providing meaningful participation by MWBEs on the Contract and achieving the Contract Goals established in section II-A above, Contractor should reference the directory of New York State Certified MBWEs found at the following internet address:
http://www.nylovesmwbe.ny.gov/cf/search.cfm

Additionally, Contractor is encouraged to contact the Division of Minority and Woman Business Development ((518) 292-5250; (212) 803-2414; or (716) 846-8200) to discuss additional methods of maximizing participation by MWBEs on this Contract.

C. Where MWBE goals have been established herein, pursuant to 5 NYCRR §142.8, Contractor must document "good faith efforts" to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract. In accordance with section 316-a of Article 15-A and 5 NYCRR §142.13, the Contractor acknowledges that if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such a finding constitutes a breach of contract and the Contractor shall be liable to the Department for liquidated or other appropriate damages, as set forth herein.

III. Equal Employment Opportunity (EEO)

A. Contractor agrees to be bound by the provisions of Article 15-A and the MWBE Regulations promulgated by the Division of Minority and Women's Business Development of the Department of Economic Development (the "Division"). If any of these terms or provisions conflict with applicable law or regulations, such laws and regulations shall supersede these requirements.

B. Contractor shall comply with the following provisions of Article 15-A:

1. Contractor and subcontractors shall undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, EEO shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.

2. The Contractor shall submit an EEO policy statement to the Department within seventy two (72) hours after the date of the notice by Department of proposed award of the Contract to the Contractor.

3. If Contractor or subcontractor does not have an existing EEO policy statement, the Department may provide the Contractor or subcontractor a model statement (see Form EEO-102 entitled "Minority and Women-Owned Business Enterprises M/WBE - Equal Employment Opportunity (EEO) Policy Statement.

4. The Contractor's EEO policy statement shall include the following language:

   a. The Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force.

   b. The Contractor shall state in all solicitations or advertisements for employees that, in the performance of the contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

   c. The Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed, color, national origin, sex age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein.

   d. The Contractor will include the provisions of sections (a) through (c) of this subsection 4 and paragraph "E" of this section III, which provides for relevant provisions of the Human Rights Law, in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the Contract.

C. Form EEO-100 – EEO Staffing Plan

To ensure compliance with this section III, the Contractor shall submit an EEO Staffing Plan to document the composition of the proposed workforce to be utilized in the performance of the Contract by the specified categories listed, including ethnic background, gender, and Federal occupational categories. The Contractor shall complete the EEO Staffing Plan form and submit it as part of its Proposal or within a reasonable time, but no later than the time of proposed award of the Contract.

D. Form EEO-101 - Workforce Utilization/Compliance Report ("Workforce Report")

1. Once proposed contract award has been made and during the term of Contract, Contractor is responsible for updating and providing notice to the Department of any changes to the previously submitted EEO Staffing Plan. This information is to be submitted on a quarterly basis during the term of the Contract to report the actual workforce utilized in the performance of the Contract by the specified categories listed including ethnic background, gender, and Federal occupational categories. The Workforce Report must be submitted to report this information.
2. Separate forms shall be completed by Contractor and any subcontractor performing work on the Contract.
3. In limited instances, Contractor may not be able to separate out the workforce utilized in the performance of the Contract from Contractor's and/or subcontractor's total workforce. When a separation can be made, Contractor shall submit the Workforce Report and indicate that the information provided related to the actual workforce utilized on the Contract. When the workforce to be utilized on the Contract cannot be separated out from Contractor's and/or subcontractor's total workforce, Contractor shall submit the Workforce Report and indicate that the information provided is Contractor's total workforce during the subject time frame, not limited to work specifically under the Contract.

E. Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

IV. MWBE Utilization Plan Form (MWBE-100) and Certification of Good Faith Efforts (Form MWBE-104)

A. The Contractor represents and warrants that Contractor has submitted an MWBE Utilization Plan (form MWBE-100) either prior to, or at the time of, the execution of the Contract for Department consideration and acceptance. The Contractor shall ensure that enterprises have been identified within the MWBE Utilization Plan, and the Contractor shall attempt, in good faith, to utilize such enterprise(s) at least to the extent indicated in the Contractor's MWBE Utilization Plan as accepted by the Department. The Contractor must document "good faith efforts" to provide meaningful participation by New York State Certified MWBE subcontractors or suppliers in the performance of the Contract. In support of such efforts, the Contractor will include with its MWBE Utilization Plan submission a Certification of Good Faith Efforts statement (Form MWBE-104).

B. Contractor agrees to use such MWBE Utilization Plan, as accepted by the Department, for the performance of MWBEs on the Contract pursuant to the prescribed MWBE goals set forth in section III-A of this Appendix D.

C. Contractor further agrees that a failure to submit and/or use such MWBE Utilization Plan shall constitute a material breach of the terms of the Contract. Upon the occurrence of such a material breach, Department shall be entitled to any remedy provided herein, including but not limited to, a finding of Contractor non-responsiveness.

V. Waiver Requests (MWBE-101)

A. For Waiver Requests Contractor should use Form MWBE-101 – Request for Waiver Form.

B. If the Contractor, after making good faith efforts, is unable to comply with MWBE goals, the Contractor may submit a Request for Waiver Form documenting good faith efforts by the Contractor to meet such goals. If the documentation included with the Waiver Request is complete, the Department shall evaluate the request and issue a written notice of acceptance or denial within twenty (20) days of receipt.

C. If the Department, upon review of the MWBE Utilization Plan and updated Quarterly M/WBE Contractor Compliance Reports determines that Contractor is failing or refusing to comply with the Contract goals and no waiver has been issued in regards to such non-compliance, the Department may issue a notice of deficiency to the Contractor. The Contractor must respond to the notice of deficiency within seven (7) business days of receipt. Such response may include a request for partial or total waiver of MWBE Contract Goals.

VI. Quarterly M/WBE Contractor Compliance Report (Form MWBE-103)

Contractor is required to submit a Quarterly M/WBE Contractor Compliance Report (Form MWBE-103) to the Department by the 10th day following each end of quarter over the term of the Contract documenting the progress made towards achievement of the MWBE goals of the Contract.

VII. Liquidated Damages - MWBE Participation

A. Where Department determines that Contractor is not in compliance with the requirements of the Contract and Contractor refuses to comply with such requirements, or if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals, Contractor shall be obligated to pay to the Department liquidated damages.

B. Such liquidated damages shall be calculated as an amount equaling the difference between:
   1. All sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and
   2. All sums actually paid to MWBEs for work performed or materials supplied under the Contract.

C. In the event a determination has been made which requires the payment of liquidated damages and such identified sums have not been withheld by the Department, Contractor shall pay such liquidated damages to the Department within sixty (60) days after they are assessed by the Department unless prior to the expiration of such sixtieth day, the Contractor has filed a complaint with the Director of the Division of Minority and Woman Business Development

pursuant to subdivision 8 of section 313 of the Executive Law in which event the liquidated damages shall be payable if Director renders a decision in favor of the Department.

VII. Further Information:

General questions concerning New York's MWBE program should be directed to:

New York State Department of Economic Development
633 Third Avenue
New York, NY 10017
Telephone: (212) 803-2414

New York State Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl Street
Albany, NY 12245
Telephone: (518) 292-5150

All of the EEO and M/WBE forms referenced herein this Appendix D are available for download at the Department's website at: http://www.cs.ny.gov/pio/mwbe-eeo-forms.cfm). These forms are to be submitted without change to the goals specified by Department in the Contract.

Exhibit I.A - Proposal Submission Requirement Checklist

Please indicate by checkmark that your Proposal meets **each** of the following submission requirements:

____**1.** **TIMELY SUBMISSION:** Proposal submitted to assure receipt by the Department no later than 3:00 p.m. ET on the Proposal Due Date as indicated in RFP Section II.A.1.

____**2.** **FORMATTING REQUIREMENTS:** The Offeror's Proposal must be organized in three parts: Administrative Proposal; Technical Proposal and Cost Proposal and each part must each comply with the formatting requirements stated in Section II.A.7.a and II.A.7.b of this RFP.

____a. Fourteen (14) separately bound hardcopies – **two (2) Originals each of the Administrative Proposal, Technical Proposal and Cost Proposal** containing original documents (i.e., original signatures, no photocopies) and marked and numbered (i.e., "ORIGINAL #1" and "ORIGINAL #2."), **Twelve(12) copies of each Administrative Proposal, Technical Proposal and Cost Proposal** marked and numbered (i.e., "COPY #1," "COPY #2," etc.) and a separate CD for the Administrative, Technical and Cost Proposal.

____b. Proposals must be prepared in Adobe Acrobat, with the exception of certain cost and provider network exhibits that have specific formatting instructions.

____c. Each Administrative, Technical and Cost Proposal must be separately bound and externally labeled with "Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan #2014MH-1" and Offeror's name(s). (No cost information [i.e., $ quotes] can be referenced in the Administrative or Technical Proposal.

____d. Table of Contents

____e. Index Tabs

____f. Pagination

____g. Updates/Corrections

____h. Required Content of Proposals - The Proposal shall consist of three parts: the Administrative Proposal must contain the documentation required in Section III of this RFP. The Technical Proposal must be responsive to the programmatic duties and responsibilities set forth in Section IV of this RFP. The Cost Proposal must demonstrate a commitment to perform all programmatic duties and responsibilities in accordance with Section V of this RFP.

____**3.** **REQUIRED CONTENT OF THE ADMINISTRATIVE PROPOSAL:** The Administrative Proposal must contain the following information, in the order enumerated below:

___A. **Formal Offeror Letter**: The Offeror must submit a formal offer in the form of the "Formal Offer Letter" as set forth in RFP, Exhibit I.S in accordance with the requirements set forth in RFP, Section III.A

___B. **Minimum Mandatory Requirements**: The Offeror must submit a completed Exhibit I.T "Offeror Attestations Form" containing the representations and warranties set forth therein.

___C. **Exhibits**: The Offeror must complete and submit the Exhibits specified in Section III.C as follows:

____Exhibit I.A Proposal Submission Requirement Checklist

____Exhibit I.D MacBride Statement and Non-Collusive Bidding Certification

____Exhibit I.G EEO Staffing Plan (form EEO-100)

____Exhibit I.K Offeror's Affirmation of Understanding & Agreement

____Exhibit I.M Compliance with Public Officers Law Requirements

____Exhibit I.N Compliance with Americans with Disabilities Act

C. **Exhibits** Continued

____Exhibit I.O MWBE Utilization Plan (form MWBE-100)

____Exhibit I.P Offeror's Certification of Compliance Pursuant to State Finance Law §139-k

____Exhibit I.Q Certification of Good Faith Efforts (form MWBE-104)

____Exhibit I.S Formal Offer Letter

____Exhibit I.T Offeror Attestations Form

____Exhibit I.U.1 Key Subcontractors

____Exhibit I.U.2 NYS Supplier & Subcontractor Exhibit

____Exhibit I.V Program References

____Exhibit I.X Extraneous Terms

____Exhibit I.Y.2 Offeror's Proposed MHSA Network

____Exhibit I.Y.3 Offeror's MHSA Network Pre-requisite Worksheet

____Exhibit I.Y.4 Comparison of Current Program Providers to Offeror's MHSA Network

____Exhibit I.Z Confidentiality Agreement and Certificate of Non-Disclosure

___D. **Key Subcontractors**: The Offeror must provide a statement identifying all Key Subcontractors, if any, that the Offeror will be contracting with to provide program services and must, for each such Key Subcontractor identified, complete and submit **Exhibit I.U.1 "Key Subcontractors"**:

1. provide a brief description of the services to be provided by the Key Subcontractor; and
2. provide a description of any current relationships with such Key Subcontractor and the clients/projects that the Offeror and Key Subcontractor are currently servicing under a formal legal agreement or arrangement, the date when such services began and the status of the project.

The Offeror must indicate whether or not, as of the date of the Offeror's Proposal, a subcontract has been executed between the Offeror and the Key Subcontractor for services to be provided by the Key Subcontractor relating to this RFP. If the Offeror will not be subcontracting with any Key Subcontractor(s) to provide program services, the Offeror must provide a statement to that effect.

___E. **Reference Checks**: The Offeror must provide four (4) references of current clients and one reference of a former client(s) for a total of five (5) references, for whom the Offeror has supplied services similar to those describe in this RFP. The number of covered lives covered by the Offeror for each referenced client must be at least 100,000. For each client reference provided, the Offeror must complete and submit **Exhibit I.V "Program References."** The Offeror shall be solely responsible for providing contact names, e-mail addresses and phone numbers of client references who are readily available to be contacted by the State.

___F. **Financial Statements**: The Offeror must provide a copy of the Offeror's last issued GAAP annual audited financial statement. A complete set of statements, not just excerpts, must be provided. Additionally, for each Key Subcontractor, if any, that provides any of the program services; provide the most recent GAAP annual audited statement. If the Offeror, or a Key Subcontractor, is a privately held business and is unwilling to provide copies of their GAAP annual audited financial statements as part of their Proposal, the Offeror/Key Subcontractor must make arrangements for the procurement evaluation team to review the financial statements.

NOTE: If financial statements have not been prepared and/or audited, the Offeror must provide the following as part of its Administrative Proposal a letter from a bank reference attesting to the Offeror's financial viability and creditworthiness. (Note: for purposes of this reference, the Offeror may not give as a reference, a parent or subsidiary company, a partner or an affiliate organization. For the purpose of this requirement, "affiliate" means an organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another organization, is controlled by another organization, or is, along with another organization, under the control of a common parent.) The letter must include the bank's name, address, contact person name and telephone number and it must address, at a minimum, the following items:

1. a brief description of the business relationship between the parties (i.e., the Offeror and the bank), including the duration of the relationship and the Offeror's current standing with the bank. For example: "*The Offeror is currently and has been for "x" number of years a client in good standing.";*
2. a description of any ownership/partner relationship that may exist between the parties, if any. (Note: One party cannot be the parent, partner or subsidiary of the other, nor can one party be an affiliate of the other.); and,
3. any other facts or conclusions the bank may deem relevant to the State in regard to the bank's assessment of the Offeror's financial viability and creditworthiness concerning the nature and scope of the Project Services, which are the subject matter of this RFP, and the parties (i.e., DCS and the Offeror) contractual obligations should it be awarded the resultant contract(s).

___G. **Vendor Responsibility Questionnaire:** The Offeror must complete and execute a NYS Vendor Responsibility Questionnaire for itself and all Key Subcontractors.

1. If the Offeror or Key Subcontractor, if any, is incorporated outside the State of New York, a recent certificate of Good Standing must be submitted for each.
2. If the Offeror or Key Subcontractor, if any, has any employees in NYS, a confirmation of NYC's Worker's Compensation and NYS Disability coverage must be submitted for each.

____**4. REQUIRED CONTENT OF THE TECHNICAL PROPOSAL:** The Technical Proposal must be responsive to the duties and responsibilities and submission requirements set forth in Section IV of this RFP and it must contain the following information, in accordance with the submissions associated requirements, and in the order enumerated below:

___A. **Program Administration**

____ 1. Executive Summary

____ 2. General Qualifications of the Offeror

___B. **Proposed Empire Plan MHSA Program Services**

____ 1. Account Team

____ 2 Premium Development Services

____ 3. Implementation

____ 4. Customer Service

____ 5. Enrollee Communication Support

____ 6. Enrollment Management

____ 7. Reporting

____ 8. Consulting

____ 9. Transition and Termination of Agreement

____10. Network Management

____11. Claims Processing

____12. Clinical Management

____13. Other Clinical Management Programs

____**5**. **REQUIRED CONTENT OF THE COST PROPOSAL:** The Offeror's Cost Proposal must demonstrate that it will execute the duties and responsibilities set forth in Section V of this RFP and it must contain the following cost exhibits and responses in strict accordance with the directions set forth in this RFP:

_____Exhibit V.A Claims Analysis

_____Exhibit V.B Administrative Fee Quote

_____Cost and Transparency Questions

____**6. REQUESTED REDACTIONS CD and HARD COPY:** The FOIL-related materials described herein which the Offeror is requested to provide per RFP, Section II.B.8 will not be considered part of the Offeror's Proposal and will not be reviewed as a part of the Procurement's evaluation process. Notwithstanding this they have been identified in this Checklist as a reminder to Offerors of the need to provide the requested items.

At the time of Proposal submission the Offeror is requested to submit:

___A. Exhibit I.C Freedom of Information Law – Request for Redaction Chart

___B. Separately bound hardcopy of the Administrative Proposal, Technical Proposal, and Cost Proposal with each specific item requested to be protected from FOIL disclosure by highlighting in yellow.

___C. Electronic copy (on CD in Adobe Acrobat Professional software, version 8 or higher) of the complete Proposal noting each the specific item requested to be protected from FOIL which contains no more than three pdf files; one for each part of the Proposal (Administrative Proposal, Technical Proposal, and Cost Proposal).

_____ Proposal Dated _____

(Name of Company)

In Response to the Procuring Agencies Request for Proposals entitled **Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, and Student Employee Health Plan, #2014MH-1**

☐ Offeror asserts that the information noted in the table below constitutes proprietary and/or trade secret information and desires that such information not be disclosed if requested pursuant to the New York State Freedom of Information Law, Article 6 of the Public Officers Law.

☐ Offeror makes NO assertion that any information in its Proposal, in whole or in part, should be protected from FOIL disclosure.

Administrative Proposal:		
Requested Redaction Page #'s and Proposal Sections or Exhibit/Attachment #	**Description**	**Offeror Rationale for Proposed Redaction**
Insert rows above as necessary		
Technical Proposal:		
Requested Redaction Page #'s and Proposal Sections or Exhibit/Attachment #	**Description**	**Offeror Rationale for Proposed Redaction**
Insert rows above as necessary		
Cost Proposal:		
Requested Redaction Page #'s and Proposal Sections or Exhibit/Attachment #	**Description**	**Offeror Rationale for Proposed Redaction**
Insert rows above as necessary		

REDACTION CHART

Please provide specific justification for each item for which you seek protection from FOIL disclosure. An appropriate justification may any one or more of the following considerations by which to demonstrate reasonably whether the item for which you seek protection may be excepted from disclosure:

a) the confidential nature of the specific item, including a description of the nature and extent of the injury to the Offeror's competitive position, such as unfair economic or competitive damage, which would be incurred were the information/record to be disclosed;

b) whether the specific information/record is treated as confidential by the Offeror, including whether it ever has been made available to any person or entity;

c) whether any patent, copyright, or similar legal protection exists for the specific item of information;

d) whether the public disclosure of the information/record is otherwise restricted by law, and the specific source and content of such restriction;

e) the date upon which the information/record no longer will need to be kept confidential, if applicable;

f) whether the item of information is known by anyone outside the Offeror's business or organization;

g) the extent to which the information is known by Offeror's employees and others involved in the Offeror's business;

h) the value of the specific information/record to the Offeror and to its competitors;

i) the amount of effort or money expended by the Offeror in developing the information/record; and

j) the ease or difficulty with which the information could be properly acquired or duplicated (not merely copied) for use by others.

INSTRUCTION: Prepare this form for each key staff individual on the Account Team, as well as any key staff individual of a Key Subcontractor or Affiliate.

Name: _____

Job Title: _____

Relationship to Project: _____

_____

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

NON-DISCRIMINATION IN EMPLOYMENT IN NORTHERN IRELAND
MACBRIDE FAIR EMPLOYMENT PRINCIPLES

In accordance with Chapter 807 of the Laws of 1992 the Offeror, by submission of this bid, certifies that it or any individual or legal entity in which the Offeror holds a 10% or greater ownership interest, or any individual or legal entity that holds a 10% or greater ownership interest in the Offeror, either (answer "yes" or "no" to one or both of the following, as applicable):
Have business operations in Northern Ireland. Yes _____ or No _____
If yes:
Shall take lawful steps in good faith to conduct any business operations they have in Northern Ireland in accordance with the MacBride Fair Employment Principles relating to nondiscrimination in employment and freedom of workplace opportunity regarding such operations in Northern Ireland, and shall permit independent monitoring of their compliance with such Principles. Yes _____ or No _____

NON-COLLUSIVE BIDDING CERTIFICATION

By submission of this bid, each Offeror and each person signing on behalf of any Offeror certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of his knowledge and belief:

1. The prices in this bid have been arrived at independently without collusion, consultation, communication or agreement for the purpose of restricting competition, as to any matter relating to such prices with any other Offeror or with any competitor;
2. Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the Offeror and will not knowingly be disclosed by the Offeror prior to opening, directly or indirectly, to any other Offeror or to any competitor; and
3. No attempt has been made or will be made by the Offeror to induce any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition.

Date:_____ _____
Signature

PRINT:
SIGNATORY'S NAME _____ **TITLE** _____

INDIVIDUAL, CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT

STATE OF }
: **SS.:**
COUNTY OF }

On the ____ day of _____in the year 20__, before me personally appeared:

_____, known to me to be the person who executed the foregoing

instrument, who, being duly sworn by me did depose and say that _he resides at _____, Town of

_____, County of _____ , State of _____ ; and further that, if applicable:

[Check One, If Applicable]
(___ If a corporation): _he is the _____ of _____, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.
(___If a partnership): _he is the _____ of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for the purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name and on behalf of said partnership as the act and deed of said partnership.

_____
Notary Public

New York State Department of Taxation and Finance

Contractor Certification to Covered Agency

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-CA
(6/06)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a* (see *Need Help? on back).*

Contractor name	*For covered agency use only* *Contract number or description*
Contractor's principal place of business — City — State — ZIP code	
Contractor's mailing address *(if different than above)*	*Estimated contract value over the full term of contract (but not including renewals)* $
Contractor's federal employer identification number (EIN) — Contractor's sales tax ID number (if different from contractor's EIN)	
Contractor's telephone number — Covered agency name	
Covered agency address	*Covered agency telephone number*

I, _____ *(name)*, hereby affirm, under penalty of perjury, that I am _____ *(title)* of the above-named contractor, that I am authorized to make this certification on behalf of such contractor, and I further certify that:

(Mark an X in only one box)

☐ The contractor has filed Form ST-220-TD with the Department of Taxation and Finance in connection with this contract and, to the best of contractor's knowledge, the information provided on the Form ST-220-TD, is correct and complete.

☐ The contractor has previously filed Form ST-220-TD with the Tax Department in connection with _____ *(insert contract number or description)* and, to the best of the contractor's knowledge, the information provided on that previously filed Form ST-220-TD, is correct and complete as of the current date, and thus the contractor is not required to file a new Form ST-220-TD at this time.

Sworn to this____ day of _____, 20____

_____ *(sign before a notary public)*

_____ *(title)*

Instructions

General information

Tax Law section 5-a was amended, effective April 26, 2006. On or after that date, in all cases where a contract is subject to Tax Law section 5-a, a contractor must file (1) Form ST-220-CA, *Contractor Certification to Covered Agency,* with a covered agency, and (2) Form ST-220-TD with the Tax Department before a contract may take effect. The circumstances when a contract is subject to section 5-a are listed in Publication 223, Q&A 3. This publication is available on our Web site, by fax, or by mail. (See *Need help?* for more information on how to obtain this publication.) In addition, a contractor must file a new Form ST-220-CA with a covered agency before an existing contract with such agency may be renewed.

If you have questions, please call our information center at 1 800 698-2931.

Note: Form ST-220-CA must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 2 of this form must be completed before a notary public.

When to complete this form

As set forth in Publication 223, a contract is subject to section 5-a, and you must make the required certification(s), if:

i. The procuring entity is a *covered agency* within the meaning of the statute (see Publication 223, Q&A 5);

ii. The contractor is a *contractor* within the meaning of the statute (see Publication 223, Q&A 6); and

iii. The contract is a *contract* within the meaning of the statute. This is the case when it (a) has a value in excess of $100,000 and (b) is a contract for *commodities* or *services*, as such terms are defined for purposes of the statute (see Publication 223, Q&A 8 and 9).

Furthermore, the procuring entity must have begun the solicitation to purchase on or after January 1, 2005, and the resulting contract must have been awarded, amended, extended, renewed, or assigned *on or after April 26, 2006* (the effective date of the section 5-a amendments).

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the ___ day of _____ in the year 20___, before me personally appeared _____,

known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that

_he resides at _____,

Town of _____,

County of _____,

State of _____; and further that:

[Mark an ***X*** in the appropriate box and complete the accompanying statement.]

☐ (If an individual): _he executed the foregoing instrument in his/her name and on his/her own behalf.

☐ (If a corporation): _he is the _____

of _____, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

☐ (If a partnership): _he is a _____

of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

☐ (If a limited liability company): _he is a duly authorized member of _____, LLC, the limited liability company described in said instrument; that _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

_____
Notary Public

Registration No. _____

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone 1 800 225-5829. From areas outside the United States and outside Canada, call (518) 485-6800.

Need help?

Internet access: *www.nystax.gov* (for information, forms, and publications)

Fax-on-demand forms: 1 800 748-3676

Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday. 1 800 698-2931

To order forms and publications: 1 800 462-8100

From areas outside the U.S. and outside Canada: (518) 485-6800

Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110

Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.

Exhibit I.F - ST-220-TD

New York State Department of Taxation and Finance

Contractor Certification

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-TD
(5/07)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a (see Need help? below).*

Contractor name			
Contractor's principal place of business	City	State	ZIP code
Contractor's mailing address *(if different than above)*			

Contractor's federal employer identification number (EIN)	Contractor's sales tax ID number (if different from contractor's EIN)	Contractor's telephone number ( )
Covered agency or state agency	Contract number or description	Estimated contract value over the full term of contract (but not including renewals) $
Covered agency address		Covered agency telephone number

General information

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded certain state contracts valued at more than $100,000 to certify to the Tax Department that they are registered to collect New York State and local sales and compensating use taxes, if they made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000, measured over a specified period. In addition, contractors must certify to the Tax Department that each affiliate and subcontractor exceeding such sales threshold during a specified period is registered to collect New York State and local sales and compensating use taxes. Contractors must also file a Form ST-220-CA, certifying to the procuring state entity that they filed Form ST-220-TD with the Tax Department and that the information contained on Form ST-220-TD is correct and complete as of the date they file Form ST-220-CA.

All sections must be completed including all fields on the top of this page, all sections on page 2, Schedule A on page 3, if applicable, and Individual, Corporation, Partnership, or LLC Acknowledgement on page 4. If you do not complete these areas, the form will be returned to you for completion.

For more detailed information regarding this form and section 5-a of the Tax Law, see Publication 223, *Questions and Answers Concerning Tax Law Section 5-a, (as amended, effective April 26, 2006),* available at *www.nystax.gov.* Information is also available by calling the Tax Department's Contractor Information Center at 1 800 698-2931.

Note: Form ST-220-TD must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 4 of this form must be completed before a notary public.

Mail completed form to:

NYS TAX DEPARTMENT
DATA ENTRY SECTION
W A HARRIMAN CAMPUS
ALBANY NY 12227

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227.

Need help?

Internet access: *www.nystax.gov* (for information, forms, and publications)

Fax-on-demand forms: 1 800 748-3676

Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday.

To order forms and publications: 1 800 462-8100

Sales Tax Information Center: 1 800 698-2909

From areas outside the U.S. and outside Canada: (518) 485-6800

Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110

Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.

I, _____ , hereby affirm, under penalty of perjury, that I am _____
(name) *(title)*

of the above-named contractor, and that I am authorized to make this certification on behalf of such contractor.

Complete Sections 1, 2, and 3 below. Make **only one** entry in each section.

Section 1 — Contractor registration status

☐ The contractor has made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made. The contractor is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law, and is listed on Schedule A of this certification.

☐ The contractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Section 2 — Affiliate registration status

☐ The contractor does not have any affiliates.

☐ To the best of the contractor's knowledge, the contractor has one or more affiliates having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each affiliate exceeding the $300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each affiliate exceeding the $300,000 cumulative sales threshold during such quarters on Schedule A of this certification.

☐ To the best of the contractor's knowledge, the contractor has one or more affiliates, and each affiliate has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Section 3 — Subcontractor registration status

☐ The contractor does not have any subcontractors.

☐ To the best of the contractor's knowledge, the contractor has one or more subcontractors having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each subcontractor exceeding the $300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each subcontractor exceeding the $300,000 cumulative sales threshold during such quarters on Schedule A of this certification.

☐ To the best of the contractor's knowledge, the contractor has one or more subcontractors, and each subcontractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Sworn to this___ day of _____ , 20 ____

_____ _____
(sign before a notary public) *(title)*

Schedule A — Listing of each entity (contractor, affiliate, or subcontractor) exceeding $300,000 cumulative sales threshold

List the contractor, or affiliate, or subcontractor in Schedule A only if such entity exceeded the $300,000 cumulative sales threshold during the specified sales tax quarters. See directions below. For more information, see Publication 223.

A Relationship to Contractor	B Name	C Address	D Federal ID Number	E Sales Tax ID Number	F Registration in progress

Column A – Enter ***C*** in column A if the contractor; ***A*** if an affiliate of the contractor; or ***S*** if a subcontractor.

Column B – Name - If the entity is a corporation or limited liability company, enter the exact legal name as registered with the NY Department of State, if applicable. If the entity is a partnership or sole proprietor, enter the name of the partnership and each partner's given name, or the given name(s) of the owner(s), as applicable. If the entity has a different DBA (doing business as) name, enter that name as well.

Column C – Address - Enter the street address of the entity's principal place of business. Do not enter a PO box.

Column D – ID number - Enter the federal employer identification number (EIN) assigned to the entity. If the entity is an individual, enter the social security number of that person.

Column E – Sales tax ID number - Enter only if different from federal EIN in column D.

Column F – If applicable, enter an X if the entity has submitted Form DTF-17 to the Tax Department but has not received its certificate of authority as of the date of this certification.

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the ____ day of _____ in the year 20__ , before me personally appeared _____ ,

known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that

_ he resides at _____ ,

Town of _____ ,

County of _____ ,

State of _____; and further that:

[Mark an ***X*** in the appropriate box and complete the accompanying statement.]

☐ (If an individual): _he executed the foregoing instrument in his/her name and on his/her own behalf.

☐ (If a corporation): _he is the _____

of _____ , the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

☐ (If a partnership): _he is a _____

of _____ , the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

☐ (If a limited liability company): _he is a duly authorized member of _____ LLC, the limited liability company described in said instrument; that _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

_____
Notary Public

Registration No. _____

State of New York
Department of Civil Service
Albany, NY 12239

EQUAL EMPLOYMENT OPPORTUNITY STAFFING PLAN

OFFICE OF FINANCIAL ADMINISTRATION **EEO-100 (9/2011)**

Solicitation No.:	Reporting Entity: ☐ Contractor ☐ Subcontractor	Report includes: ☐ Contractor's work force to be utilized on this contract ☐ Contractor's total work force ☐ Subcontractor's work force to be utilized on this contract ☐ Subcontractor's total work force
Contractor/Subcontractor's Name:		
Contractor/Subcontractor's Address: FEIN:		

Enter the total number of employees in each classification in each of the EEO-Job Categories identified.

EEO Job Categories	Total Work Force	Work force by Gender		Work force by Race/Ethnic Identification													
		Total Male (M)	Total Female (F)	White (M)	White (F)	Black (M)	Black (F)	Hispanic (M)	Hispanic (F)	Asian (M)	Asian (F)	American Indian or Alaskan Native (M)	American Indian or Alaskan Native (F)	Disabled Individual (M)	Disabled Individual (F)	Veteran (M)	Veteran (F)
Executive/Senior level Officials & Managers																	
First/Mid level officials & Managers																	
Professionals																	
Technicians																	
Sales Workers																	
Administrative Support Workers																	
Craft Workers																	
Operatives																	
Laborers and Helpers																	
Service Workers																	
Totals																	

PREPARED BY (Signature):	**TELEPHONE NO.:** **EMAIL ADDRESS:**	**DATE:**
NAME AND TITLE OF PREPARER (Print or Type):		

State of New York
Department of Civil Service
Albany, NY 12239

EQUAL EMPLOYMENT OPPORTUNITY STAFFING PLAN

OFFICE OF FINANCIAL ADMINISTRATION **EEO-100 (9/2011)**

General Instructions: All Offerors must complete an EEO Staffing Plan (EEO 100) and submit it as part of the bid or proposal package. Where the work force to be utilized in the performance of the State contract can be separated out from the contractor's total work force, the Offeror shall complete this form only for the anticipated work force to be utilized on the State contract. Where the work force to be utilized in the performance of the State contract cannot be separated out from the contractor's total work force, the Offeror shall complete this form for the contractor's total work force. Subcontractors awarded a subcontract over $25,000 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor must complete this form upon request of the Department.

Instructions for completing:

1. Enter the Solicitation Number that this report applies to along with the name and address of the Offeror (contractor).
2. Check off the appropriate box to indicate if the report is the contractor or a subcontractor.
3. Check off the appropriate box to indicate if the contractor's/subcontractor's work force being reported is just for the contract or the total work force.
4. Enter the total work force by EEO job category.
5. Break down the total work force by gender and enter under the heading "Work force by Gender."
6. Break down the total work force by race/ethnic background and enter under the heading "Work force by Race/Ethnic Identification."
7. Enter information on any disabled or veteran employees included in the work force under the appropriate heading.
8. Enter the name, title, phone number and email address for the person completing the form. Sign and date the form in the designated boxes.

RACE/ETHNIC IDENTIFICATION

Race/ethnic designations as used by the Equal Employment Opportunity Commission do not denote scientific definitions of anthropological origins. For the purposes of this report, an employee may be included in the group to which he or she appears to belong, identifies with, or is regarded in the community as belonging. However, no person should be counted in more than one race/ethnic group. The race/ethnic categories for this survey are:

WHITE: (Not of Hispanic origin) All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

BLACK: A person, not of Hispanic origin, who has origins in any of the black racial groups of the original peoples of Africa.

HISPANIC: A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

ASIAN & PACIFIC ISLANDER: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands.

AMERICAN INDIAN OR ALASKAN NATIVE (Not of Hispanic Origin): A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

DISABLED INDIVIDUAL - any person who:

- has a physical or mental impairment that substantially limits one or more major life activity
- has a record of such an impairment; or
- is regarded as having such an impairment.

VIETNAM ERA VETERAN: A veteran who served at any time between and including January 1, 1963 and May 7, 1975.

NYS State Finance Law §163(9)(c), as amended by Section 3 of Chapter 137 of the Laws of 2008, requires that:

> *"A state agency shall, upon request, provide a debriefing to any unsuccessful offerer[1] that responded to a request for proposal or an invitation for bids, regarding the reasons that the proposal or bid submitted by the unsuccessful offerer was not selected for an award. The opportunity for an unsuccessful offerer to seek a debriefing shall be stated in the solicitation, which shall provide a reasonable time for requesting a debriefing."*

The Procurement Council Guidelines define "Debriefing" as:

> *The practice whereby, upon the request of a bidder, the state agency advises such bidder of the reasons why its bid was not selected for an award. It is viewed as a learning process for the bidder to be better prepared to participate in future procurements.*

In accordance with the law, the Department shall make a Debriefing available to any entity that submitted a proposal or bid in response to a given solicitation ("Offeror"), including the selected Offeror after notice award is made by the Department. All Offerors shall be given written notice of award, via email with hardcopy to follow.

Timeframes associated with requesting/conducting Debriefings:

Debriefing must be requested by Offerors in writing to the designated individual or email address as set forth in the notice of award.

- Pre-Award Debriefings:
  Any Offeror, upon request, will be afforded an opportunity for a pre-award Debriefing at least five business days prior to the date by which any protest must be filed. An Offeror's failure to timely request a pre-award Debriefing shall not cause an extension of the time period within which a protest must be filed. In those cases where the Offeror fails to make a timely request for a pre-award Debriefing, the Department will schedule the Debriefing as soon after the time the request is made as it deems practicable.

- Post-Award Debriefings:
  In the case of requests made by an Offeror(s) for a post-award Debriefing, the request must be received by the Department not more than twenty calendar days after final approval of the contract is received or the date the award is posted on OSC' website at the address set forth below and the Department will schedule the Debriefing as soon after the time the request is made as it deems practicable.

  http://wwe1.osc.state.ny.us/transparency/contracts/contractsearch.cfm

How Debriefings shall be conducted by the Department:

A Debriefing may be requested by any unsuccessful Offeror after a contract award is made regarding the reasons that the proposal or bid submitted by the unsuccessful Offeror was not selected for award. While a Debriefing is typically conducted in person, it may be conducted

[1] For purposes of this policy, the terms Offeror, Offerer and Bidder are understood to have same meaning.

by video conference, over the phone, or through written summaries, if agreed to by the Offeror.

Since Debriefings are intended to make the procurement process open and transparent and to help the vendor community become more viable competitors for New York State goods and services, when conducting a Debriefing, the Department will, at a minimum, discuss the strengths and weaknesses of the Offeror's proposal and provide information as to the relative rating of the Offeror's proposal in each of the major evaluation categories as provided for in the solicitation document. Typically such a debriefing will include information as to the rating of the Offeror's proposal in both the technical and cost components of the evaluation and an identification of any areas in the proposal deemed deficient. The Department will not provide any documents/materials at a Debriefing as their release is subject to NYS FOIL laws.

During a **pre-award** Debriefing, the Department:

- will limit the discussion to the reasons why the Offeror's proposal/bid was unsuccessful;
- will not provide information concerning any other Offerors' proposals, including the winning proposal; will not discuss any other aspects of the Procurement Record, including but not limited to the detailed scoring and evaluation criteria as such information is subject to NYS FOIL laws; and
- may, but is not required to, offer general advice and guidance to the Offeror for the Offeror's consideration as regards future bidding opportunities.

During a **post-award** Debriefing, the Department:

- will provide information as to the reasons why the Offeror's proposal/bid was unsuccessful;
- will provide information concerning the other Offerors' proposals, including the winning proposal, but only in the context of the bid evaluation scoring;
- will not discuss specific details of other Offerors' proposals, including their individual strengths and weakness as such information is subject to NYS FOIL laws
- will not discuss any other aspects of the Procurement Record, including but not limited to the detailed scoring and evaluation criteria as such information is subject to NYS FOIL laws and
- may offer advice and guidance to the Offeror for the Offeror's consideration as regards future bidding opportunities, including those services which were the subject matter of the procurement.

General:

- ✓ The Department will schedule the same amount of time for each Offeror who requests a debriefing.
- ✓ Debriefing will not be scheduled for more than one hour.
- ✓ Debriefings will be held individually with a requesting Offeror.
- ✓ The Department's Designated Agency Contact (i.e., the Procurement Manager) is the sole person authorized to schedule a Debriefing.
- ✓ The Offeror must provide a list of intended attendees prior to the Debriefing, including their titles or relationship to the Offeror and notify the Department if the Offeror is intending to bring legal counsel, so that the Department can notify agency legal counsel.
- ✓ At a minimum at least two agency employees must be present at each Debriefing.

- ✓ Debriefings will not be taped or transcribed by the Department, and Offerors are prohibited from taping the Debriefing.
- ✓ Any discussion of a proposal's strengths and weaknesses will relate to scoring of that bid submission against the RFP requirements, not against a competitor's proposal. The Department will not discuss the relative merits of one Offeror's submission against its competitors as that is not how proposals are evaluated and scored.
- ✓ Requests for copies of documents made by an Offeror at the Debriefing must be handled in accordance with the Department's FOIL procedures.

April 2011

This Exhibit has been intentionally left blank

NYS Department of Civil Service
RFP No. 2014MH-1
entitled
"Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan"

Notice of Bidding Intention Form

(Please PRINT Firm's Name Above)

With regard to this RFP, (check one of the following boxes applicable):

☐ We **ARE INTERESTED & MAY** submit a bid response.

☐ We **ARE NOT INTERESTED & WILL NOT** be submitting a bid response because:

_____

_____

_____

_____

INTEREST IN M/WBE SUBCONTRACTING POSTING:
(Check box if applicable)

☐ Our firm is a NYS certified M/WBE interested in a subcontracting opportunity. Please add our firm's contact information, indicated at the top of this Form, to the list of certified M/WBE subcontractors that have expressed interest in this Procurement. The list will be posted on Department's web page for this Procurement. The NYS M/WBE certification documentation for our firm is attached

_____
Name of Contact at Firm

_____
Title

_____
Email Address

_____/ _____ /_____
Date

Complete the tables above and submit it to the MHSA Program Procurement Manager specified in RFP, Section II.A.2.b. The completed table may be emailed, faxed and/or mailed (see addresses provided in RFP, Section II.A.2.b.).

Part 1 of this Exhibit I.K, as contained on the following page, should be completed by the Offeror and emailed, faxed and/or mailed to the MHSA Program Procurement Manager as set forth in RFP, Section II.A.2.b.

Part 2 of this Exhibit I.K should, prior to initiating any contact with the Department, be completed for each Offeror officer, employee, agent or consultant retained, employed or designated, by or on behalf of the Offeror to appear before or contact the Department in regards to this Procurement and submit it to the MHSA Program Procurement Manager specified in RFP, Section II.A.2.b.

Part 1

Offeror's Affirmation of Understanding and Agreement

Instructions:
Pursuant to State Finance Law §§139-j and 139-k, this solicitation imposes certain procurement lobbying limitations. Offerors are restricted from making contacts during the procurement's "Restricted Period" (from the earliest written notice, advertisement or solicitation of a request for proposal, invitation for bids, or solicitation of proposals, or any other method for soliciting a response from Offerors intending to result in a procurement contract with a governmental entity and ending with the final contract award and approval by the governmental entity and, where applicable, approval by the State Comptroller) to other than designated staff, unless the contact falls within certain statutory exceptions ("permissible contacts"). the Department's employees are required to obtain certain information from Offerors and others whenever there is a contact about the procurement during the Restricted Period, and are required to make a determination of the Offeror's responsibility that addresses the Offeror's compliance with the statutes' requirements. Findings of non-responsibility result in rejection for contract award, and if an Offeror is subject to two non-responsibility findings within four years the Offeror also will be determined ineligible to submit a proposal on or be awarded a contract for four years from the date of the second non-responsibility finding.
Further information about these requirements can be found at:
http://www.ogs.ny.gov/aboutOGS/regulations/defaultAdvisoryCouncil.html.

As a prerequisite for participating in this procurement, an Offeror must provide the following Affirmation of Understanding and Agreement to comply with these procurement lobbying restrictions in accordance with State Finance Law §§139-j and 139-k.

Offeror Affirmation and Agreement

The Offeror affirms that it understands the procurement lobbying requirements set forth in State Finance Law §§139-j and 139-k, and agrees to comply with the Department's procedures regarding permissible contacts as required thereby.

Name of Offeror:	
By:	
	(Signature)
Name:	
Title:	
Address:	
Date:	

Part 2

Offeror Designated Contact	
First Name	
Last Name	
Company Name	
Company Address:	
Street Address	
City	
State	
Zip	
Individual's Business Telephone # (xxx) xxx-xxxx	
Principal Place of Business (1)	
Individual's Occupation	

(1) Enter the location of the individual's Principal Place of Business (e.g. Albany, NY)

Complete the table above for each Offeror officer, employee, agent or consultant retained, employed or designated, by or on behalf of the Offeror to appear before or contact the Department in regards to this Procurement, prior to the individual initiating any contact with the Department, and submit it to the MHSA Program Procurement Manager specified in Section II.A.2.b. of the RFP.

State of New York
Department of Civil Service
Albany, NY 12239

ADMINISTRATION DIVISION

Procurement Lobbying Policy: Restrictions on Contacts During the Procurement Process

Policy on Restrictions on Contacts During the Procurement Process
Procurement Lobbying, Ch.4, L. 2010 State Finance Law (SFL)
Sections 139-j and 139-k

I. Definitions

For the purpose of this policy as it regards RFP#2014-MH1, the following definitions apply:

"Article of procurement" means a commodity, service, technology, public work, construction, revenue contract, the purchase, sale or lease of real property or an acquisition or granting of other interest in real property, that is the subject of a Department governmental procurement.

"Contacts" means any oral, written, or electronic communication with DCS or any other State governmental entity under circumstances where a reasonable person would infer that the communication was intended to influence the governmental entity's conduct or decision regarding the governmental procurement. However, any communications received by the Department from members of the State legislature or legislative staff, when acting in his or her official capacity, shall not be considered to be a "contact" and shall not be recorded by the Department's staff pursuant to this policy.

"Procurement Contract" means any contract or other agreement, including an amendment, extension, renewal, or change order to an existing contract (other than amendments, extensions, renewals, or change orders that are authorized and payable under the terms of the contract as it was finally awarded or approved by the comptroller, as applicable), for an article of procurement involving an estimated annualized expenditure in excess of $15,000. Grants, contracts entered into under SFL Article 11-B, and intergovernmental agreements shall not be deemed "procurement contracts" for the purpose of this policy.

"Governmental entity" means: (1) any department, board, bureau, commission, division, office, council, committee or officer of the state, whether permanent or temporary, including the Department; (2) each house of the state legislature; (3) the unified court system; (4) any public authority, public benefit corporation or commission created by or existing pursuant to the public authorities law; (5) any public authority or public benefit corporation, at least one of whose members is appointed by the governor or who serves as a member by virtue of holding a civil office of the state; (6) a municipal agency, as that term is defined in paragraph (ii) of subdivision (s) of section one-c of the legislative law; (7) a subsidiary or affiliate of such a public authority.

"Offeror" means any individual or entity, or any employee, agent, consultant, or person acting on behalf of such individual or entity, who contacts the Department or any other State governmental entity about a governmental procurement during that procurement's restricted period of such governmental procurement whether or not the caller has a financial interest in the outcome of the procurement; provided, however, that a governmental agency or its employees that communicates with the Department regarding a governmental procurement in the exercise of its oversight duties shall not be considered an Offeror. "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids in response to the solicitation document.

"Proposal" means any bid, quotation, offer or response to the Department's solicitation of submissions relating to procurement.

"Governmental procurement" means:

a) the public announcement, public notice, or public communication to any potential vendor of a determination of need for a procurement, which shall include, but not be limited to, the public notification of the specifications, , bid documents, request for proposals or evaluation criteria for a procurement contract;

b) the solicitation for a procurement contract;

c) the evaluation of a procurement contract;

d) the award, approval, denial, or disapproval of a procurement contract; or

e) the approval or denial of an assignment, amendment (other than amendments that are authorized and payable under the terms of the procurement contract as it was finally awarded or approved by the State Comptroller, as applicable), renewal or extension of a procurement contract, or any other material change in the procurement contract resulting in a financial benefit to the Offeror/Contractor.

"Restricted period" means the period of time commencing with the earliest written notice, advertisement or solicitation of a request for proposal, or invitation for bids, or solicitation of proposals, or any other method for soliciting a response from Offerors intending to result in a procurement contract, and ending with the final contract award and approval of the Department and, where applicable, the State Comptroller.

"Revenue contract" means any written agreement between the Department and an Offeror whereby the Department gives or grants a concession or a franchise.

II. Designated Contacts

For each governmental procurement, the Department shall at the same time that a restricted period is imposed, designate, with regard to each governmental procurement, a person or person(s) who are knowledgeable about the procurement and who may be contacted by Offerors relating to the governmental procurement. Each Offeror who contacts the Department during procurement's restricted period is permitted to make permissible contacts only the person(s) designated by the Department for that purpose (i.e., Designated Contact). Such contacts must comply with the requirements established by SFL sections 139-j and 139-k, and with the requirements set forth by the Department in the solicitation document.

III. Offeror Affirmation of Understanding and Agreement to Comply

As a threshold requirement to participating in a procurement, the Department shall require each Offeror to provide written affirmation of its understanding of and agreement to comply with the Department's policy and procedures relating to permissible contacts during the governmental procurement's restricted period. Such a written affirmation by an Offeror shall be deemed to apply to any amendments to a procurement submitted by the Department after an initial affirmation is received with an initial bid.

IV. Contact Documentation

Upon any contact during the procurement's restricted period, the Department's staff shall obtain the name, address, telephone number, place of principal employment, and occupation of the person or organization making the contact, and also shall inquire whether the person or organization making the contact was the Offeror or was retained, employed, or designated by or on behalf of the Offeror to appear before or contact the Department about the procurement. All recorded contacts shall be recorded on the appropriate form(s) and included in the procurement record.

V. Non-responsibility Disclosure

The Procuring Agencies' staff shall ensure that all solicitation documents require Offerors to disclose findings of non-responsibility made within the previous four years by any State governmental entity where such prior finding of non-responsibility was due to:

a) a violation of the procurement lobbying requirements established at SFL section 139-j; or

b) the intentional provision of false or incomplete information to a government entity.

VI. Non-responsibility Determination

The failure of an Offeror to timely disclose accurate or complete information to the Department regarding the above shall be considered by the Department in their determination of the Offeror's responsibility. No procurement contract shall be awarded to any such Offeror, its subsidiaries, and any related or successor entity with substantially similar function, management, board of directors, officers and shareholders unless the Department finds that the award of the contract to that entity is necessary to protect public property or public health or safety, and that the entity is the only source capable of supplying the required article of procurement within the necessary timeframe, provided however, that the Department shall include in the procurement record a statement describing the basis for such finding.

VII. Contractor Certification

A contract award subject to SFL sections 139-j and 139-k shall contain a certification by the successful Offeror that all information provided to the Department with respect to the procurement lobbying requirements established by those sections is complete, true and accurate.

Each contract shall contain a provision authorizing the Department to terminate such contract in the event such certification is found to be intentionally false or intentionally incomplete. The Department shall include in the procurement record a statement describing the basis for such termination.

Any employee of the Department who becomes aware that an Offeror has made an impermissible contact(s) during the procurement shall immediately notify the DCS Ethics Officer or the DCS Director of Internal Audit. If an Offeror violates these requirements with regard to permissible contacts at a governmental entity other than the Department, the employee of that entity who becomes aware of the violation shall notify that entity's Ethics Officer, Inspector General, if any, or other official of that entity responsible for reviewing or investigating such matters, who shall in turn notify the DCS Ethics Officer or the DCS Director of Internal Audit.

VIII. DCS Review of Alleged Violations and the Imposition of Sanctions

a) If the DCS Ethics Officer or the DCS Director of Internal Audit receives notification of an allegation that an Offeror has made an impermissible contact during the procurement's restricted period as described above, the DCS Director of Internal Audit shall immediately investigate such allegation. If the position of Director of Internal Audit is vacant, the Ethics Officer shall conduct the investigation, or the Commissioner may appoint a designee to investigation the allegation. In no event shall the person conducting the investigation be someone who has participated in the preparation of the solicitation document, the evaluation of Proposals, or the selection decision.

b) If the investigation indicates that sufficient cause exists to believe that the allegation is true, the Department shall give the Offeror reasonable notice that an investigation is ongoing and an opportunity to be heard in response to the allegation. At the Department's discretion, such opportunity to be heard may be provided by giving the Offeror the opportunity to meet with the Department staff conducting the investigation or by the Offeror's submission of a written statement, or both. The Offeror may, but need not, be represented by counsel during the investigation. Any and all issues concerning the manner in which the investigation process is conducted shall be determined solely by the Department staff conducting the investigation.

c) If it is found that an Offeror has knowingly and willfully made an impermissible contact in violation of these requirements, then the Department staff making such findings shall report to the President of the Civil Service Commission related instances, if any, of any Department employee's violation of Public Officers Law sections 73(5) and 74.

IX. Sanctions

a) A finding that an Offeror has knowingly and willfully made an impermissible contact shall result in a determination of non-responsibility for such Offeror. Concomitantly, such Offeror and its subsidiaries, and any related or successor entity with substantially similar function, management, board of directors, officers and shareholders, shall not be awarded the procurement contract, unless the Department finds that the award of the procurement contract to that entity is necessary to protect public property or public health or safety, and that the entity is the only source capable of supplying the required article of procurement within the necessary timeframe. If such in the case, the Department shall include in the procurement record a statement describing the basis for such a finding.

b) Any subsequent determination of an Offeror's non-responsibility due to violation of these requirements within four years of a prior determination of non-responsibility due to a violation of these requirements shall result in the Offeror being rendered ineligible to submit a proposal on or be awarded any procurement contract for a period of four years from the date of the second non-responsibility determination.

X. Model Language For Solicitation Documents

The Department's staff shall ensure that the model language set forth below is included in all solicitation documents issued by the Department, subject to final review by their Offices of Counsel:

Restrictions on Contacts Between
Offerors and State Staff During the Procurement Process

a) Pursuant to State Finance Law sections 139-j and 139-k, this procurement imposes certain procurement lobbying limitations. Offerors are restricted from making contacts during the procurement's "Restricted Period" to other than designated staff of the Department and the Executive Branch of New York State government, unless the contact falls within certain statutory exceptions ("permissible contacts"). Staff is required to obtain certain information from Offerors and others whenever there is a contact about the procurement during the Restricted Period, and are required to make a determination of the Offeror's responsibility that addresses the Offeror's compliance with the statutes' requirements. Findings of non-responsibility result in rejection for contract award, and if an Offeror is subject to two non-responsibility findings within four years the Offeror also will be determined ineligible to submit a proposal on or be awarded a contract for four years from the date of the second non-responsibility finding. The Department's policy and procedures are attached as Exhibit (TBD) to this RFP. Further information about these requirements can be found at:

http://www.ogs.ny.gov/aboutOGS/regulations/defaultAdvisoryCouncil.html

b) In order to ensure public confidence and integrity in the procurement process, the Department will control strictly all communications between any Offeror and participants in the evaluation process from the earliest notice of intent to solicit offers in this procurement through the final award and approval of the procurement contract by the Department and OSC, if applicable. "Offeror" means any individual or entity, or any employee, agent, consultant, or person acting on behalf of such individual or entity, who contacts the Department or any other State governmental entity about a governmental procurement during that procurement's restricted period whether or not the caller has a financial interest in the outcome of the governmental procurement; provided, however, that a governmental agency or its employees that communicates with the Department regarding a governmental procurement in the exercise of its oversight duties shall not be considered an Offeror. "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids in response to the solicitation document. All contacts and inquiries concerning this procurement must be made to the Procurement Manager. The Department shall disqualify any Offeror who fails to comply with this requirement.

MHSA Benefit Services Procurement Manager
Attn: Linda Burk
NYS Civil Service
Agency Bldg. 1
Empire State Plaza
Albany, NY 12239
Fax: **(518) 402-2835**
E-mail: **2014MHSARFP@cs.state.ny.us**

Additionally, any Offeror is strictly prohibited from making any contacts or inquiries concerning the procurement with any member, officer or employee of

any governmental entity other than the Department from the date the public announcement, public notice, or public communication to any potential vendor of a determination of need for a procurement, which shall include, but not be limited to, the date the RFP is released until the end of the procurement, subject only to the specific exceptions listed below. Further, any Offeror shall not attempt to influence the procurement in any manner that would result in a violation or an attempted violation of Public Officers Law sections 73(5) or 74.

c) The following contacts are exempted from the provisions of paragraph 3 of section 139-j and as such do not need to be directed to the Procurement Manager pursuant to section 139-k:

(1) the submission of written proposals in response to the solicitation document;

(2) the submission of written questions by a method set forth in the solicitation document when all written questions and responses are to be distributed to all Offerors who have expressed an interest in the procurement;

(3) participation in a demonstration, conference or other means for exchange of information in a setting open to all potential bidders provided for in the solicitation document;

(4) complaints by an Offeror regarding the failure of the Department's Procurement Manager to respond to an Offeror's authorized contacts, when such complaints are made in writing to the Department's Office of the General Counsel, provided that any such written complaints shall become a part of the procurement record;

(5) communications by a successful Offeror(s) who has been tentatively awarded a contract and is engaged in communications with the Department solely for the purpose of negotiating the terms of the contracts after having been notified of tentative award;

(6) contact by an Offeror to request the review of a procurement award when done in accordance with the procedure specified in the solicitation document;

(7) A. contacts by an Offeror in protests, appeals or other review proceedings (including the apparent successful Offeror and its representatives) before the Department seeking a final administrative determination, or in a subsequent judicial proceeding; or

B. complaints of alleged improper conduct in the procurement when such complaints are made to the State Attorney General, Inspector General, District Attorney, or to a court of competent jurisdiction; or

C. protests, appeals or complaints to the State Comptroller's office during the process of contract approval, where the State Comptroller's approval is required provided that the state comptroller shall make a record of such communications and any response thereto which shall be entered into the procurement record pursuant to State Finance Law section 163; or

D. complaints of alleged improper conduct in a governmental procurement conducted by a municipal agency or local legislative body to the state comptroller's office; and

(8) communications between Offerors and governmental entities that solely address the determination of responsibility by a governmental entity of an Offeror.

Revised 4/2011

State of New York
Department of Civil Service
Alfred E. Smith State Office Building
Albany, NY 12239

Compliance with Public Officers Law Requirements

ADM-992 (1/07)

The New York State Public Officers Law ("POL"), particularly POL Sections 73 and 74, as well as all other provisions of New York State law, rules and regulations, and policy establishes ethical standards for current and former State employees. In submitting its Proposal, the Offeror must guarantee knowledge and full compliance with such provisions for purposes of this RFP and any other activities including, but not limited to, contracts, bids, offers, and negotiations. Failure to comply with these provisions may result in disqualification from the procurement process, termination, suspension or cancellation of the contract and criminal proceedings as may be required by law.

The Offeror hereby submits its affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed contracts, engagements, or affiliations.

Please provide below an affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed contracts, engagements, or affiliations. Please attach additional pieces of paper as necessary.

Name of Offeror: _____

Name & Title of Representative: _____

Signature: _____

Date: _____

State of New York
Department of Civil Service
Albany, NY 12239

Compliance with Americans with Disabilities Act

ADM-987 (1/07)

The Offeror hereby provides assurance of its compliance with the Americans With Disabilities Act (42 USC§12101 et. seq.), in that any services and programs provided during the course of performance of the Agreement resultant from this RFP shall be accessible under Title II of the Americans With Disabilities Act, and as otherwise may be required under the Americans With Disabilities Act.

Name of Offeror: _____

Name & Title of Representative: _____

Signature: _____

Date: _____

State of New York
Department of Civil Service
Albany, NY 12239

MWBE UTILIZATION PLAN

OFFICE OF FINANCIAL ADMINISTRATION **MWBE-100 (9/2011)**

INSTRUCTIONS: All Offerors must complete this MWBE Utilization Plan and submit it as part of their Proposal. The Plan must contain a detailed description of the services to be provided by each Minority and/or Woman-Owned Business Enterprise (M/WBE) identified by the Offeror.

Offeror Name:			**Federal Identification No.:**	
Address:			**Solicitation No.:**	
City, State, Zip Code:			**M/WBE Goals for the Solicitation: MBE: % WBE: %**	
1. M/WBE Subcontractors/Suppliers Name, Address, Email Address, Telephone No.	**2. Classification**	**3. Federal ID No.**	**4. Detailed Description of Work (Attach additional sheets, if necessary.)**	**5. Dollar Value of Subcontracts/Supplies**
A.	**NYS ESD Certified** ☐ **MBE** ☐ **WBE**			
B.	**NYS ESD Certified** ☐ **MBE** ☐ **WBE**			

6. WAIVER REQUESTED: MBE: ☐ YES ☐ NO If YES, submit form MWBE101 / WBE: ☐ YES ☐ NO If YES, submit form MWBE101

PREPARED BY (Signature):	**TELEPHONE NO.:**	**EMAIL ADDRESS:**
NAME AND TITLE OF PREPARER (Print or Type):		
DATE: Offeror's Certification Status: ☐ MBE ☐ WBE		

SUBMISSION OF THIS FORM CONSTITUTES THE OFFEROR'S ACKNOWLEDGEMENT AND AGREEMENT TO COMPLY WITH THE M/WBE REQUIREMENTS SET FORTH UNDER NYS EXECUTIVE LAW, ARTICLE 15-A. FAILURE TO SUBMIT COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A FIUNDING OF NONCOMPLIANCE AND/OR PROPOSAL DISQUALIFICATION.

********************FOR DEPARTMENT USE ONLY********************

REVIEWED BY:	**DATE:**

UTILIZATION PLAN APPROVED: ☐ YES ☐ NO Date:____

MBE CERTIFIED: ☐ YES ☐ NO

WBE CERTIFIED: ☐ YES ☐ NO

WAIVER GRANTED: ☐ YES ☐ NO

☐ Total Waiver ☐ Partial Waiver

NOTICE OF DEFICIENCY ISSUED: ☐ YES ☐ NO

Date: _____

Offeror's Certification of Compliance Pursuant to State Finance Law §139-k(5)

Instructions:

New York State Finance Law (SFL) §139-k(5) requires that every contract award subject to the provisions of SFL §§139-k or 139-j shall contain a certification by the Offeror that all information provided to the Department with respect to SFL §139-k is complete, true and accurate.

At the time an Offer or Bid is submitted to the Department, the Offeror must provide the following certification that the information it has and will provide to the Department pursuant to SFL §139-k is complete, true and accurate including, but not limited to, disclosures of findings of non-responsibility made within the previous four years by any State governmental entity where such finding of non-responsibility was due to a violation of SFL §139-j or due to the intentional provision of false or incomplete information to a State governmental entity.

Offeror Certification

I certify that all information provided to the Governmental Entity with respect to State Finance Law §139-k is complete, true and accurate.

Name of Offeror: _____

By: _____
(Signature)

Name: _____

Title: _____

Address: _____

_____

Date: _____

State of New York
Department of Civil Service
Albany, NY 12239

M/WBE GOAL REQUIREMENTS
CERTIFICATION OF GOOD FAITH EFFORTS

OFFICE OF FINANCIAL ADMINISTRATION **MWBE-104 (1/2012)**

The Contractor must document "good faith efforts" to provide meaningful participation by New York State Certified M/WBE subcontractors or suppliers in the performance of the State Contract.

The undersigned hereby certifies that he/she has taken the following actions on behalf of the Contractor to demonstrate the aforesaid good faith efforts [check actions as applicable]:

☐ (a) The Contractor attended any pre-bid meetings that were scheduled by the Department or the NYS Department of Economic Development or its designee to inform minority and women business enterprises of contracting and subcontracting opportunities available on the project;

☐ (b) The Contractor identified economically feasible units of the project that could be contracted or subcontracted to minority and women small business enterprises in order to increase the likelihood of participation by such enterprises;

☐ (c) The Contractor advertised in general circulation, trade association, and trade-oriented, minority and women-focused publications, if any, concerning the contracting or subcontracting opportunity;

☐ (d) The Contractor solicited and provided written notice to a reasonable number of minority and women business enterprises identified from current certified lists of such business enterprises provided or maintained by the NYS Empire State Development's Division of Minority and Women Owned Business Development, or its designee, of the contracting or subcontracting opportunity in sufficient time to allow the enterprises to participate effectively;

☐ (e) The Contractor followed up initial solicitations by contacting the enterprises to determine whether the enterprises were interested in such contracting or subcontracting opportunity;

☐ (f) The Contractor provided interested minority and women business enterprises with adequate information about the plans, specifications and requirements for the contracting or subcontracting opportunity;

☐ (g) The Contractor used the services of community organizations, contractor groups, state and federal business assistance offices and other organizations identified by the NYS Department of Economic Development or its designee that provide assistance in the recruitment and placement of minority and women business enterprises; and

☐ (h) The Contractor negotiated in good faith with minority and women business enterprises submitting bids, proposals, or quotations and did not, without justifiable reason, reject as unsatisfactory any bids, proposals or quotations prepared by any minority or women business. "Good faith" negotiating means engaging in good faith discussions with minority or women businesses about the nature of the work, scheduling, requirements for special equipment, opportunities for dividing of work among the bidders, proposers, and various subcontractors and the bids of the minority or women businesses, including sharing with them any cost estimates from the request for proposal or invitation to bid documents, if available.

Signature:	Date:
Print Name:	
Title:	
Company:	

Sworn to before me this _____ day of 20_____

_____
Notary Public

"Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, and Student Employee Health Plan RFP"

Questions Template

Question Number	RFP Page #	Section and Sub-Section Reference	Question

Offerors are requested to use the Questions Template table above in submitting questions. An Offeror's questions must be submitted to the MHSA Program Procurement Manager at the address specified in Section II.A.6 of this RFP, with an electronic copy (in Microsoft Word format) of the Offeror's questions sent to the MHSA Program Procurement Manager's attention at: **MHSA2014RFP@cs.state.ny.us**.

[TO BE COMPLETED ON OFFEROR'S LETTERHEAD]

Date

Ms. Linda Burk
Procurement Manager
Employee Benefits Division – Room 1106
NYS Department of Civil Service
Albany, NY 12239

RE: Request for Proposals entitled:
"Mental Health and Substance Abuse Program for the
Empire Plan, Excelsior Plan, and Student Employee Health Plan", #2014-MH1
Firm Offer to the State of New York

[INSERT OFFEROR NAME] hereby submits this firm and binding offer to the State of New York in response to the Department's Request for Proposals entitled **"Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan", 2014MH-1** (RFP). The Proposal hereby submitted meets or exceeds all terms, conditions, and requirements set forth in the above-referenced RFP and in the manner set forth in this RFP.

[INSERT OFFEROR NAME] accepts the terms and conditions as set forth in RFP, Section VII and Appendices A, B, C, and D and agrees to satisfy the comprehensive programmatic duties and responsibilities outlined in this RFP in the manner set forth in this RFP.

[INSERT OFFEROR NAME] agrees to execute a contractual agreement composed substantially of the terms and conditions set forth in the draft contract included in the RFP, and accepts as non-negotiable the terms and conditions set forth in Appendices A, B, C and D to the draft contract.

[INSERT OFFEROR NAME] further agrees, if selected as a result of the RFP, to comply with 1) the provisions of Tax Law Section 5-a, Certification Regarding Sales and Compensating Use Tax; and 2) the Workers' Compensation Law as set forth in Section II.B.7 of the RFP.

This formal offer will remain firm and non-revocable for a minimum period of 365 days from the Proposal Due Date as set forth in the RFP. In the event that a contract is not approved by the NYS Comptroller within the 365 day period, this offer shall remain firm and binding beyond the 365 day period and until a contract is approved by the NYS Comptroller, unless **[INSERT OFFEROR NAME]** delivers to the Department of Civil Service written notice of withdrawal of its Proposal.

[INSERT OFFEROR NAME]'s complete offer is set forth as follows:

Administrative Proposal:	Total of fourteen (14) hard copy volumes [two (2) original and twelve (12) copies] and one (1) electronic copy on CD.
Technical Proposal:	Total of fourteen (14) hard copy volumes [two (2) original and twelve (12) copies] and one (1) electronic copy on CD.
Cost Proposal:	Total of fourteen (14) hard copy volumes [two (2) original and twelve (12) copies] and one (1) electronic copy on CD.

The undersigned affirms and swears s/he has the legal authority and capacity to sign and make this offer on behalf of, **[INSERT OFFEROR NAME]** and possesses the legal authority and capacity to act on behalf of **[INSERT OFFEROR NAME]** to execute a contract with the State of New York.

The undersigned affirms and swears as to the truth and veracity of all documents included in this offer.

Date:_____ **[INSERT OFFEROR NAME]**

By: _____
(signature)

_____
(name)

_____
(title)

_____
(phone number)

_____
(email address)

CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT

STATE OF }
: SS.:
COUNTY OF }

On the ____ day of _____in the year 2014, before me personally appeared: _____, known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that _he resides at _____, Town of _____, County of _____ , State of _____ ; and further that:

[Check One]

(___ If a corporation): _he is the _____ of _____, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

(___If a partnership): _he is the _____ of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for the purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name and on behalf of said partnership as the act and deed of said partnership.

_____
Notary Public

Exhibit I.T - Offeror Attestations Form

An authorized representative of the Offeror who is legally authorized to certify the information requested in the name of and on behalf of the Offeror is required to complete and sign the Offeror Attestations and provide all requested information. Offeror's authorized representative must certify as to the truth of the representations made by signing where indicated, below.

CERTIFICATION:
The Offeror (1) recognizes that the following representations are submitted for the express purpose of assisting the State of New York in making a determination to award a contract; (2) acknowledges and agrees by submitting the Attestation, that the State may at its discretion, verify the truth and accuracy of all statements made herein; (3) certifies that the information submitted in this certification and any attached documentation is true, accurate and complete.

Name of Business Entity Submitting Bid:		
Entity's Legal Form:		□ Corporation □ Partnership □ Sole Proprietorship □ Other _____
No.	**RFP Ref.**	**RFP Requirement:**
1.	Section III.B.1	At time of Proposal Due Date, Offeror represents and warrants that it: □ possesses □ does not possess the legal capacity to enter into a contract with the Department.
2.	Section III.B.2	At time of Proposal Due Date, Offeror represents and warrants that it, and/or its Key Subcontractor or Affiliate: □ attests □ does not attest provides behavioral management and associated claims adjudication services for a minimum of five million (5,000,000) lives as specified below. The Offeror must provide a list of client organizations with the number of lives served through each client to clearly demonstrate that the Offeror and/or its Key Subcontractor or Affiliate meets the minimum requirement of five million (5,000,000) lives. In determining lives, the Offeror should: • Include both at-risk and fee-for-service business; • Include Medicaid business; • Count all lives [e.g., an employee, a spouse and two (2) eligible dependents count as four (4)]; • Exclude any non-behavioral health management business; • Exclude any employee assistance program business

3.	Section III.B.3	At time of Proposal Due Date, Offeror represents and warrants that it: ☐ attests ☐ does not attest its Empire Plan MHSA Provider Network, as proposed, meets or exceeds all of the following <u>minimum</u> Network access guarantees: <u>URBAN AREAS</u> a. Seventy-five percent (75%) of Enrollees will have at least: • one (1) Inpatient, ALOC, and Outpatient Clinic Groups–Mental Health within five (5) miles; and, • one (1) Inpatient, ALOC, and Outpatient Clinic Groups–Substance Abuse within five (5) miles. b. Seventy-five percent (75%) of Enrollees will have at least: • one (1) Psychiatrist within three (3) miles; and, • one (1) Psychologist within three (3) miles; and, • one (1) Master's Level Clinicians within three (3) miles. <u>SUBURBAN AREAS</u> c. Seventy-five percent (75%) of Enrollees will have at least: • one (1) Inpatient, ALOC, and Outpatient Clinic Groups–Mental Health within fifteen (15) miles; and, • one (1) Inpatient, ALOC, and Outpatient Clinic Groups–Substance Abuse within fifteen (15) miles. d. Seventy-five percent (75%) of Enrollees will have at least: • one (1) Psychiatrist within fifteen (15) miles; and, • one (1) Psychologist within fifteen (15) miles; and, • one (1) Master's Level Clinicians within fifteen (15) miles. <u>RURAL AREAS</u> e. Seventy-five percent (75%) of Enrollees will have at least: • one (1) Inpatient, ALOC, and Outpatient Clinic Group–Mental Health within forty (40) miles; and, • one (1) Inpatient, ALOC, and Outpatient Clinic Groups–Substance Abuse within forty (40) miles. f. Seventy-five percent (75%) of Enrollees will have at least: • one (1) Psychiatrist within forty (40) miles; and, • one (1) Psychologist within forty (40) miles; and, • one (1) Master's Level Clinicians within forty (40) miles.
4.	Section III.B.4	At time of Proposal Due Date, Offeror represents and warrants that it: ☐ attests ☐ does not attest understands and agrees to comply with all specific duties and responsibilities set forth in Section IV.B.3. of this RFP, entitled "Implementation," including Section IV.B.3.b.(2) requiring the Offeror to propose a financial guarantee supporting its commitment to satisfy all implementation requirements.
5.	Section III.B.5	<u>As of the Proposal Due Date</u>, Offeror represents and warrants that it: ☐ attests ☐ does not attest will maintain and make available as required by the Department a complete and accurate set of records related to the Agreement resulting from this RFP as required by Appendices A and B and the draft Agreement set forth in Section VII of this RFP. This includes, but is not limited to, provider contracts, detailed claim records, and any and all other financial records as deemed necessary by the Department to perform its fiduciary responsibilities to the Empire Plan MHSA Program' s participants and to ensure that public dollars are spent appropriately.

6.	Section III.B.6	At time of Proposal Due Date, Offeror represents and warrants that it: ☐ attests ☐ does not attest has submitted as part of its Proposal, if so required by the RFP, or will submit all Transmittal letters, Statements, Formal Certifications and Exhibits as required in Section II of this RFP related to the Offeror's compliance with all rules, laws, regulations and executive orders.
7.	Section III.B.7	At time of Proposal Due Date, Offeror represents and warrants that it: ☐ attests ☐ does not attest will execute the duties and responsibilities set forth in Section IV of this RFP in strict conformance to the requirements described in that section of the RFP.
8.	Section III.B.8	At time of Proposal Due Date, Offeror represents and warrants that it: ☐ attests ☐ does not attest has current URAC-case management, JCAHO, ACHC, NCQA or CARF full accreditation at the proposed primary worksite where case management will be performed for the Program services.

Date:_____ _____

Signature

[INSERT OFFEROR NAME]
[INSERT TITLE]
[INSERT COMPANY NAME]

CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT

STATE OF }
: SS.:
COUNTY OF }

On the _____ day of _____in the year 2014, before me personally appeared: **_____**, known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that _he resides at _____, Town of _____, County of _____ , State of _____ ; and further that:

[Check One]

(___ If a corporation): _he is the _____ of _____, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

(___If a partnership): _he is the _____ of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for the purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name and on behalf of said partnership as the act and deed of said partnership.

_____

Notary Public

Exhibit I.U.1 - Key Subcontractors or Affiliates

The Offeror must complete and submit this Exhibit as part of its Administrative Proposal. A separate form should be completed for each Key Subcontractor or Affiliate, if any. If the Offeror will not be subcontracting with any Key Subcontractor(s) or Affiliate(s) to provide any of the services required under the RFP, the Offeror must complete and submit a single Exhibit I.U.1 to that affect.

INSTRUCTION: Prepare this form for each Key Subcontractor or Affiliate	
Offeror's Name:	
The Offeror: ☐ is ☐ is not proposing to utilize the services of a Key Subcontractor(s) or Affiliate(s) to provide Program Services ☐ is ☐ is not proposing to utilize the services of a subcontractor(s) to provide Program Services totaling $100,000 or more during the term of the 5 year agreement	
Subcontractor's Legal Name:	
Business Address:	
Subcontractor's Legal Form:	☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other _____
As of the date of the Offeror's Proposal, a subcontract ☐ has ☐ has not been executed between the Offeror and the subcontractor(s) for services to be provided by such subcontractor(s) relating to the Mental Health and Substance Abuse Program Services.	
In the space provided below, describe the Key Subcontractor's or Affiliate's role(s) and responsibilities regarding Program Services to be provided.	
Relationship between Offeror and Key Subcontractor or Affiliate for Current Engagements: (Complete items 1 through 5 for each client engagement identified)	
1. Client:	
2. Client Reference Name and Phone #	
3. Program Title:	
4. Program Start Date:	
5. In the space provided below, Program Status:	
6. In the space provided below, describe the roles and responsibilities of the Offeror and subcontractor in regard to the program identified in 3, above:	

REQUEST FOR PROPOSALS #2014MH-1
"MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM FOR THE EMPIRE PLAN, EXCELSIOR PLAN AND STUDENT EMPLOYEE HEALTH PLAN"

NEW YORK SUBCONTRACTORS AND SUPPLIERS

As stated in Section II.B.11 of the RFP, Offerors are encouraged to use New York State businesses in the performance of Program Services. Please complete the following exhibit to reflect the Offeror's proposed utilization of New York State businesses.

Name(s) of New York Subcontractors and/or Suppliers	Address, City, State, and Zip Code	Description of Services or Supplies Provided	Estimated Value Over 5-Year Contract Period	Identify if Subcontractor or Supplier

Exhibit I.V - Program References

Reference #: _____

Current or Former Customer?: _____

Abstract
Customer For Whom Services Were Performed: _____ Number of covered Lives: _____ Customer Address: _____ _____ _____
Program Description: (The Offeror should submit specific details concerning the program identified in satisfaction of the requirements in RFP, Section III.E. This information should be provided as an attachment to this form and the information provided should support the Offeror's assertion that it can successfully implement and administer programs of the scope and complexity as set forth in this RFP.)
Program Contact References: (Required And Will Be Verified) (Attach 4 current and 1 former client reference) Contact Name: _____ Contact Title: _____ Phone Number: _____ E-Mail Address: _____ Contact Name: _____ Contact Title: _____ Phone Number: _____ E-Mail Address: _____

Exhibit I.W - Compliance with NYS Workers' Compensation Law

Sections 57 and 220 of the New York State Workers' Compensation Law (WCL) provide that the Department shall not enter into any contracts unless proof of workers' compensation and disability benefits insurance coverage is produced. Prior to entering into contracts with DCS, the selected Offeror will be required to verify for DCS, on forms authorized by the New York State Workers' Compensation Board, the fact that they are properly insured or are otherwise in compliance with the insurance provisions of the WCL. The forms to be used to show compliance with the WCL are listed below. DCS requests the Offeror submit this insurance verification information with their Proposals. Any questions relating to either workers' compensation or disability benefits coverage should be directed to the State of New York Workers' Compensation Board, Bureau of Compliance at (518)486-6307. You may also find useful information at their website http://www.wcb.state.ny.us. Failure to provide verification of either of these types of insurance coverage by the time the winning Offeror is selected and the Contract is ready to be executed will be grounds for disqualification of an otherwise successful Proposal.

Workers' Compensation Requirements under WCL § 57:

To comply with coverage provisions of the WCL, businesses must:

A) be legally exempt from obtaining workers' compensation insurance coverage; or
B) obtain such coverage from insurance carriers; or
C) be a Board-approved self-insured employer or participate in an authorized group self-insurance plan.

To assist State and municipal entities in enforcing WCL Section 57, businesses requesting permits or seeking to enter into contracts **MUST** provide **ONE** of the following forms to the government entity issuing the permit or entering into a contract:

A) CE-200, Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage [(1)]; **OR**
B) C-105.2 -- Certificate of Workers' Compensation Insurance (the business's insurance carrier will send this form to the government entity upon request) **PLEASE NOTE**: The State Insurance Fund provides its own version of this form, the U-26.3; **OR**
C) SI-12 -- Certificate of Workers' Compensation Self-Insurance (the business calls the Board's Self-Insurance Office at 518-402-0247), **OR** GSI-105.2 -- Certificate of Participation in Worker's Compensation Group Self-Insurance (the business's Group Self-Insurance Administrator will send this form to the government entity upon request).

Disability Benefits Requirements under Workers' Compensation Law §220(8)

To comply with coverage provisions of the WCL regarding disability benefits, businesses may:

A) be legally exempt from obtaining disability benefits insurance coverage; or
B) obtain such coverage from insurance carriers; or
C) be a Board-approved self-insured employer.

Accordingly, to assist State and municipal entities in enforcing WCL Section 220(8), businesses requesting permits or seeking to enter into contracts **MUST** provide **ONE** of the following forms to the entity issuing the permit or entering into a contract:

A) CE-200, Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage[(1)]; **OR**
B) DB-120.1 -- Certificate of Disability Benefits Insurance (the business's insurance carrier will send this form to the government entity upon request); **OR**
C) DB-155 -- Certificate of Disability Benefits Self-Insurance (the business calls the Board's Self-Insurance Office at 518-402-0247).

(1) Starting December 1, 2008, Form CE-200 can be filled out electronically on the Board's website, www.wcb.state.ny.us, under the heading "Forms." Applicants filing electronically are able to print a finished Form CE-200 immediately upon, completion of the electronic application. Applicants without access to a computer may obtain a paper application for the CE-200 by writing or visiting the Customer Service Center at any District Office of the Workers' Compensation Board. Applicants using the manual process may wait up to four weeks before receiving a CE-200. Once the applicant receives the CE-200, the applicant can then submit that CE-200 to the government agency from which he/she is getting the permit, license or contract.

Extraneous Terms Template
(Instructions for Documentation and Submission)

Offerors shall identify all Extraneous Terms in the table provided on the following page, and shall adhere to all instructions below for preparing the table.

INSTRUCTIONS:

RFP Section and Sub-Section Reference: The Offeror must insert the exact RFP Section, and Sub-Section number of the requirement(s) that the Offeror is proposing to modify. The Offeror must insert the nature of the proposed change and its impact on the Requirement.

RFP Requirement: The Offeror must insert a concise description of the requirement(s) that the Offeror is proposing to modify.

Proposed Extraneous Term Type: The Offeror must insert a one-word description, of the type of modification to each of the requirement(s) that the Offeror is proposing to modify, selected from the following list:

- ☐ Additional;
- ☐ Supplemental;
- ☐ "Or Equal"; or
- ☐ Alternative

Proposed Extraneous Term: The one-word description must be followed by proposed alternate wording of the requirement(s).

Impact on RFP Requirement: The Offeror should describe the impact of the alternate wording. Then, the comments should explain how the modification(s) would benefit the State and provide best value. If there is a corresponding impact on the Administrative, Technical or Financial Proposal(s), that impact should be explained here with reference(s) to the parts of the volume(s) that are affected. However, **DO NOT INCLUDE ANY COST DATA IN THE ADMINISTRATIVE OR TECHNICAL PROPOSALS**.

The Offeror must use the table format described above and detailed on the following page to summarize its proposed Extraneous Terms, if any. The Offeror may refer to more voluminous narratives, tables, figures and appendices that more fully describe aspects of the Extraneous Terms, provided that the additional material is fully cross-referenced by this required table.

Extraneous Terms Template

EXTRANEOUS TERM(S)			
No.	**RFP Section and Sub-Section Reference**	**RFP Requirement**	**Proposed Extraneous Term Type**
1.			□ Additional; □ Supplemental; □ "Or Equal"; or □ Alternative
Proposed Extraneous Term(s):			
Impact on RFP Requirement:			

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

File Layout Specifications for the Offeror's Proposed MHSA Provider Network File

Instructions: Utilize these file layouts to prepare Exhibit I.Y.2 of your technical proposal and submit on a CD using Microsoft Excel. Do not submit a paper copy. These files (one for facilities and one for practitioners) must include each Provider and Facility with whom you have an executed contract for participation in the MHSA Network commencing in 2015. The providers listed in this file must be included in the MHSA Network implemented for the Program in 2015 in accordance with Section IV.B.3.a(2)(a) "Implementation" and Section IV.B.10 "Network Management" of this RFP.

Facility File

Include all Facilities, Alternate Levels of Care and Outpatient Clinics in this file. Alternate Level of Care (ALOC) means residential treatment centers, halfway houses, group homes, partial hospitalization programs or continuing treatment programs which satisfy the requirements of an approved facility.

1) The Provider Tax ID is a number that represents a unique identifier of the contracting entity. Place this identifier in column 1 for each Network Facility included in this file.

2) Enter the facility name in column 2. Enter the street address, city, state, five-digit zip code, county, specialty, area code, and local phone number for each facility listed in this file in Columns 3 through 10.

3) In Column 11 enter the Facility, ALOC, or Clinic type as follows:

MHF	Mental Health Facility
SAF	Substance Abuse Facility
MHSAF	Mental Health and Substance Abuse Facility
MH - OCC	Mental Health Outpatient Clinic Group
SA - OCC	Substance Abuse Outpatient Clinic Group

4) In column 12, please answer "Y" for Yes or "N" for No if the facility provides inpatient care.

5) In column 13, please answer "Y" for Yes or "N" for No if the facility provides Alternate Levels of Care.

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

File Layout Specifications for the Offeror's Proposed MHSA Provider Network File

Practitioner File

Include the following Practitioner types in this file:

a. psychiatrist

b. psychologist

c. A licensed clinical social worker who qualifies for the "R" certification in New York State. If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body.

d. A Registered Nurse Clinical Specialist or Psychiatric Nurse/Clinical Specialist: advanced practice Nurses hold a master's or doctoral degree in a specialized area of pscyhiatric nursing.

e. A Registered Nurse Practitioner: a nurse with a master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided. Nurse Practitioners may diagnose, treat and prescribe for a patient's condition that falls within their specialty of practice. This must be done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols.

f. A Certified Behavioral Analyst who provides covered services solely limited to diagnosed autism spectrum disorders.

g. Applied behavioral analysis or ABA Agency: An agency providing ABA services under the program oversight and direct supervision of a certified behavioral analyst.

1) The Provider Tax ID is a number that represents a unique identifier of the contracting entity. Place this identifier in column 1 for each Network Provider included in this file.

2) Enter the first name, last name, middle name, suffix, street address, city, state, five-digit zip code, county, specialty, area code and local phone number for each Network Practitioner listed in this file in columns 2 through 13.

3) In Column 14, enter "Y" for Yes if the Practitioner is Board Certified and "N" for No if the Practitioner is not Board Certified.

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

File Layout Specifications for the Offeror's Proposed MHSA Provider Network File

4) In Column 15 enter the Practitioner Licensure type, as follows:

PSYI	Licensed Psychiatrist
PSYCH	Licensed Psychologist
MLC	Licensed Clinical Social Worker who qualifies for the "R" designation in NYS, Master's Level Clinician with the highest level of licensure in other states
CBA	Certified Behavioral Analyst Provider
ABA	Applied Behavioral Analysis Agency
MHSAP	Mental Health/Substance Abuse Practitioner - Other Prescriber

5) In Column 16, enter the Practitioner's License number.

6) In column 17, for any Practitioner listed as MLC or MHSAPO, enter the Practitioner's license subcategory, (i.e. LCSW-R, LCSW, APRN, NP, etc.).

Facilities

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8	Column 9	Column 10	Column 11	Column 12	Column 13
Provider Tax ID	**Facility Name**	**Street Address**	**City**	**State**	**5-Digit Zip Code**	**County**	**Specialty**	**Area Code**	**Local Phone Number**	**Facility Type (Category)**	**Does this facility provide inpatient care?**	**Does this facility provide ALOC?**

Practitioners

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8	Column 9	Column 10	Column 11	Column 12	Column 13	Column 14	Column 15	Column 16	Column 17
Provider Tax ID	**First Name**	**Last Name**	**Middle Name**	**Suffix**	**Street Address**	**City**	**State**	**5-Digit Zip Code**	**County**	**Specialty**	**Area Code**	**Local Phone Number**	**Board Certification**	**Practitioner Licensure Type (Category)**	**Practitioner License Number**	**MLC and MHSAPO Subcategory**

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Offeror's Proposed MHSA Provider Network Files

All Offerors are required to submit their proposed MHSA provider network in two files, one for Facilities and one for Practitioners as Exhibit I.Y.2 entitled, "Offeror's Proposed MHSA Provider Network File – Facilities" and "Offeror's Proposed MHSA Provider Network File - Practitioners" in the format specified in Exhibit I.Y.1.

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Offeror's Proposed MHSA Provider Network Access Prerequisite

Psychiatrists

Location Column (1)	# of Empire Plan Enrollees With Access Column (2)	# of Empire Plan Enrollees Without Access Column (3)	Total Empire Plan Enrollees Column (4)	% With Access Column (5)
Urban			215,649	0.0%
Suburban			114,845	0.0%
Rural			197,081	0.0%
Total	0	0	527,861	0.0%

Psychologists

Location Column (1)	# of Empire Plan Enrollees With Access Column (2)	# of Empire Plan Enrollees Without Access Column (3)	Total Empire Plan Enrollees Column (4)	% With Access Column (5)
Urban			215,649	0.0%
Suburban			114,845	0.0%
Rural			197,081	0.0%
Total	0	0	527,861	0.0%

Master's Level Clinicians

Location Column (1)	# of Empire Plan Enrollees With Access Column (2)	# of Empire Plan Enrollees Without Access Column (3)	Total Empire Plan Enrollees Column (4)	% With Access Column (5)
Urban			215,649	0.0%
Suburban			114,845	0.0%
Rural			197,081	0.0%
Total	0	0	527,861	0.0%

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Offeror's Proposed MHSA Provider Network Access Prerequisite Worksheet

Inpatient, ALOC, and Outpatient Clinic Groups - Mental Health

Location Column (1)	# of Empire Plan Enrollees With Access Column (2)	# of Empire Plan Enrollees Without Access Column (3)	Total Empire Plan Enrollees Column (4)	% With Access Column (5)
Urban			215,649	0.0%
Suburban			114,845	0.0%
Rural			197,081	0.0%
Total	0	0	527,861	0.0%

Inpatient, ALOC, and Outpatient Clinic Groups - Substance Abuse

Location Column (1)	# of Empire Plan Enrollees With Access Column (2)	# of Empire Plan Enrollees Without Access Column (3)	Total Empire Plan Enrollees Column (4)	% With Access Column (5)
Urban			215,649	0.0%
Suburban			114,845	0.0%
Rural			197,081	0.0%
Total	0	0	527,861	0.0%

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Offeror's Proposed MHSA Provider Network Access Prerequisite

Instructions:

A. Include facility or practitioner type based on the following specifications and categorizations from I.Y.2:

1) Psychiatrists should only include Licensed Psychiatrists (PSYI)

2) Psychologists should only include Licensed Psychologists (PSYCH)

3) Master's Level Clinicians should only include Licensed Clinical Social Workers who qualify for the "R" designation in New York and Master's level clinicians with the highest level of licensure in other states (MLC)

4) Inpatient, ALOC, and Outpatient Clinic Groups - Mental Health should include facilities that provide facility-based Mental Health Services (MHF, MHSAF, MH - OCG)

5) Inpatient, ALOC, and Outpatient Clinic Groups - Substance Abuse should include facilities that provide facility-based Substance Abuse services (SAF, MHSAF, SA - OCG)

6) Facilities providing Services for both Mental Health and Substance Abuse should be included in both "Inpatient, ALOC, and Outpatient Clinic Groups - Mental Health" and "Inpatient, ALOC, and Outpatient Clinic Groups - Substance Abuse"

7) Provider types CBA, ABA, and MHSAPO should <u>not</u> be included in the prerequisite worksheet

B. Enter the number of Empire Plan Enrollees who are within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (column 2)

C. Enter the number of Empire Plan Enrollees who are not within the Program's minimum access requirements from your GeoAccess Accessibility Summaries. (column 3)

D. Column (4) equals Column (2) plus Column (3).

E. Column (5) equals Column (2) divided by Column (4).

F. The Offeror's proposed MHSA provider network access %'s in column (5) must equal the Program's minimum mandatory access requirements, set forth in Section III of this RFP, for each of the five categories in order for their proposal to be evaluated.

Note: All Enrollees must be counted in calculating whether the Offeror meets the MHSA provider Network access pre-requisites. No Enrollee may be excluded even if there is no provider located within the minimum mandatory access requirements.

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Comparison of 2013 MHSA Program Providers and the Offeror's Proposed Provider Network

INSTRUCTIONS/FILE LAYOUT:

1) The first four columns in the Exhibit I.Y.4 file list DCS Provider Identifier, Provider Tax ID, Provider Name and Provider Zip Code.

2) In Column 5, identify whether each of the Providers will or will not participate in the Offeror's proposed 2015 MHSA Network by indicating the following:

"0"- not participating in 2015 Provider Network

"1"- participating in 2015 Provider Network, fully contracted and credentialed as of Proposal Due Date

3) Submit completed Exhibit I.Y.4 in the Technical Proposal using Microsoft Excel. Do not password-protect the file or use any other security measures.

File Layout:

Column 1	Column 2	Column 3	Column 4	Column 5
DCS Provider Identifier	Provider Tax ID	Provider Name	Provider Zip Code	Network Indicator (0 or 1)

Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan, and Student Employee Health Plan, #2014MH-1

CONFIDENTIAL AGREEMENT AND CERTIFICATE OF NON-DISCLOSURE

This Exhibit MUST be filled out by all Offerors and Key Subcontractors and Affiliates

THIS AGREEMENT is between the New York State Department of Civil Service (DCS) its successors and assigns, acting on behalf of the State of New York, and having its principal place of business at: DCS; Empire State Plaza, Albany, New York, 12239, *and*

_____ (Respondent), it successors and assigns, having its principal place of business at:

_____.

_____ being duly sworn, deposes and says that he/she is _____
(Print or type full name) (Title or Capacity)

of _____, the firm that executed this instrument and that he/she is authorized by said firm to execute
(Name of firm)
this instrument, and further, in consideration of release of detailed claims data and enrollee demographic data by DCS, the firm hereby agrees that any information pertaining to the Program and its documentation, including the information contained on the detailed claims and enrollee demographic data as referenced in the Request for Proposals entitled, Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan, and Student Employee Health Plan, which has been or may be supplied to or obtained by the firm, its officers, agents and employees, based upon the representations made above in relation to the procurement of a Contractor to administer the Programs under New York State Civil Service Law, Article XI, is confidential and may not be used for any purpose other than the formulation of a good faith offer for said procurement, and that any other use, release or dissemination to any party, of any such confidential information, without the prior written consent of DCS, shall constitute a breach of this Confidentiality Agreement and Statement of Non-Disclosure and may result in disqualification of the firm from said procurement, or the imposition of other sanctions as determined by the DCS or as required by the State of New York or by law.

The firm further acknowledges that receipt to the detailed claims and enrollee demographic data is subject to the following warranty disclaimer by the DCS: all detailed claims data supplied for the Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan, and Student Employee Health Plan, Request for Proposal contain information provided by the current insurer/administrator which has not been audited by the DCS and is provided on an "as is" basis. For purposes of the data, any interested Offeror's or Offerors' use of the data, or the results of any interested Offeror's or Offerors' use of the data, the DCS and State of New York make no warranties, guarantees or representations of any kind expressed or implied, or arising by custom or trade usage, as to any matter whatsoever, without limitation, and specifically make no implied warranty of fitness for any particular purpose or use, including but not limited to adequacy, accuracy, completeness or conformity to any representation, description, sample or model.

Please complete to receive detailed claims and enrollee demographic data			
Designated Contact Information		**Alternate Contact Information**	
Contact Name:		Contact Name:	
Address:		Address:	
Phone Number:		Phone Number:	
Fax:		Fax:	
E-Mail:		E-Mail:	

Complete Exhibit I.Z and submit it to the MHSA Program Procurement Manager specified in Section II.A.2.b. of this RFP. The completed Exhibit I.Z may be emailed at: MHSA2014RFP@cs.state.ny.us, faxed at: 518-402-2835 and/or mailed (see address provided in RFP, Section II.A.2.b.)

VENDOR

Name/Address of Corporate Headquarters

_____

_____

_____

IN WITNESS WHEREOF, Vendor has caused this Agreement to be signed as of the date set forth below.

VENDOR'S AUTHORIZED LEGAL REPRESENTATIVE
Name/Title/Address (If Different from Above)

_____

_____

_____

_____

Signature of Authorized Legal Representative as the act and deed and on behalf of Vendor is Required.*

*_____ Date: _____

The undersigned affirms and swears s/he has the legal authority and capacity to sign and make this offer on behalf of, **[INSERT OFFEROR NAME]** and possesses the legal authority and capacity to act on behalf of **[INSERT OFFEROR NAME]** to execute a contract with the State of New York.

The undersigned affirms and swears as to the truth and veracity of all documents included in this offer.

Date: _____ **[INSERT OFFEROR NAME]**

By: _____
(Signature)

_____
(Name)

_____
(Title)

CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT

STATE OF }
: **SS.:**
COUNTY OF }

On the ____ day of _____in the year 2014, before me personally appeared:
_____, known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that _he resides at:
_____, Town of _____,
County of _____ , State of _____ ; and further that:

[Check One]

(___ If a corporation): _he is the _____ of _____, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

(___If a partnership): _he is the _____ of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for the purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name and on behalf of said partnership as the act and deed of said partnership.

_____
Notary Public

Exhibit II.A

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE'S

"MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM FOR THE EMPIRE PLAN, EXCELSIOR PLAN, STUDENT EMPLOYEE HEALTH PLAN RFP"

ENROLLMENT BY CONTRACT TYPE - January 2014

	NEW YORK STATE					PARTICIPATING EMPLOYERS					PARTICIPATING AGENCIES					
	Actives	Retirees	COBRA	Other	Subtotal	Actives	Retirees	COBRA	Other	Subtotal	Actives	Retirees	COBRA	Other	Subtotal	Total
EMPIRE																
Individual	59,833	65,727	528	13,120	139,208	8,212	4,620	332	1,338	14,502	30,309	42,834	298	6,761	80,202	233,912
Drug	59,833	65,721	528	13,115	139,197	7,585	4,402	327	1,338	13,652	30,309	42,832	298	6,756	80,195	233,044
No Drug	0	6	0	5	11	627	218	5	0	850	0	2	0	5	7	868
Family	89,748	49,765	160	964	140,637	19,417	9,272	88	421	29,198	74,075	43,855	207	579	118,716	288,551
Drug	89,748	49,765	160	964	140,637	18,058	8,829	86	421	27,394	74,075	43,855	207	579	118,716	286,747
No Drug	0	0	0	0	0	1,359	443	2	0	1,804	0	0	0	0	0	1,804
Total Empire	149,581	115,492	688	14,084	279,845	27,629	13,892	420	1,759	43,700	104,384	86,689	505	7,340	198,918	522,463
SEHP																
Individual (all with Drug)	2,767	0	148	0	2,915	1,808	0	114	0	1,922						4,837
Family (all with Drug)	369	0	13	0	382	391	0	31	0	422						804
Total SEHP	3,136		161	0	3,297	2,199		145	0	2,344						5,641
EXCELSIOR PLAN																
Individual											32	64	1	15	112	112
Drug											32	64	1	15	112	112
No Drug											0	0	0	0	0	0
Family											49	54	0	2	105	105
Drug											49	54	0	2	105	105
No Drug											0	0	0	0	0	0
Total Excelsior											81	118	1	17	217	217
TOTAL EMPIRE EXCELSIOR & SEHP																
Individual	62,600	65,727	676	13,120	142,123	10,020	4,620	446	1,338	16,424	30,341	42,898	299	6,776	80,314	238,861
Drug																
No Drug																
Family	90,117	49,765	173	964	141,019	19,808	9,272	119	421	29,620	74,124	43,909	207	581	118,821	289,460
Drug																
No Drug																
Total	152,717	115,492	849	14,084	283,142	29,828	13,892	565	1,759	46,044	104,465	86,807	506	7,357	199,135	528,321

	Actives	Retirees	COBRA	Other	Subtotal	Actives	Retirees	COBRA	Other	Subtotal	Actives	Retirees	COBRA	Other	Subtotal	Total
HMO's																
Individual	13,346	11,950	86	1,388	26,770	2,164	1,006	21	136	3,327						30,097
Drug	13,346	11,950	86	1,388	26,770	2,058	949	20	136	3,163						29,933
No Drug	0	0	0	0	0	106	57	1	0	164						164
Family	18,975	7,342	11	136	26,464	3,588	1,125	5	35	4,753						31,217
Drug	18,975	7,342	11	136	26,464	3,328	1,061	5	35	4,429						30,893
No Drug	0	0	0	0	0	260	64	0	0	324						324
Total HMO	32,321	19,292	97	1,524	53,234	5,752	2,131	26	171	8,080						61,314

	Actives	Retirees	COBRA	Other	Subtotal	Actives	Retirees	COBRA	Other	Subtotal	Actives	Retirees	COBRA	Other	Subtotal	Total
NYSHIP TOTAL	**185,038**	**134,784**	**946**	**15,608**	**336,376**	**35,580**	**16,023**	**591**	**1,930**	**54,124**	**104,465**	**86,807**	**506**	**7,357**	**199,135**	**589,635**

* NYBEAS Run 1/2/2014

Note: As of 1/2/2014 there are 3,370 (2,617 family, 753 individual) Opt-Out enrollees.

New York State Department of Civil Service

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Covered Lives by Bargaining Unit or Other Group

January 2014

Bargaining Unit or Other Group	Coverage	Enrollee	Spouse	Dependent Child	Total Covered Lives	Medicare Primary Lives(1)
CSEA	Individual	19,555	-	-	19,555	
	Family	24,474	17,900	36,458	78,832	
	Total	44,029	17,900	36,458	98,387	36
PEF	Individual	14,235	-	-	14,235	
	Family	19,897	16,735	28,681	65,313	
	Total	34,132	16,735	28,681	79,548	41
UUP	Individual	9,388	-	-	9,388	
	Family	12,384	11,180	16,671	40,235	
	Total	21,772	11,180	16,671	49,623	21
NYSCOPBA	Individual	4,975	-	-	4,975	
	Family	13,120	10,671	22,481	46,272	
	Total	18,095	10,671	22,481	51,247	8
PBA Troopers	Individual	580	-	-	580	
	Family	1,735	1,611	3,391	6,737	
	Total	2,315	1,611	3,391	7,317	-
PBA Supervisors	Individual	72	-	-	72	
	Family	548	503	1,169	2,220	
	Total	620	503	1,169	2,292	-
PIA	Individual	99	-	-	99	
	Family	805	742	1,727	3,274	
	Total	904	742	1,727	3,373	-
APSU	Individual	342	-	-	342	
	Family	617	560	1,024	2,201	
	Total	959	560	1,024	2,543	-
DC-37	Individual	129	-	-	129	
	Family	115	93	156	364	
	Total	244	93	156	493	-
C-82	Individual	79	-	-	79	
	Family	403	362	675	1,440	
	Total	482	362	675	1,519	-
UUP Lifeguards	Individual	7	-	-	7	
	Family	-	-	-	-	
	Total	7	-	-	7	-
M/C (2)	Individual	5,397	-	-	5,397	
	Family	7,482	6,579	10,347	24,408	
	Total	12,879	6,579	10,347	29,805	17
Office of Court Administration (OCA) (3)	Individual	4,968	-	-	4,968	
	Family	8,165	6,745	12,055	26,965	
	Total	13,133	6,745	12,055	31,933	15
NYS Other (4)	Individual	13,667	-	-	13,667	
	Family	1,129	580	1,467	3,176	
	Total	14,796	580	1,467	16,843	12,024
NYS Retirees (5)	Individual	65,715	-	-	65,715	
	Family	49,763	48,230	14,084	112,077	
	Total	115,478	48,230	14,084	177,792	116,091
PE (6)	Individual	14,502	-	-	14,502	
	Family	29,198	25,874	34,721	89,793	
	Total	43,700	25,874	34,721	104,295	12,459
PA Empire Plan (7)	Individual	80,202	-	-	80,202	
	Family	118,716	108,532	124,589	351,837	
	Total	198,918	108,532	124,589	432,039	106,116
PA Excelsior Plan (8)	Individual	112	-	-	112	
	Family	105	98	86	289	
	Total	217	98	86	401	155
Graduate Student Employee Union (GSEU) (9)	Individual	4,575	-	-	4,575	
	Family	760	716	462	1,938	
	Total	5,335	716	462	6,513	-
Graduate Student Employee Union (GSEU) Other (10)	Individual	262	-	-	304	
	Family	44	42	55	103	
	Total	306	42	55	403	-
TOTAL	**Individual**	**238,861**	**-**	**-**	**238,903**	
	Family	**289,460**	**257,753**	**310,299**	**857,474**	
	Total	**528,321**	**257,753**	**310,299**	**1,096,373**	**246,983**

(1) Represents Total Medicare Primary Lives included within the Total Covered Lives for each respective group.
(2) Management Confidential Employees and other unrepresented NYS employees.
(3) Represents all Court System employees; excludes all Court System COBRA, YAO and other Post Employment Court System enrollees.
(4) Represents all NYS (including OCA) Dependent Survivor, Preferred List, Vestee, Extended Benefits, LTD enrollees, COBRA and YAO enrollees.
(5) Represents all NYS (including OCA) Retirees.
(6) Represents all Participating Employer enrollees (employees and all others).
(7) Represents all Participating Agency Empire Plan enrollees (employees and all others).
(8) Represents all Participating Agency Excelsior Plan enrollees (employees and all others).

(9) GSEU employees only.
(10) Represents GSEU COBRA and YAO enrollees.

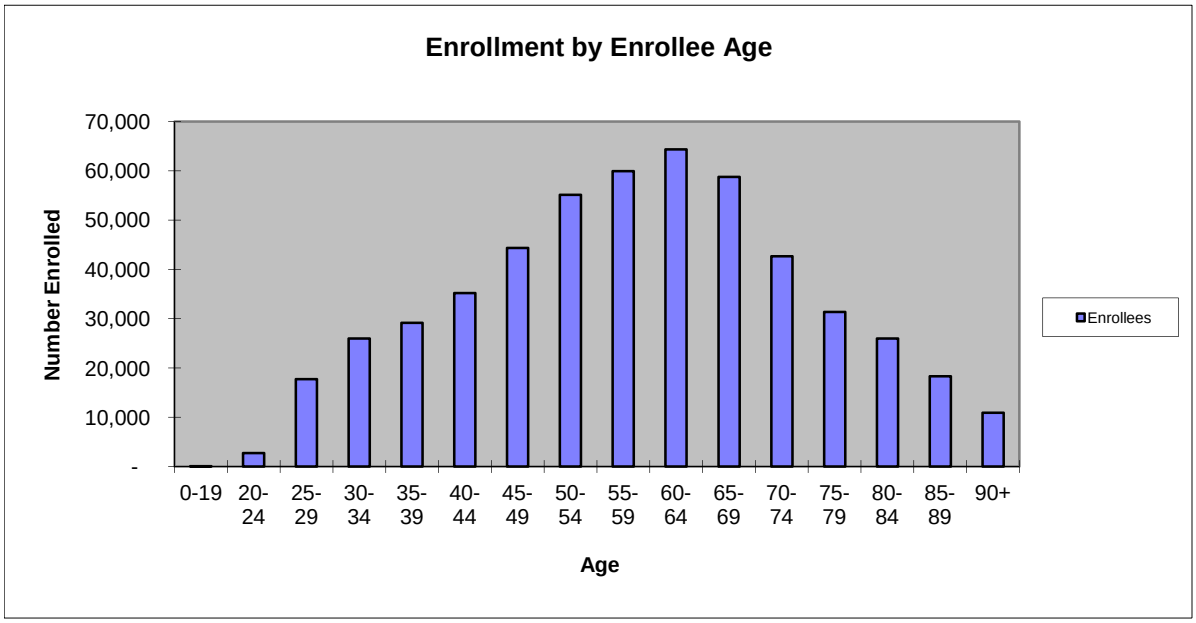
New York State Department of Civil Service

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

ENROLLMENT BY AGE

EMPIRE PLAN
AS OF JANUARY 9, 2014

Age Group	Enrollees	Spouses	Dependents	Total
0-19	112	21	215,958	216,091
20-24	2,753	426	78,556	81,735
25-29	17,763	4,796	13,837	36,396
30-34	25,948	12,738	549	39,235
35-39	29,139	18,037	348	47,524
40-44	35,188	23,651	295	59,134
45-49	44,371	28,554	196	73,121
50-54	55,128	32,748	137	88,013
55-59	59,911	33,707	60	93,678
60-64	64,348	32,887	23	97,258
65-69	58,734	27,329	6	86,069
70-74	42,648	18,657	3	61,308
75-79	31,354	11,499	-	42,853
80-84	25,988	7,149	-	33,137
85-89	18,301	3,602	-	21,903
90+	10,893	1,133	-	12,026
Total:	**522,579**	**256,934**	**309,968**	**1,089,481**



Source: NYBEAS

Exhibit II.A4

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Enrollment by Month

Empire Plan

	Individual Coverage	Family Coverage	Total
Jan-07	221,875	286,529	508,404
Feb-07	222,375	286,541	508,916
Mar-07	222,560	286,522	509,082
Apr-07	223,004	286,797	509,801
May-07	223,420	286,667	510,087
Jun-07	223,478	286,718	510,196
Jul-07	223,637	287,023	510,660
Aug-07	223,404	286,929	510,333
Sep-07	224,337	287,580	511,917
Oct-07	225,488	288,001	513,489
Nov-07	226,534	288,596	515,130
Dec-07	226,649	288,916	515,565
Jan-08	227,961	289,250	517,211
Feb-08	228,138	289,456	517,594
Mar-08	228,677	289,649	518,326
Apr-08	229,029	289,577	518,606
May-08	229,202	289,637	518,839
Jun-08	229,736	289,713	519,449
Jul-08	229,521	290,184	519,705
Aug-08	229,041	290,069	519,110
Sep-08	229,978	290,506	520,484
Oct-08	230,884	290,681	521,565
Nov-08	231,394	291,018	522,412
Dec-08	230,989	291,140	522,129
Jan-09	232,227	292,858	525,085
Feb-09	232,102	292,760	524,862
Mar-09	232,106	292,780	524,886
Apr-09	232,199	292,647	524,846
May-09	232,170	292,354	524,524
Jun-09	232,270	292,303	524,573
Jul-09	233,443	291,263	524,706
Aug-09	232,599	291,029	523,628
Sep-09	232,964	291,253	524,217
Oct-09	233,291	291,385	524,676

	Individual Coverage	Family Coverage	Total
Jan-10	242,310	288,664	530,974
Feb-10	240,678	290,469	531,147
Mar-10	243,969	287,165	531,134
Apr-10	241,697	289,427	531,124
May-10	241,955	289,228	531,183
Jun-10	241,265	290,237	531,502
Jul-10	240,799	290,738	531,537
Aug-10	239,753	291,157	530,910
Sep-10	240,205	291,470	531,675
Oct-10	240,489	291,769	532,258
Nov-10	240,494	292,037	532,531
Dec-10	240,497	292,117	532,614
Jan-11	238,042	294,037	532,079
Feb-11	237,377	294,068	531,445
Mar-11	236,929	294,234	531,163
Apr-11	236,294	294,182	530,476
May-11	235,955	293,990	529,945
Jun-11	235,666	293,927	529,593
Jul-11	234,841	293,672	528,513
Aug-11	234,183	293,679	527,862
Sep-11	233,884	293,624	527,508
Oct-11	233,851	293,336	527,187
Nov-11	233,653	293,184	526,837
Dec-11	233,244	292,909	526,153
Jan-12	232,807	292,247	525,054
Feb-12	232,094	291,451	523,545
Mar-12	231,794	291,369	523,163
Apr-12	231,683	291,321	523,004
May-12	231,510	290,984	522,494
Jun-12	231,390	290,584	521,974
Jul-12	231,667	291,035	522,702
Aug-12	231,018	290,672	521,690
Sep-12	231,140	290,733	521,873
Oct-12	231,297	290,800	522,097

	Individual Coverage	Family Coverage	Total
Jan-13	231,883	289,552	521,435
Feb-13	232,070	289,421	521,491
Mar-13	232,305	289,258	521,563
Apr-13	232,483	289,145	521,628
May-13	232,155	288,602	520,757
Jun-13	232,240	288,565	520,805
Jul-13	232,282	288,655	520,937
Aug-13	231,626	287,952	519,578
Sep-13	232,023	287,901	519,924
Oct-13	232,546	287,990	520,536
Nov-13	232,848	288,038	520,886
Dec-13	232,994	288,119	521,113
Jan-14	233,912	288,551	522,463
Feb-14			-
Mar-14			-
Apr-14			-
May-14			-
Jun-14			-
Jul-14			-
Aug-14			-
Sep-14			-
Oct-14			-
Nov-14			-
Dec-14			-
Jan-15			-
Feb-15			-
Mar-15			-
Apr-15			-
May-15			-
Jun-15			-
Jul-15			-
Aug-15			-
Sep-15			-
Oct-15			-

Nov-09	233,388	291,644	525,032
Dec-09	233,338	291,873	525,211

Nov-12	231,412	290,985	522,397
Dec-12	231,355	290,964	522,319

Nov-15	-
Dec-15	-

Exhibit II.B

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Non-Network Mental Health Practitioner Services Deductibles & Coinsurance Maximums - Effective January 1, 2014

Employee Group	**Annual Deductible** *(per enrollee; per spouse or domestic partner; per all dependent children combined)*	**Coinsurance Maximum** *(Out-of-Pocket Expense per contract)*	**In-Network Out of Pocket Maximum** (per enrollee and covered dependents combined)
Executive Branch-CSEA	$1,000/$500***	$3,000/$1,500***	Individual: $6,350; Family: $12,700
DC 37	$329**	$705 CPI**/$300***	N/A
PBA – Troopers	$426 *CPI***	$939 *CPI***	N/A
PBA – Supervisors	$426 CPI**	$939*CPI***	N/A
PIA	$426 CPI**	$939 *CPI***	N/A
Council 82	$1,000	$3,000	Individual: $6,350; Family: $12,700
APSU (formerly ALESU)	$1,000	$3,000	Individual: $6,350; Family: $12,700
NYSCOPBA	$1,000/$500***	$3,000/$1,500***	Individual: $6,350; Family: $12,700
UUP	$1000/$500***	$3,000/$1500***	Individual: $6,350; Family: $12,700
UUP Lifeguards	$417*** *CPI***	$1,545*** *CPI***	Individual: $6,350; Family: $12,700
PEF	$1,000/$500***	$3,000/$1,500***	Individual: $6,350; Family: $12,700
M/C	$1,000/$500***	$3,000/$1,500***	Individual: $6,350; Family: $12,700
Legislature	$1,000/$500***	$3,000/$1,500***	Individual: $6,350; Family: $12,700
Participating Employers	$1,000	$3,000	Individual: $6,350; Family: $12,700
Unified Court System	$1,000/$500***	$3,000/$1,500***	Individual: $6,350; Family: $12,700
Retirees, Vestees, Dependent Survivors and Preferred List	$1,000	$3,000	Individual: $6,350; Family: $12,700
Student Employee Health Plan (GSEU)	$100	N/A	N/A
Participating Agencies	$1,000	$3,000	Individual: $6,350; Family: $12,700
Excelsior Plan	$1,250	$4,000	Individual: $6,350; Family: $12,700

*** These changes reflect the 2.2% increase in the medical care component of the Consumer Price Index for Urban Wage Earners and Clerical workers, all Cities (C.P.I.-W) for the period July 1, 2012 through June 30, 2013.*

**** The annual deductible and coinsurance maximum out-of-pocket expense will be reduced for calendar year 2014 for employees in (or equated to) salary grade 6 or below on January 1, 2014; for UUP represented employees(including UUP Lifeguards), the annual deductible and coinsurance maximum out-of-pocket expense will be reduced for employees earning less than $34,318.*

New York State Department of Civil Service's

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Network Copays - Effective January 1, 2014

Employee Group	Outpatient Substance Abuse Treatment	Visit to Mental Health Professional	Emergency Room Care	Inpatient Hospital Services
Executive Branch				
CSEA	$20	$20	$60	$0
DC 37	$20	$20	$70	$0
PBA – Troopers	$20	$20	$70	$0
PBA – Supervisors	$20	$20	$70	$0
PIA	$20	$20	$70	$0
Council 82	$20	$20	$70	$0
APSU (formerly ALESU)	$20	$20	$70	$0
NYSCOPBA	$20	$20	$70	$0
UUP	$20	$20	$70	$0
UUP Lifeguards	$20	$20	$70	$0
PEF	$20	$20	$70	$0
M/C	$20	$20	$70	$0
Legislature	$20	$20	$70	$0
Participating Employers	$20	$20	$70	$0
Unified Court System	$20	$20	$60	$0
Retirees, Vestees, Dependent Survivors and Preferred List	$20	$20	$70	$0
Student Employee Health Plan	$10	$10	$25	$200
Participating Agencies	$20	$20	$70	$0
Excelsior Plan	$30	$30	$100	$250

NYSHIP
New York State Health Insurance Program

2014 NYSHIP Benefit Plan Comparison

Program Component	THE EMPIRE PLAN		THE EXCELSIOR PLAN — AN EMPIRE PLAN OPTION	
Hospital Benefits[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Covered Inpatient Services *Preadmission Certification Required*	Paid-in-full	Not subject to deductible. Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined.[2] When the combined coinsurance maximum is satisfied, benefits are provided at network levels.	$250 copayment per stay	No coverage in a non-network hospital except network benefits apply in the event of an emergency or when there is no network hospital available within 30 miles of your residence or when no network facility within 30 miles of your residence can provide the covered service you require.
Skilled Nursing Facility Care (No coverage if Medicare primary)	Paid-in-full in an approved facility when medically necessary and provided in lieu of hospitalization		Paid-in-full in an approved facility when medically necessary and provided in lieu of hospitalization	
Hospice Care	Paid-in-full when provided by an approved network program		Paid-in-full when provided by an approved network program	
Outpatient chemotherapy, radiation therapy, dialysis, preadmission testing	Paid-in-full	Not subject to deductible. Coinsurance of 10 percent of billed charges or $75 (whichever is greater) up to combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined.[2] When the combined coinsurance maximum is satisfied, benefits are provided at network levels.	Paid-in-full	
Covered Outpatient Services (diagnostic radiology/laboratory)	$40 copayment per visit		$75 copayment per visit	
Covered Outpatient Surgery	$60 copayment per visit		$100 copayment per visit	
Physical Therapy following related Hospitalization or Inpatient/Outpatient Surgery	$20 copayment when medically necessary		$30 copayment when medically necessary	
Emergency Room Visit	$70 copayment (waived if admitted)	Network benefit applies	$100 copayment (if admitted, only inpatient copayment applies)	Network benefit applies
Medical/Surgical Benefits[1]	**Participating Providers**	**Non-Participating**	**Participating Providers**	**Non-Participating**
Physician Office Visits and covered services provided during office visit	$20 copayment for each of the following services: Office visit/office surgery; laboratory/radiology. No copayment for prenatal visits, well child care, preventive care services and certain approved contraceptive drugs and devices.	Basic Medical Program: After the combined annual deductible of $1,000 per enrollee, $1,000 per spouse/domestic partner, and $1,000 per all dependent children combined is met, Plan pays 80 percent of reasonable and customary charges for covered services.[3] After combined coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined is met, Plan pays 100 percent of reasonable and customary charges.[2]	Single $30 copayment for all covered services provided during the visit and billed by the provider. No copayment for prenatal visits, well child care, preventive care services and certain approved contraceptive drugs and devices.	Basic Medical Program: After the combined annual deductible of $1,250 per enrollee, $1,250 per spouse/domestic partner, and $1,250 per all dependent children combined is met, Plan pays 80 percent of allowed amount for covered services.[3] After the combined coinsurance maximum of $4,000 is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.[4]
Diagnostic Laboratory Services	$20 copayment		Single $30 copayment for all covered services provided during the visit and billed by the provider.	
Diagnostic Radiology and Imaging Services (Certain radiology procedures subject to a Prospective Procedure Review)	$20 copayment		$30 copayment per visit $75 copayment per visit for procedures subject to Prospective Procedure Review	
Routine Pediatric Care	Paid-in-full	Basic Medical Program benefits	Paid-in-full	Basic Medical Program benefits
Routine Newborn Care	Paid-in-full	Not subject to deductible or coinsurance	Paid-in-full	Not subject to deductible or coinsurance
Routine Health Exams	No copayment for covered preventive care services as defined by the Patient Protection and Affordable Care Act. Other covered services subject to $20 copayment per visit.	Routine health exams are covered for you, the active employee, if you are age 50 or over and for your spouse or domestic partner age 50 or older. This benefit is not subject to deductible or coinsurance.	No copayment for covered preventive care services as defined by the Patient Protection and Affordable Care Act. Other covered services subject to $30 copayment per visit.	Basic Medical Program benefits for an active employee age 50 or older. This benefit is not subject to deductible or coinsurance. There is no Basic Medical coverage for routine health exams for spouses, retirees, vestees or dependent survivors.
Adult Immunizations		No coverage		No coverage
Outpatient Surgical Locations	$30 copayment	Basic Medical Program benefits	$75 copayment per visit	Basic Medical Program benefits

[1] Certain covered preventive care services are paid-in-full when received from a participating provider or at a network hospital.
[2] The annual coinsurance maximum for The Empire Plan is shared among the Basic Medical Program, non-network Hospital Program coverage and non-network Mental Health and Substance Abuse Program coverage.
[3] The annual deductible for The Empire Plan and the Excelsior Plan is shared among the Basic Medical Program, non-network coverage under the Home Care Advocacy Program and the Mental Health and Substance Abuse Program.
[4] The annual coinsurance maximum for the Excelsior Plan is shared among the Basic Medical Program and non-network coverage under the Mental Health and Substance Abuse Program.

Program Component	THE EMPIRE PLAN		THE EXCELSIOR PLAN SM AN EMPIRE PLAN OPTION	
Medical/Surgical Benefits	**Participating Providers**	**Non-Participating**	**Participating Providers**	**Non-Participating**
Emergency Ambulance Service	Local commercial ambulance covered except first $35		Local commercial ambulance covered except first $35	
Prostheses and Orthotic Devices	Paid-in-full	Basic Medical Program benefits for Prostheses/ Orthotic devices that meet the individual's functional needs.	Paid-in-full	Basic Medical Program benefits for Prostheses/ Orthotic devices that meet the individual's functional needs.
External Mastectomy Prostheses	Paid-in-full benefit once each calendar year for one single or double external mastectomy prosthesis. Any single external mastectomy prosthesis costing $1,000 or more requires approval through HCAP.		Paid-in-full benefit once each calendar year for one single or double external mastectomy prosthesis. Any single external mastectomy prosthesis costing $1,000 or more requires approval through HCAP.	
Chiropractic Treatment and Physical Therapy	$20 copayment for each office visit. An additional $20 copayment for radiology and diagnostic laboratory services provided during the visit (maximum of two copayments per visit).	$250 annual deductible per enrollee; $250 per spouse/domestic partner; $250 per all dependent children combined. The Plan pays up to 50 percent of the network allowance after you meet the annual deductible. There is no coinsurance maximum.	$30 copayment for all covered services provided during the visit and billed by the provider.	No coverage
Home Care Services, Skilled Nursing Services and Durable Medical Equipment	Paid-in-full when precertified through Home Care Advocacy Program (HCAP).	First 48 hours of nursing care not covered. After the combined annual deductible is met, Plan pays up to 50 percent of HCAP network allowance. There is no coinsurance maximum.	Paid-in-full when precertified through Home Care Advocacy Program (HCAP).	First 48 hours of nursing care not covered. After the combined annual deductible is met, Plan pays up to 50 percent of HCAP network allowance. There is no coinsurance maximum.
Mental Health and Substance Abuse Benefits	**Network Providers/Facilities**	**Non-Network**	**Network Providers/Facilities**	**Non-Network**
Inpatient Services – Approved Facilities	Paid-in-full No annual or lifetime benefit maximums	Not subject to deductible. Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner and $3,000 per all dependent children combined.[2] When combined coinsurance maximum is satisfied, benefits are provided at network level.	$250 copayment per stay	No coverage in a non-network facility except network benefits apply in the event of an emergency or when there is no network facility available within 30 miles of your residence or when no network facility within 30 miles of your residence can provide the covered service you require.
Inpatient Practitioner Treatment or Consultation	Paid-in-full		Paid-in-full	
Outpatient Services	Paid-in-full benefit for up to three visits per crisis; additional visits subject to a $20 copayment	After the combined annual deductible of $1,000 per enrollee; $1,000 per enrolled spouse/domestic partner; $1,000 per all dependent children combined is met, the Plan pays 80 percent of reasonable and customary charges for covered services.[3] After the combined coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined is reached, the Plan pays 100 percent of reasonable and customary amount for covered services.[2]	Paid-in-full benefit for up to three visits per crisis; Additional visits subject to a $30 copayment.	After the combined annual deductible of $1,250 per enrollee, $1,250 per spouse/domestic partner, and $1,250 per all dependent children combined is met, Plan pays 80 percent of allowed amount for covered services.[3] After the combined coinsurance maximum of $4,000 is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.[4]
Covered Outpatient Substance Abuse Services	$20 copayment per visit		$30 copayment per visit	
Emergency Room Visit	$70 copayment (waived if admitted)	Network benefits apply	$100 copayment (if admitted, only inpatient copayment applies)	Network benefits apply
Emergency Ambulance Service	Ambulance service covered when medically necessary		Local commercial ambulance covered except first $35	

Prescription Drug Program[5,6]

	Empire Plan		Excelsior Plan	
	Mail Order Pharmacy	**Network Pharmacy**	**Mail Order Pharmacy**	**Network Pharmacy**
Level 1	(most generics)		(most generics)	
Up to 30 Days	$5	$5	$10	$10
31-90 Days	$5	$10	$20	$25
Level 2	(Preferred Drugs)		(Preferred Drugs)	
Up to 30 Days	$25	$25	$40	$40
31-90 Days	$50	$50	$95	$95
Level 3	(all other covered drugs)		(all other covered drugs)	
Up to 30 Days	$45	$45	$70	$70
31-90 Days	$90	$90	$180	$180

[5] Empire Plan: If enrollee's doctor believes a brand drug is medically necessary, enrollee may appeal mandatory generic substitution. If approved, Level 3 copayment applies and ancillary fee is waived. Quantity level limits exist for erectile dysfunction and migraine medications.
[6] Excelsior Plan: No generic appeal, Level 3 copayment and applicable ancillary fee is charged. Quantity level limits are included in most therapeutic categories.

EMPIRE PLAN MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM: CERTIFICATE AMENDMENTS

Substitute the following for the UnitedHealthcare Insurance Company of New York Certificate of Insurance on pages 104-128 of your Empire Plan Certificate as amended in your January 2008 Empire Plan Report.

UnitedHealthcare Insurance Company of New York

(Herein referred to as UHIC-NY)
Hauppauge, New York

UHIC-NY certifies that under and subject to the terms and conditions of Group Policy 715116 issued to

State of New York
(Herein called the State)

each eligible Enrollee shall become insured on the Enrollee's own account and on account of each of the Enrollee's eligible Dependents for the coverage described in this Certificate, on the later of:

A. January 1, 2012 or

B. The date determined in accordance with the Regulations of the President of the Civil Service Commission.

The benefits under this Program do not at any time provide paid-up insurance, or loan or cash values.

No agent has the authority:

A. To accept or to waive any required notice or proof of a claim; nor

B. To extend the time within which any such notice or proof must be given to UHIC-NY.

This Certificate may not be assigned by the Enrollee. An Enrollee's benefits may not be assigned prior to a loss.

The insurance evidenced by this Certificate does NOT provide basic hospital insurance, basic medical insurance or major medical insurance as defined by the New York State Insurance Department.

UnitedHealthcare Insurance Company of New York
Form No. 0110MHSA
UnitedHealthcare Insurance Company of New York
Certificate of Insurance

UNITEDHEALTHCARE CERTIFICATE OF INSURANCE

Empire Plan Mental Health and Substance Abuse Program

Program Overview

The Empire Plan Mental Health and Substance Abuse Program provides comprehensive coverage for mental health and substance abuse care, including alcoholism. UHIC-NY is the Program insurer and OptumHealth is the administrator of the Program.

The Empire Plan Mental Health and Substance Abuse Program has two levels of benefits for covered services: network coverage and non-network coverage. Review the benefits and exclusions in this certificate before you obtain services. Please refer to the "Schedule of Benefits for Covered Services" for a complete description of the two benefit levels. Excluded services and conditions will not be covered under the Program. Please review "Exclusions" for a complete description.

Coverage

Covered services for medically necessary mental health and substance abuse care, include:

- Emergency assessments at all times;
- Inpatient psychiatric care and aftercare for psychiatric cases following hospital discharge;
- Alternatives to inpatient care (such as certified residential treatment facilities and certified halfway houses;
- Outpatient mental health services;
- Inpatient/residential rehabilitation and aftercare following hospital discharge for substance abuse treatment;
- Substance abuse structured outpatient rehabilitation and aftercare;
- Electroconvulsive therapy;
- Medication management;
- Ambulance services;
- Psychiatric second opinions; and
- Applied Behavioral Analysis with a confirmed diagnosis of Autism Spectrum Disorder (effective January 1, 2013)

IMPORTANT: See your *NYSHIP General Information Book and Empire Plan Certificate* for other conditions that may affect this coverage.

If you have questions about the Empire Plan Mental Health and Substance Abuse Program, you or a member of your family or household may call OptumHealth at 1-877-769-7447 and choose the Mental Health and Substance Abuse Program.

Calling OptumHealth is the first step in ensuring that you will be eligible to receive the highest level of benefits. The *Clinical Referral Line* is available 24 hours a day, every day of the year. It is staffed by clinicians who have professional experience in the mental health and substance abuse field. These highly trained and experienced clinicians are available to help you determine the most appropriate course of action.

By making the call before you receive services, and then obtaining care from a provider referred to you by OptumHealth, you will receive the highest level of benefit with network coverage. Usually, OptumHealth will refer you to a network practitioner or network facility. However, you will also qualify for network coverage if no network provider is available and OptumHealth refers you to a non-network provider.

Meaning of Terms Used

Here are definitions of the key terms used throughout this Certificate. In order to understand them fully, read the entire Certificate to see how these terms are used in the context of the coverage provided to you.

A. **Applied Behavioral Analysis** (ABA) means a behavioral approach that seeks to reinforce adaptive behaviors and reduce maladaptive behaviors commonly used with children with Autistic Spectrum Disorders. ABA includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

B. **Approved Facility** means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Law of New York State. If located outside New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug abuse treatment. Partial Hospitalization, Intensive Outpatient Program, Day Treatment, 23 Hour Extended Bed and 72 Hour Crisis Bed will be considered approved facilities if they satisfy the foregoing requirements. In all cases other than an emergency, the facility must also be approved by OptumHealth.

   Under network coverage, residential treatment centers, halfway houses and group homes will be considered approved facilities, if they satisfy the requirements listed previously and admission is certified by OptumHealth.

C. **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.

D. **Certification or Certified** means a determination by OptumHealth that mental health care or substance abuse care or proposed care is a medically necessary, covered service in accordance with the terms of this Certificate.

E. **Clinical Referral Line** means the clinical resource and referral service that you may call prior to receiving any covered services to obtain network referrals or benefit information. You may call 24 hours a day, every day of the year. Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Mental Health and Substance Abuse Program.

F. **Coinsurance** means, for Approved Facility services, the difference between the billed charge and the percentage covered; and, for non-network practitioner services, the difference between the reasonable and customary charge and the percentage covered. The Plan's coinsurance maximum is shared between Basic Medical, the Hospital Program and the Mental Health and Substance Abuse Program. **Note:** Copayments paid to a network practitioner count toward meeting your plan coinsurance maximum.

G. **Combined Annual Coinsurance Maximum** means the amount the enrollee, the enrolled spouse/domestic partner and all dependent children combined must pay in total, each calendar year, for coinsurance amounts incurred under the Basic Medical, Hospital and Mental Health and Substance Abuse (MHSA) Programs. Copayments for Participating Provider and network MHSA practitioner services also count toward the combined annual coinsurance maximum. After the combined annual coinsurance maximum is reached, benefits are paid at 100 percent of reasonable and customary charges for non-network covered services.

H. **Combined Annual Deductible** means the amount you must pay each calendar year for medically necessary covered services undemeans the amount the enrollee, the enrolled spouse/domestic partner and all dependent children combined must pay in total, each calendar year, for covered Basic Medical Program expenses, non-network Home Care Advocacy Program expenses and/or nonnetwork Mental Health and Substance Abuse Program expenses before benefits will be paid under these components of the Plan. The amount applied toward satisfaction of the combined annual deductible will be the lower of the following:

1. The amount you actually paid for a medically necessary service under the non-network portion of the Program; or
2. For Practitioner services, the reasonable and customary charge; or
3. For Approved Facility services, the billed amount for such service.

I. **Concurrent Review** means OptumHealth's utilization review and medical management program under which OptumHealth reviews the medical necessity of mental health care and substance abuse services. OptumHealth's review is conducted by a team of licensed psychiatric nurses, licensed social workers, board-certified or board-eligible psychiatrists and clinical psychologists, to determine whether proposed services are medically necessary for your diagnosed condition(s). This program includes combined outpatient and inpatient review as described in this Certificate.

J. **Copayment** means the amount you are required to pay for covered services you obtain from a network provider for outpatient services under the Mental Health and Substance Abuse Program. Please refer to the "Schedule of Benefits for Covered Services" for the exact amount of copayment. Copayment applies only to network covered services and non-network emergency room covered services. **Note**: Copayments paid to a network practitioner count toward meeting your plan coinsurance maximum.

K. **Course of Treatment** means the period of time, as determined by OptumHealth, required to provide mental health and substance abuse care to you for the resolution or stabilization of specific symptoms or a particular disorder. A course of treatment may involve multiple providers.

L. **Covered Expenses** means:

1. Under the network portion of the Program, the network allowance for any medically necessary covered services provided to you by a network provider.
2. Under the non-network portion of the Program, the reasonable and customary charge by a non-network practitioner. These services must be medically necessary as defined in this section. No more than the reasonable and customary charge will be considered by the program for medically necessary covered services. More detail on covered expenses is provided in the section "Schedule of Benefits for Covered Services."

A covered expense is incurred on the date the service is received by you.

Charges for services performed by a person or facility **not** listed in the definition of practitioner or approved facility are **not** covered expenses under the program. A more detailed description of covered expenses and exclusions is provided on the following pages.

M. **Covered Services** means medically necessary mental health and substance abuse care as defined under the terms of the Program, except to the extent that such care is otherwise limited or excluded under the Program.

N. **Crisis Intervention Visits** means visits for stabilization of an acute emotional disturbance that requires immediate attention to a patient in high distress.

O. **Emergency Care** is care received for an emergency condition. An emergency condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such a person or others in serious jeopardy;
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

P. **Inpatient Services** means those services rendered in an approved facility to a patient who has been admitted for an overnight stay and is charged for room and board.

Q. **Intensive Outpatient Program (IOP):** is a freestanding or hospital-based program that provides medically necessary services more than once weekly. Intensive outpatient programs are used as a step-up from routine outpatient services, or as a step-down from acute inpatient, residential care or a partial hospital program. Intensive outpatient programs can be used to treat mental health conditions or substance abuse disorders, or can specialize in the treatment of co-occurring mental health conditions and substance-use disorders.

R. **Medically Necessary** means a service that OptumHealth has certified to be:

1. Medically required;
2. Having a strong likelihood of improving your condition; and
3. Provided at the lowest appropriate level of care, for your specific diagnosed condition, in accordance with both generally accepted mental health and substance abuse practices and the professional and technical standards adopted by OptumHealth.

Although a practitioner may recommend that a covered person receive a service or be confined to an approved facility, that recommendation does not mean:

1. That such service or confinement will be deemed to be medically necessary; or
2. That benefits will be paid under this Program for such service or confinement.

S. **Mental Health Care** means medically necessary care rendered by a covered practitioner or approved facility and that, in the opinion of OptumHealth, is directed predominately at treatable behavioral manifestations of a condition that OptumHealth determines:

1. Is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and
2. Substantially or materially impairs a person's ability to function in one or more major life activities; and
3. Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

T. **Network Allowance** means the amount network providers have agreed to accept as payment in full for services they render to you, including applicable copayments under The Empire Plan Mental Health and Substance Abuse Program.

U. **Network Coverage** means the level of benefits provided by the Program when you receive medically necessary services from a network provider or a provider recommended to you by OptumHealth.

V. **Network Facility** means an approved facility that has entered into a network provider agreement as an independent contractor with OptumHealth. The records of OptumHealth shall be conclusive as to whether a facility has a network provider agreement in effect on the date that you obtain services. A non-network facility can be considered a network facility on a case-by-case basis when approved by OptumHealth.

W. **Network Practitioner** means a practitioner who has entered into an agreement with OptumHealth as an independent contractor to provide covered services to you. The records of OptumHealth shall be conclusive as to whether a person had a network provider agreement in effect on the date that you obtained services. A non-network practitioner can be considered a network practitioner on a case-by-case basis when approved by OptumHealth.

X. **Network Provider** means either a network practitioner or a network facility.

Y. **Non-Network Coverage** means the level of reimbursement paid by the Program when you receive medically necessary covered services from a non-network provider and you comply with the Program requirements outlined in this Certificate.

Z. **Non-Network Facility** means an approved facility that has not entered into an agreement with OptumHealth as an independent contractor to provide covered services to you.

AA. **Non-Network Practitioner** means a practitioner who has not entered into an agreement with OptumHealth as an independent contractor to provide covered services to you. A non-network practitioner can be considered a network practitioner on a case-by-case basis when approved by OptumHealth.

BB. **Non-Network Provider** means a practitioner or approved facility that has not entered into an agreement with OptumHealth to provide covered services to you.

CC. **OptumHealth** is the company selected by the State of New York to administer The Empire Plan Mental Health and Substance Abuse Program. OptumHealth provides services for UnitedHealthcare Insurance Company of New York in the administration of this Program.

DD. **Outpatient Services** means those services rendered in a practitioner's office or in the department of an approved facility where services are rendered to persons who have not had an overnight stay and are not charged for room and board.

EE. **Partial Hospitalization** means a freestanding or hospital-based program that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for less than four hours per day. A partial hospital/day treatment program may be used as a step up from a less intensive level of care or as a step down from a more intensive level of care and does not include an overnight stay. An approved facility has a program certified in New York State, according to the Mental Hygiene Law of New York State. If the facility is located in another state, it must be certified by the appropriate state agency to provide this kind of care or, if not regulated by a state agency, it must be certified by the Joint Commission on Accreditation of Health Care Organizations as a mental health care program.

FF. **Peer Advisor** means a psychiatrist or Ph.D. psychologist with a minimum of five years of clinical experience who renders medical necessity decisions.

GG. **Practitioner** means:

1. A psychiatrist; or
2. A psychologist; or
3. A licensed clinical social worker in New York State with the "R" privilege. If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body; or
4. A Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist: Advanced Practice nurses who hold a master's or doctoral degree in a specialized area of psychiatric nursing practice nurse; or
5. A Registered Nurse Practitioner: a nurse with a Master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided; must be certified and have a practice agreement in effect with a network psychiatrist; Nurse Practitioners may diagnose, treat, and prescribe for a patient's condition that falls within their specialty area of practice. This is done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols. **Benefits for these services are available under network coverage only.**

6. Applied behavioral analysis provider or ABA provider means: A licensed provider who is certified as a behavior analyst pursuant to a behavioral analyst certification board. For ABA services only, licensed provider means a psychiatrist, psychologist or licensed clinical social worker, or an individual licensed or otherwise authorized under Education Law Title VIII to practice a profession for which ABA is within the scope of that profession. Coverage for ABA by a licensed provider and certified behavioral analyst does not extend to basic behavioral health coverage or non-ABA services.
7. ABA Agency: An agency providing ABA services under the program oversight and direct supervision of a licensed provider and certified behavioral analyst. An ABA Agency may also employ ABA aides to deliver the treatment protocol of the ABA provider. Coverage of behavioral health services by a ABA Agency or ABA Aide does not extend to basic behavioral health coverage or to non-ABA services.

HH. **Program** means The Empire Plan Mental Health and Substance Abuse Program.

II. **Provider** means a practitioner or facility that supplies you with covered services under the Mental Health and Substance Abuse Program. The fact that a practitioner or approved facility claims to supply you with mental health or substance abuse services has no bearing on whether that practitioner or approved facility is a provider covered under the Program.

A service or supply that can lawfully be provided only by a licensed practitioner or approved facility will be covered by this Program only if such practitioner or approved facility is in fact properly licensed and is permitted, under the terms of that license, to do so at the time you receive a covered service or supply. A person or facility that is not properly licensed cannot be a covered provider under the Program. The records of any agency authorized to license persons or facilities who supply covered services shall be conclusive as to whether that person or facility was properly licensed at the time you receive any service or supply.

JJ. **Reasonable and Customary** means the lowest of:

1. The actual charge for services; or
2. The usual charge for services by the Practitioner; or
3. The usual charge for services of other Practitioners in the same or similar geographic area for the same or similar service.

KK. **Referral** means the process by which OptumHealth's 24-hour, toll-free *Clinical Referral Line* refers you to a network provider to obtain covered mental health and substance abuse care.

LL. **Structured Outpatient Rehabilitation Program** means a program that provides substance abuse care and is an operational component of an approved facility that is state licensed. If located in New York State, the program must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York. If the program is located outside New York State, it must be part of an approved facility accredited by the Joint Commission on Accreditation of Health Care Organizations as a hospital or as a health care organization that provides psychiatric and/or drug abuse or alcoholism services to adults and/or adolescents.

The program must also meet all applicable federal, state and local laws and regulations.

A Structured Outpatient Rehabilitation Program is a program, in which the patient participates, on an outpatient basis, in prescribed formalized treatment, including an aftercare component of weekly follow-up. In addition, Structured Outpatient Rehabilitation Programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.

MM. **Substance Abuse Care** means medically necessary care provided by an eligible provider for the illness or condition that OptumHealth has determined:

1. Is a clinically significant behavioral or psychological syndrome or pattern; and
2. Substantially or materially impairs a person's ability to function in one or more major life activities; and
3. Is a condition that has been classified as a substance abuse disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, unless such condition is otherwise excluded under this Program.

NN. **Total Disability** and **Totally Disabled** means that because of a mental health/substance abuse condition you, the enrollee, cannot do your job or your dependent cannot do his or her usual duties.

OO. **UHIC-NY** means UnitedHealthcare Insurance Company of New York, which is the insurer for The Empire Plan Mental Health and Substance Abuse Program.

PP. **You/Your** means any Empire Plan enrollee covered by this Program and any dependent member of an enrollee's family who is also covered. Enrollee and dependent are defined in your *NYSHIP General Information Book*. Where this Certificate refers to "you" making the call to obtain network coverage, "you"/"your" can also mean a member of your family or household.

How to Receive Benefits for Mental Health and Substance Abuse Care

The Mental Health and Substance Abuse Program has two levels of benefits: network coverage and non-network coverage.

Network Coverage

Using a network provider offers you the highest benefit level under the Empire Plan:

1. Network providers have been credentialed by OptumHealth, so you know they meet high standards of education, training and experience.
2. Non-network providers can bill you for amounts significantly over the amount reimbursed by OptumHealth. A network provider has agreed to accept the network allowance, plus your copayment, if applicable.
3. You will have no claims to file. Network providers collect only a copayment from you.

By using a network provider, you will receive network coverage for medically necessary treatment. OptumHealth's network gives you access to a wide range of providers when you need mental health or substance abuse care. These providers are in your community and many of them have been caring for Empire Plan enrollees and their families for years. For assistance with identifying a network provider, who can meet your needs, call the OptumHealth *Clinical Referral Line* 24 hours a day, every day of the year at 1-877-7-NYSHIP (1-877-769-7447).

You are guaranteed access to network benefits. If you cannot locate a network provider in your area, contact the *Clinical Referral Line*. By using a provider that OptumHealth refers you to, you will receive network benefits even if the provider is not in the network.

Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Mental Health and Substance Abuse Program.

Non-Network Coverage

Before you choose a non-network provider, consider the high cost of treatment. **If you choose or use a non-network provider, it is your responsibility to ensure that the non-network provider obtains required certification of services provided to you.**

For a nonemergency inpatient admission to a non-network facility, you must call OptumHealth before the admission to have the medical necessity of the admission certified. This requirement applies nationwide even if another plan is your primary coverage.

Most outpatient services do not need prior certification (see "Schedule of Benefits for Covered Services"). However, all care is subject to review under the program's medical necessity guidelines. When using a non-network provider, it is your responsibility to ensure that your provider responds to OptumHealth's requests for the information necessary to review and certify coverage for the services you receive from that provider.

Out-of-pocket expenses: When you use a non-network provider you are responsible for the deductible and any difference between the amount billed and the amount you are reimbursed under this Program.

To be certain that your care is medically necessary when you choose to use a non-network provider, you should call OptumHealth to start the certification process prior to receiving services, or as soon as is reasonably possible.

If your inpatient or outpatient treatment is determined to be not medically necessary, you will not receive any Empire Plan benefits and you will be responsible for the full cost of care.

Emergency services

In an emergency situation, you should go or be taken to the nearest hospital emergency room for treatment. If you are admitted to a facility for emergency care, you should call OptumHealth within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization for certification.

You must pay the first $70 in charges (copayment) for emergency care in a hospital emergency room. You will not have to pay this $70 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

When you receive medically necessary covered services from a non-network provider in a certified emergency, the Program will provide network coverage until you can be transferred to a network facility.

Show your identification card

You may be required to show your Empire Plan Benefit Card every time you request covered services from network providers. Possession and use of an identification card is not entitlement to benefits. Coverage for benefits is subject to verification of eligibility for the date covered services are rendered, and all the terms, conditions, limitations and exclusions set out in this Certificate.

Release of medical records

As a condition of receiving benefits under this Program, you authorize any provider who has provided services to you to provide OptumHealth and UHIC-NY with all information and records relating to such services. At all times, OptumHealth and UHIC-NY will treat medical records and information in strictest confidence.

What is Covered Under the Mental Health and Substance Abuse Program

This section describes Program coverage for inpatient and outpatient care.

Inpatient care

Coverage for inpatient care includes the following medically necessary services:

A. **Hospital Services** for the treatment of mental health and substance abuse are covered. If OptumHealth determines that inpatient treatment is no longer necessary, OptumHealth will notify you, your doctor and the facility no later than the day before the day on which inpatient benefits cease.

   OptumHealth will assist you in making the transition from inpatient care to the appropriate level of treatment with a network provider.

B. **Residential Treatment Facilities, Halfway Houses and Group Homes.** Covered charges will be payable in full under the network coverage if the admission is certified by OptumHealth. Confinements for these services are covered only under the network portion of the Program. **No benefits are available under non-network coverage.**

C. Mental health or Substance Abuse treatment in a **partial hospitalization** program (day or night care center) and Intensive Outpatient programs, maintained by an approved facility, on its premises, is covered.

D. **Psychiatric Treatment or Consultation While You Are in a Mental Health, Substance Abuse or Medical Inpatient in an Approved Facility.** If you are receiving inpatient mental health/substance abuse treatment from a practitioner who bills separately from the hospital or approved facility, you are covered for medically necessary visits. This benefit will be paid under the inpatient care benefit according to network status of the treating practitioner.

   If you are admitted to a hospital for a medical condition and the admission interrupts your certified outpatient mental health and substance abuse care, you may continue to receive certified care from your practitioner during your inpatient stay. This benefit will be paid under the inpatient care benefit according to network status of the treating practitioner.

E. **Inpatient Psychiatric Consultations on a Medical Unit.** You are covered for medically necessary inpatient mental health visits by a practitioner while you are on the medical unit of a hospital. This benefit will be paid under the inpatient care benefit according to network status of the treating practitioner.

F. **Prescription drugs,** when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or substance abuse care at that approved facility. Take-home drugs are not covered under the Mental Health and Substance Abuse Program.

Outpatient care

Coverage for outpatient care includes the following medically necessary services:

A. **Emergency Care** at a hospital for treatment of mental health/substance abuse disorders, where you are not admitted as an inpatient following that care, is considered an outpatient service.

B. **Office Visits.** You are covered for office visits for medically necessary mental health care.

C. **Psychiatric Second Opinion.** You are covered for a second opinion by a practitioner of equal or higher credentials. Example: Only another psychologist or a psychiatrist may give a second opinion on a psychologist's diagnosis.

D. **Family Sessions.** For each patient's alcoholism, alcohol abuse, or substance abuse treatment program, benefits are allowed for covered family sessions. When the covered alcoholic, alcohol abuser or substance abuser is participating in a Structured Outpatient Substance Abuse Rehabilitation Program, up to 20 family sessions (per calendar year) for family members covered under the same Empire Plan enrollment are covered by the program. If the alcoholic, alcohol abuser, or substance abuser is not in active treatment, non-addicted family members covered under the same Empire Plan enrollment are covered for up to 20 family sessions (per calendar year), subject to OptumHealth certification.

E. **Substance Abuse-Structured Outpatient Rehabilitation Program.** Substance Abuse Structured Outpatient Rehabilitation Program benefits are covered.

F. **Psychological Testing and Evaluations.** These services are covered if OptumHealth certifies that they are medically necessary for the condition(s) indicated. The network provider **must** obtain OptumHealth certification of this care **before** testing begins. If testing is being provided by a non-network provider, you **must** have your practitioner call OptumHealth and obtain certification of the care **before** testing begins.

G. **Ambulance Services for Mental Health and Substance Abuse Care.** Emergency ambulance transportation to the nearest hospital where emergency care can be performed is covered when the service is provided by a licensed ambulance service and ambulance transportation is required because of an emergency condition. Nonemergency transportation is covered, when medically necessary, if provided by a licensed ambulance service. Covered medical expenses for ambulance service are:

1. Local emergency ambulance charges. These amounts are not subject to deductible or coinsurance.
2. When the enrollee has no obligation to pay for the use of an organized voluntary ambulance service, donations up to a maximum of $50 for services less than 50 miles, $75 for 50 miles or over. These amounts are not subject to copayment, deductible or coinsurance.

You are not covered under this Program for ambulance service to a facility in which you do not receive mental health and substance abuse care.

H. **Crisis Intervention Visits.** Under network coverage, Crisis Intervention Visits are payable in full up to the network allowance for up to three visits in a given crisis. OptumHealth may request documentation in order to determine if visits are considered crisis intervention. **Paid-in-full benefits for these services are available under network coverage only.**

I. **Electroconvulsive Therapy.** Electroconvulsive therapy is a procedure conducted by a psychiatrist in the treatment of certain mental disorders through the application of controlled electric current. All Electroconvulsive therapy must be certified by OptumHealth before the service is received.

J. **Medication Management.** You are covered for office visits to a psychiatrist or registered network nurse practitioner for the ongoing review and monitoring of medications used to treat mental health or psychiatric conditions. **Benefits for nurse practitioners are available under network coverage only**.

K. **Home-Based Counseling.** You are covered for **medically necessary** home based counseling provided by network practitioners and following all outpatient procedures as practiced in outpatient office visits. **Benefits for these services are available under network coverage only.**

L. **Registered Nurse Practitioner.** Services provided by a Registered Nurse Practitioner under the direct supervision of a network psychiatrist are covered under the Plan when medically necessary. Nurse practitioners may diagnose, treat, and prescribe for a patient's condition that falls within their specialty area of practice. This is done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols. **Benefits for these services are available under network coverage only.**

M. **Telephone Counseling. Medically necessary** telephone counseling provided by a network practitioner is covered. **Benefits for these services are available under network coverage only.**

N. **Applied Behavioral Analysis (ABA) - effective January 1, 2013.** Services must be provided by or supervised by a licensed provider who is also a Certified Behavioral Analyst. The network provider **must** obtain OptumHealth certification of this care **before** services begin. If services are being provided by a non-network provider, you **must** have your practitioner call OptumHealth and obtain certification of the care **before** services begin.

OptumHealth reviews outpatient and inpatient treatment

After the initial certification, OptumHealth monitors your care throughout your course of treatment to make sure it remains consistent with your medical needs. The Concurrent Review is based on the following criteria and applies whether you choose a network or non-network provider:

- Medical necessity of treatment to date;
- Diagnosis;
- Severity of illness;

- Proposed level of care; and
- Alternative treatment approaches.

OptumHealth must continue to certify the medical necessity of your care for your Empire Plan mental health and substance abuse benefits to continue.

Certification denial and appeal process: deadlines apply

Only an OptumHealth peer advisor can deny certification. If certification for any covered service is denied, OptumHealth will notify you and the applicable provider of the denial and provide information on how to request an appeal of such decision by telephone. This information will also be provided to you in writing. You will have 180 days to request an appeal.

When you or your provider requests an appeal involving a clinical matter, a different OptumHealth peer advisor will review your case and make a determination. The determination will be made as soon as your provider provides all pertinent information to the OptumHealth peer advisor in a telephone review. You and your provider will be advised in writing of OptumHealth's decision.

If the peer advisor's determination is to continue to deny certification, you and your provider will be provided with written information on how to request a second level appeal of OptumHealth's decision. You have 60 days from the date of your receipt of OptumHealth's written denial notice to request a second level appeal.

Level 2 Clinical appeals are conducted by a panel of two board-certified psychiatrists from OptumHealth and a Clinical Manager from OptumHealth. Panel members must not have been involved in the previous determinations of the case. A determination will be made within 10 business days of the date OptumHealth received all pertinent medical records from your provider. You and your provider will be notified in writing of the decision. See "Appeals: 180-day deadline" for additional information.

If an appeal involves an administrative matter, it will be reviewed by an employee of OptumHealth with problem-solving authority above that of the original reviewer. Administrative appeals are reviewed by OptumHealth, in consultation with UHIC-NY as needed.

Schedule of Benefits for Covered Service

OPTUMHEALTH MUST CERTIFY ALL COVERED SERVICES AS MEDICALLY NECESSARY. IF OPTUMHEALTH DOES NOT CERTIFY YOUR INPATIENT OR OUTPATIENT TREATMENT AS MEDICALLY NECESSARY, YOU WILL NOT RECEIVE ANY EMPIRE PLAN BENEFITS AND YOU WILL BE RESPONSIBLE FOR THE FULL COST OF CARE.

NETWORK COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE

If you follow the requirements for network coverage, you are responsible for paying only the following copayments:

A. You pay the first $20 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse.

B. You pay the first $20 charged for any other outpatient visit including Home-Based and Telephone Counseling in place of an office visit, except no copayment is required for:

- Crisis Intervention, up to three visits per crisis
- Electroconvulsive Therapy – facility and therapist charges, if certified by OptumHealth
- Psychiatric Second Opinion, if requested and certified by OptumHealth
- Ambulance Service
- Mental Health Psychiatric Evaluations, if requested and certified by OptumHealth
- Prescription drugs, if billed by an approved facility
- Home-based counseling when provided in place of inpatient care

C. You pay the first $70 charged for emergency care in a hospital emergency room. You will not have to pay this $70 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

D. Effective January 1, 2013: You pay the first $20 charged for each visit for approved ABA therapy for Autism Spectrum Disorder. One copayment per visit will apply for all covered ABA services rendered during that visit.

Note: Copayments paid to a network provider count toward meeting your Empire Plan combined annual coinsurance maximum.

Your payment to the network provider is limited to your copayment. Except for the copayment that the network provider obtains directly from you, a network provider can not bill you directly for services you obtain as a network benefit. The network provider requests payment directly from UHIC-NY.

NON-NETWORK COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE

YOU ARE RESPONSIBLE FOR OBTAINING OPTUMHEALTH CERTIFICATION FOR CARE OBTAINED FROM A NON-NETWORK PROVIDER

When you use a provider that is not in the network or not referred to you by OptumHealth, OptumHealth pays the following covered percentages:

A. For Practitioner Services: 80 percent of reasonable and customary charges for covered services after you meet the Empire Plan combined annual deductible. The covered percentage becomes 100 percent of the reasonable and customary charge for covered services once the Empire Plan combined annual coinsurance maximum is met.

B. For Approved Facility Services: 90 percent of billed charges for covered services. The covered percentage becomes 100 percent of the billed charges for covered services once the Empire Plan combined annual coinsurance maximum is met.

The Empire Plan **combined annual deductible** is $1,000 for the enrollee, $1,000 for the enrolled spouse/domestic partner and $1,000 for all dependent children combined. The combined annual deductible must be met before your claims can be reimbursed.

The $1,000 deductible amounts shall be reduced to $500 per calendar year for employees in or equated to salary level six or below as of January 1 of that year.

The Empire Plan **combined annual coinsurance maximum** is $3,000 for the enrollee, $3,000 for the spouse/domestic partner and $3,000 for all dependent children combined.

The $3,000 coinsurance maximum amounts shall be reduced to $1,500 per calendar year for employees in or equated to salary level six or below as of January 1 of that year.

OptumHealth will consider non-network coverage for covered expenses after you meet your combined annual deductible. You are responsible for the coinsurance amount up to the combined annual coinsurance maximum for medically necessary covered services, as well as any charges in excess of the reasonable and customary charge for covered practitioner services.

Maximums

Mental Health and Substance Abuse coverage is unlimited (no maximum) for medically necessary outpatient and inpatient services, except that outpatient treatment sessions for family members of an alcoholic, alcohol abuser, or substance abuser are covered for a maximum of 20 visits per year for all family members combined.

Coverage for applied behavior analysis is limited to $45,000 for the 2013 plan year; effective January 1, 2014, applied behavior analysis will be limited to 680 hours each plan year.

Exclusions and Limitations

Covered services do not include and no benefits will be provided for the following:

A. Expenses incurred prior to your effective date of coverage or after termination of coverage, except under conditions described in the "Miscellaneous Provisions" section.

B. Services that are not Medically Necessary as defined in the section "Meaning of Key Terms."

C. Treatment that is not Mental Health Care or Substance Abuse Care as defined in the section "Meaning of Key Terms."

D. Services that are solely for the purpose of professional or personal growth, marriage counseling, development training, professional certification, obtaining or maintaining employment or insurance, or solely pursuant to judicial or administrative proceedings.

E. Services to treat conditions that are identified in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders as non-disorder conditions that may be a focus of clinical attention (V codes); except for family visits for substance abuse or alcoholism.

F. Services deemed Experimental or Investigational are not covered under this Plan. However, OptumHealth and UHIC-NY may deem an Experimental or Investigational Service is covered under this program for treating a life-threatening sickness or condition if they determine that the Experimental or Investigational Service at the time of the determination:

- Is proved to be safe with promising efficacy; and
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

G. Custodial Care – Custodial care means the spectrum of clinical and non-clinical services provided expressly for protection and monitoring in a controlled environment, regardless of setting, that do not seek a cure once the signs and symptoms of the patient have been stabilized, resolved or at baseline level of functioning or the patient is not responding to treatment or otherwise not improving. Examples include but are not limited to:

- Respite services;
- State hospital care that is custodial for children who are wards of the state;
- Enrollees or eligible dependents who are incarcerated in a state hospital facility;
- Days awaiting placement;
- Activities that are social and recreational in nature;
- Used solely to prevent runaway/truancy or legal problems.

H. Prescription drugs, except when medically necessary and when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or substance abuse care at that approved facility. Take-home drugs are not covered.

I. Private duty nursing.

J. Any charges for missed appointments, completion of a claim form, medical summaries and medical invoice preparations including, but not limited to, clinical assessment reports, outpatient treatment reports and statements of medical necessity.

K. Charges for services, supplies or treatments that are covered charges under any other portion of The Empire Plan, including but not limited to detoxification of newborns and medically complicated detoxification cases.

L. Services, treatment or supplies provided as a result of any Workers' Compensation Law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof.

M. Services or supplies you receive for which no charge would have been made in the absence of coverage under the Mental Health and Substance Abuse Program, including services from an Employee Assistance Program.

N. Services or supplies for which you are not required to pay, including amounts charged by a provider that are waived by way of discount or other agreements made between you and the provider of care.

O. Any charges for professional services performed by a person who ordinarily resides in your household or who is related to you, such as a spouse, parent, child, brother or sister or by an individual or institution not defined by OptumHealth as a provider.

P. Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement other than from an insurance carrier under an individual policy issued to you, to the extent that medical expenses are identified in the judgment or settlement.

Q. Conditions resulting from an act of war (declared or undeclared) or an insurrection that occurs after December 5, 1957.

R. Services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the Mental Health and Substance Abuse Program were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U.S. Department of Veterans' Affairs for a non-service-connected disability in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and amendments.

S. Coverage for ABA by a licensed provider and certified behavioral analyst does not extend to basic behavioral health coverage or non-ABA services. Coverage of behavioral health services by an ABA Agency or ABA Aide does not extend to basic behavioral health coverage or to non-ABA services.

T. ABA services is not a covered benefit when provided pursuant to an individualized education plan (IEP) under article eighty-nine of the education law, or under an individualized family service plan (IFSP) or an individualized services plan. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act is not a covered benefit.

Coordination of Benefits

If you are covered by an additional group health insurance program (such as a program provided by your spouse's employer) that contains coverage for mental health or substance abuse, The Empire Plan will coordinate benefit payments with the other program. One program pays its full benefit as the primary insurer and the other program pays secondary benefits.

Coordination of benefits helps ensure that you receive all the benefits to which you are entitled from each plan, while preventing duplicate payments and overpayments. In no event shall payment exceed 100 percent of a charge.

The Empire Plan does not coordinate benefits with any health insurance policy that you or your dependent carries on a direct-pay basis with a private carrier.

The procedures followed when Empire Plan benefits are coordinated with those provided under another program are detailed as follows. Each of The Empire Plan carriers follows these procedures.

A. "Coordination of Benefits" means that the benefits provided for you under The Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of coordination of benefits is to avoid duplicate benefit payments so that the total payment under The Empire Plan and under another plan is not more than the actual charge or the Reasonable and Customary Charge, whichever is less, for a service covered under both group plans.

B. Definitions

1. "Plan" means a plan that provides benefits or services for or by reason of mental health or substance abuse care and that is:

   a. A group insurance plan; or

   b. A blanket plan, except for blanket school accident coverage or such coverages issued to a substantially similar group where the policyholder pays the premium; or

   c. A self-insured or non-insured plan; or

   d. Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or

e. A group service plan; or

f. A group prepayment plan; or

g. Any other plan that covers people as a group; or

h. A governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan; or

i. A mandatory "no fault" automobile insurance plan.

2. "Order of Benefit Determination" means the procedure used to decide which plan will determine its benefits before any other plan.

3. Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of The Empire Plan that reserves the right to take the benefits or services of other plans into account to determine its benefits will be treated separately from those parts that do not.

C. When coordination of benefits applies and The Empire Plan is secondary, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the actual charge or the Reasonable and Customary Charge, whichever is less, for the service you receive.

D. Payments under The Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has coordination of benefits or similar provision with the same order of benefit determination as stated in Item E. Empire Plan benefits are to be determined, in that order, before the benefits under the other plan.

E. When more than one plan covers the person making the claim, the order of benefit payments is determined using the first of the following rules that applies:

1. The benefits of the plan that covers the person as an enrollee are determined before those of other plans that cover that person as a dependent;

2. When this plan and another plan cover the same child as a dependent of different persons called "parents" and the parents are not divorced or separated: (For coverage of a dependent of parents who are divorced or separated, see paragraph 3.)

a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but

b. If both parents have the same birthday, the benefits of the plan that has covered one parent for a longer period of time are determined before those of the plan that has covered the other parent for the shorter period of time;

c. If the other plan does not have the rule described in subparagraphs a. and b., but instead has a rule based on gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

d. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. First, the plan of the parent with custody of the child;

b. Then, the plan of the spouse of the parent with custody of the child;

c. Then, the plan of the parent not having custody of the child; and

d. Finally, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such actual knowledge.

4. The benefits of a plan that cover a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan that covers that person as a laid off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule 4. is ignored.

5. If none of the rules in 1. through 4. determined the order of benefits, the plan that has covered the person for the longest period of time determines its benefits first.

F. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under The Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.

G. Any information about covered expenses and benefits that is needed to apply this provision may be given or received without consent of or notice to any person, subject to the provisions in article twenty-five of the general business law.

H. If an overpayment is made under The Empire Plan before it is learned that you also had other coverage, The Empire Plan carriers have the right to recover the overpayment. You will be required to return any overpayment to the appropriate Empire Plan carrier; or at UHIC-NY's discretion, future benefits may be offset by this amount. In most cases, this will be the amount that was paid by the other plan.

I. If payments that should have been made under The Empire Plan have been made under other plans, the party that paid will have the right to recover the appropriate amount from The Empire Plan carriers.

J. There is a further condition that applies under the network provider program. When either Medicare or a plan other than The Empire Plan pays first, and if for any reason the total sum reimbursed by the other plan and The Empire Plan is less than the network provider billed the other plan, the network provider may not charge the balance to you.

When The Empire Plan is Secondary to Another Insurance Plan

If a provider receives prior approval to provide services from the primary carrier, The Empire Plan will not deny a claim for services on the basis that no prior approval from The Empire Plan was received. However, the fact that the primary carrier has given prior approval for services does not preclude The Empire Plan from determining that the services that were provided were not medically necessary or otherwise not covered under the certificate language.

Impact of Medicare on this Plan

Definitions

A. **Medicare** means the Health Insurance for the Aged and Disabled Provisions of the Social Security Act of the United States as it is now and as it may be amended.

B. **Primary Payor** means the plan that will determine the mental health and substance abuse benefits that will be payable to you first.

C. **Secondary Payor** means a plan that will determine your mental health and substance abuse benefits after the primary payor.

D. **Active Employee** refers to the status of you, the enrollee, prior to your retirement and other than when you are disabled.

E. **Retired Employee** means you, the enrollee, upon retirement under the conditions set forth in your *NYSHIP General Information Book*.

F. You will be considered **disabled** if you are eligible for Medicare due to your disability.

G. You will be considered to have **end-stage renal disease** if you have permanent kidney failure.

Coverage

When you are eligible for primary coverage under Medicare, the benefits under this Plan may change.

Please refer to your NYSHIP General Information Book for information on when you must enroll for Medicare and when Medicare becomes your primary coverage. **If you or your dependent is eligible for primary Medicare coverage, even if you or your dependent fails to enroll, your covered mental health and substance abuse expenses will be reduced by the amount available under Medicare, and UHIC-NY will consider the balance for payment, subject to copayment, deductible and coinsurance.**

If you or your dependent is eligible for primary coverage under Medicare and you enroll in a Health Maintenance Organization under a Medicare Advantage plan, your Empire Plan benefits will be dramatically reduced under some circumstances, as explained in the last paragraph of this section, "Medicare Advantage Plans and your Empire Plan coverage."

A. **Retired Employees and/or their Dependents** – If you or your dependents are eligible for primary coverage under Medicare, even if you or they fail to enroll, your covered mental health and substance abuse expenses will be reduced by the amount that would have been paid by Medicare, and UHIC-NY will consider the balance for payment, subject to copayment, deductible and coinsurance.

   If the provider has agreed to accept Medicare assignment, covered expenses will be based on the provider's reasonable charge or the amount approved by Medicare, whichever is less. If the provider has not agreed to accept Medicare assignment, covered expenses will be based on Medicare's limiting charge, as established under federal, or in some cases, state regulations.

   No benefits will be paid for services or supplies provided by a skilled nursing facility.

B. **Active State Employees and/or their Dependents** – This Plan will automatically be the primary payor for active employees, regardless of age, and for the employee's enrolled dependents (except for a domestic partner or same-sex spouse eligible for Medicare due to age) unless end-stage renal disease provisions apply; Medicare is the secondary payor. As the primary payor, UHIC-NY will pay benefits for covered mental health and substance abuse expenses under this Plan; as secondary payor, Medicare's benefits will be available to the extent they are not paid under this plan or under the plan of any other primary payor.

   The only way you can choose Medicare as the primary payor is by canceling this Plan; if you do so, there will be no further coverage for you under this Plan.

   Note to domestic partners or same-sex spouses: Under Social Security law, Medicare is primary for an active employee's domestic partner or same-sex spouse who becomes Medicare eligible at age 65. If the domestic partner or same-sex spouse becomes Medicare eligible due to disability, NYSHIP is primary.

C. **Disability.** Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must be enrolled in Parts A and B of Medicare when first eligible and apply for available Medicare benefits. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you.

D. **End-Stage Renal Disease.** For those eligible for Medicare due to end-stage renal disease, whose coordination period began on or after March 1, 1996, NYSHIP will be the primary insurer for the first

30 months of treatment, then Medicare becomes primary. See "Medicare end-stage renal disease coordination" in your *NYSHIP General Information Book*. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you. Therefore, you must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits.

E. **Veterans' Facilities.** Where services are provided in a U.S. Department of Veterans' Affairs facility or other facility of the federal government, benefits under this Plan are determined as if the services were provided by a nongovernmental facility and covered under Medicare. The Medicare amount payable will be subtracted from this Plan's benefits. The Medicare amount payable is the amount that would be payable to a Medicare-eligible person covered under Medicare. You are not responsible for the cost of services in a governmental facility that would have been covered under Medicare in a nongovernmental facility.

F. ***If you or your dependents are eligible and enrolled for primary coverage under Medicare and receive services from a health care provider who has elected to opt-out of Medicare, or whose services are otherwise not covered under Medicare due to failure to follow applicable Medicare program guidelines, we will estimate the Medicare benefit that would have been payable and subtract that amount from the allowable expenses under this Plan.***

Medicare Advantage Plans and your Empire Plan coverage

If you or your dependent enrolls in a Medicare Advantage plan, in addition to your Empire Plan coverage, The Empire Plan will not provide benefits for any services available through your Medicare Advantage plan or services that would have been covered by your Medicare Advantage plan if you had complied with the plan's requirements for coverage. Covered mental health and substance abuse expenses under The Empire Plan are limited to expenses not covered under your Medicare Advantage plan. If your Medicare Advantage plan has a Point-of- Service option that provides partial coverage for services you receive outside the plan, covered mental health and substance abuse expenses under The Empire Plan are limited to the difference between the Medicare Advantage plan's payment and the amount of covered expenses under The Empire Plan.

Claims

OptumHealth as administrator for UHIC-NY is responsible for processing claims at the level of benefits determined by OptumHealth and for performing all other administrative functions under The Empire Plan Mental Health and Substance Abuse Program.

Claim payment for covered services

Claim payments for covered services you receive under this Program will be made only as follows:

A. **Network Coverage:** When you receive network coverage, UHIC-NY will make any payment due under this Program directly to the provider, except for the copayment amount that you pay to the provider.

B. **Non-Network Coverage:** When you receive non-network coverage, any payment due under the Program will be made **ONLY** to you. You are responsible for payment of charges at the time they are billed to you. You must file a claim with OptumHealth for services rendered under non-network coverage in order to receive reimbursement. UHIC-NY pays you the non-network covered amount for the covered service you obtained. You are always required to pay the deductible, coinsurance amounts and the amount billed to you in excess of the non-network covered amount. Also, you are ultimately responsible for paying your provider any amount not paid by UHIC-NY. However, UHIC-NY may pay the non-network covered amount directly to an approved facility in lieu of paying you.

C. **Assignment Prohibited:** Your right under this Program to receive reimbursement for outpatient covered services when such services are provided under non-network coverage, except inpatient services and partial hospitalization where agreed to by UHIC-NY, may not be assigned or otherwise transferred to any other person or entity including, without limitation, any such provider. Such assignments or transfers are prohibited, will not be honored and will not be enforceable against the Program, UHIC-NY or OptumHealth.

How, When and Where to Submit Claims

How

If you use non-network coverage, you must submit a claim. You may obtain a claim form from your agency Health Benefits Administrator or by calling The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Mental Health and Substance Abuse Program. You may also download a claim form from the New York State Department of Civil Service web site at https://www.cs.ny.gov or from The Empire Plan's Mental Health and Substance Abuse Program's enrollee web site at www.liveandworkwell.com.

When

If you are enrolled in Medicare, an "Explanation of Medicare Benefits" form **must be submitted with the completed claim form or detailed bills** to receive benefits in excess of the Medicare payment.

Benefits will not be paid for claims submitted after the 120 days regardless of whether you or a provider submits the claim unless meeting this deadline has not been reasonably possible (for example, due to your illness). Claims must be submitted to either OptumHealth or Medicare, if applicable, within 120 days after the end of the calendar year in which covered expenses were incurred. If the claim is first sent to Medicare, it must be submitted to OptumHealth within 120 days after Medicare processes the claim.

Make and keep a duplicate copy of the "Explanation of Medicare Benefits" form and other documents for your records.

A. If you use network coverage, your provider will submit a claim to OptumHealth.

B. If you use non-network coverage, you must meet the combined annual deductible before the claims are paid.

Remember: If you are enrolled with Medicare as the primary payor, bills must be submitted to Medicare first.

Where

Send completed claim forms for non-network coverage with supporting bills, receipts, and, if applicable, an "Explanation of Medicare Benefits" form to:

OptumHealth Behavioral Solutions
PO Box 5190
Kingston, NY 12402-5190

Fraud

Any person who intentionally defrauds an insurance company by filing a claim that contains false or misleading information, or conceals information that is necessary to properly examine a claim has committed a crime.

Verification of claims information

OptumHealth and UHIC-NY have the right to request from approved facilities, practitioners or other providers any information that is necessary for the proper handling of claims. This information is kept confidential.

Questions

For questions about referrals for treatment, certification of medical necessity, case management services or payment of claims, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Mental Health and Substance Abuse Program.

Miscellaneous Provisions

Confined on effective date of coverage

If you become covered under this Plan and on that date are confined in a hospital or inpatient facility for care or mental health or substance abuse treatment or are confined at home under the care of a practitioner for mental health or substance abuse treatment, your Empire Plan benefits will be coordinated with any benefits payable through your former health insurance plan. Empire Plan benefits will be payable only to the extent that they exceed benefits payable through your former health insurance plan.

Benefits after termination of coverage

If you are totally disabled due to a mental health or substance abuse condition on the date coverage ends on your account, UHIC-NY will pay benefits for covered expenses for that total disability, on the same basis as if coverage had continued without change, until the day you are no longer totally disabled or 90 days after the day your coverage ended, whichever is earlier.

Confined on date of change of options

"Option" means your choice under the New York State Health Insurance Program of either The Empire Plan, which includes the Mental Health and Substance Abuse Program, or a Health Maintenance Organization (HMO). See your *NYSHIP General Information Book* for information on option transfer.

If, on the effective date of transfer without break from one option to the other, you are confined in a hospital or inpatient facility for mental health/substance abuse care or confined at home under the care of a practitioner for mental health/substance abuse care:

A. If the transfer is out of The Empire Plan, and you are confined on the day coverage ends, benefits will end on the effective date of option transfer; and

B. If the transfer is into The Empire Plan, benefits under the Mental Health and Substance Abuse Program are payable for covered expenses to the extent they exceed or are not paid through your former HMO.

Termination of coverage

A. Coverage will end when you are no longer eligible to participate in The Empire Plan. Refer to your *NYSHIP General Information Book*.

B. If this Program ends, your coverage will end.

C. Coverage of a dependent will end on the date that dependent ceases to be a dependent as defined in your *NYSHIP General Information Book*.

D. If a payment that is required by the State of New York for coverage is not made, the coverage will end on the last day of the period for which a payment required by the State was made.

If coverage ends, any claim that is incurred before your coverage ends will not be affected.

COBRA: Continuation of Coverage

Your rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal continuation of coverage law for you and your covered dependents, are explained in your *NYSHIP General Information Book*.

Refund to UHIC-NY for overpayment of benefits

If UHIC-NY pays benefits under this Program for covered expenses incurred on your account, and it is found that UHIC-NY paid more benefits than should have been paid because all or some of those expenses were not paid by you, or you were also paid for all or some of those expenses by another source, UHIC-NY will have the right to a refund from you.

The amount of the refund is the difference between the amount of benefits paid by UHIC-NY for those expenses and the amount of benefits that should have been paid by UHIC-NY for those expenses.

If benefits were paid by UHIC-NY for expenses not covered by this Program, UHIC-NY will have the right to a refund from you.

Time limit for starting lawsuits

Lawsuits to obtain benefits may not be started less than 60 days or more than two years following the date you receive notice that benefits have been denied.

Utilization Review Guidelines

If we have all the information necessary to make a determination regarding a preadmission or prospective procedure review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three business days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of the earlier of our receipt of the information or the end of the 45-day time period.

With respect to preadmission or prospective procedure review of urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 24 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider, by telephone and in writing, within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

Concurrent Reviews. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision. If we need additional information, we will request it within one business day. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of the earlier of our receipt of the information or the end of the 45-day time period.

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified previously for preadmission or prospective procedure review of urgent claims.

If we have already approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

Retrospective Reviews. If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you (or your designee) and your provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

Notice of Adverse Determination. A notice of adverse determination (notice that a service is not Medically Necessary or is experimental/investigational) will include the reasons, including clinical rationale, for our

determination, date of service, provider name and claim amount (if applicable). The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the plan provision on which the denial is based. We will send notices of determination to you (or your designee) and, as appropriate, to your health care provider.

Appeals

Appeals: 180-day deadline

In the event a certification or claim has been denied, in whole or in part, you can request a review. This request for review must be sent within 180 days after you receive a notice of denial of the certification or claim to:

OptumHealth
Attn: Appeals Dept.
PO Box 5190
Kingston, NY 12402-5190

When requesting a review, please state the reason you believe the certification or claim was improperly denied and submit any data, questions or comments you deem appropriate. Upon request to OptumHealth and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefit. In addition, if any new or additional evidence is relied upon or generated by OptumHealth during the determination of the appeal, it will be provided to you free of charge and sufficiently in advance of the due date of the decision of the appeal.

Please refer to “Certification denial and appeal process: deadlines apply” on page 360 for information about the appeals process.

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Services Bureau of the New York State Department of Financial Services at: New York State Department of Financial Services, One Commerce Plaza, Albany, New York 12257. Phone: 1-800-342-3736, Monday through Friday, 9 a.m. to 5 p.m., Eastern time.

Your right to an external appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if UHIC-NY has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, including treatment of a rare disease, you or your representative may appeal for review of that decision by an External Appeal Agent, an independent entity certified by the New York State Department of Financial Services to conduct such appeals.

Your right to appeal a determination that a service is not medically necessary

If you have been denied coverage on the basis that the service is not medically necessary (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit), you may appeal for review by an External Appeal Agent if you satisfy the following two criteria:

A. The service, procedure or treatment must otherwise be a Covered Service under the Policy; and

B. You must have received a final adverse determination through the internal appeal process described previously and, if any new or additional information regarding the service or procedures was presented for consideration, UHIC-NY must have upheld the denial; or you and UHIC-NY must agree in writing to waive any internal appeal.

Your right to appeal a determination that a service is experimental or investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two criteria:

A. The service must otherwise be a Covered Service under the Policy; and

B. You must have received a final adverse determination through the internal appeal process described previously and, if any new or additional information regarding the service or procedures was presented for consideration, UHIC-NY must have upheld the denial; or you and UHIC-NY must agree in writing to waive any internal appeal.

Your attending physician must also certify that you have a condition/disease whereby standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Plan or one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

A. A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation – your attending physician should contact the New York State Department of Financial Services to obtain current information about what documents will be considered acceptable) or, in the case of a rare disease, a health service or procedure that is likely to benefit you in the treatment of a rare disease; or

B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat condition or disease.

The External Appeal process

If, through the internal appeal process described previously, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have four months from receipt of such notice to file a written request for an external appeal. If you and UHIC-NY have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal.

UHIC-NY will provide an external appeal application with the final adverse determination issued through UHIC-NY's internal appeal process described previously or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the Department of Financial Services will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which UHIC-NY based its denial, the External Appeal Agent will share this information with UHIC-NY in order for it to exercise its right to reconsider its decision. If UHIC-NY chooses to exercise this right, UHIC-NY will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described in the following), UHIC-NY does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or UHIC-NY. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and UHIC-NY by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns UHIC-NY's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, UHIC-NY will provide coverage subject to the other terms and conditions of the Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, UHIC-NY will only cover the costs of services required to provide treatment to you according to the design of the trial. UHIC-NY shall not be responsible for the costs of investigational drugs or devices, the costs of nonhealth-care services, the costs of managing research, or costs that would not be covered under the Policy for nonexperimental or noninvestigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and UHIC-NY. The External Appeal Agent's decision is admissible in any court proceeding.

You will be charged a fee of $25 for each external appeal, and the annual limit on filing fees for any claimant within a single year will not exceed $75. The external appeal application will instruct you on the manner in which you must submit the fee. OptumHealth will also waive the fee if it is determined that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

Your responsibilities in filing an External Appeal

It is **YOUR RESPONSIBILITY** to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Financial Services. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

Four-month deadline

Under New York State law, your completed request for appeal must be filed within four months of either the date upon which you receive written notification from UHIC-NY that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. UHIC-NY has no authority to grant an extension of this deadline.

UPDATED

January 1, 2014

At a GLANCE

SEHP

Student Employee Health Plan

For Graduate Student Employees and for their enrolled Dependents, COBRA Enrollees with SEHP benefits and Young Adult Option Enrollees

This guide briefly describes the principal New York State Health Insurance Program (NYSHIP) SEHP benefits. It is not a complete description and is subject to change.

If you have questions about eligibility, enrollment procedures or the cost of health insurance, contact the Health Benefits Administrator (HBA) on your SUNY campus.

CUNY SEHP enrollees with questions may contact their Health Benefits Administrator (HBA) at the CUNY University Benefits Office.

THE EMPIRE PLAN

New York State
Department of Civil Service
Employee Benefits Division
Albany, NY 12239
https://www.cs.ny.gov

Benefit Summary

The NYSHIP Student Employee Health Plan (SEHP) is a health insurance plan for SUNY and CUNY graduate and teaching assistant employees and their families. The Plan provides medical, hospital, mental health and substance abuse, prescription drug, dental and vision care benefits.

What's New

- **2014 Empire Plan Flexible Formulary Drug List** – The annual update lists the most commonly prescribed generic and brand-name drugs included in the 2014 Empire Plan Flexible Formulary and newly excluded drugs with 2014 Empire Plan Flexible Formulary alternatives.
- **The Empire Plan Mental Health and Substance Abuse Program** – Beginning January 1, 2014, The Empire Plan Mental Health and Substance Abuse Program will be administered by ValueOptions, Inc. under a self-insured administrative services agreement with DCS.
- **The Empire Plan Prescription Drug Program** – Beginning January 1, 2014, The Empire Plan Prescription Drug Program will be administered by CVS Caremark under a self-insured administrative services agreement with the New York State Department of Civil Service (DCS).
- **Autism Coverage** – Effective January 1, 2014, Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorder is limited to 680 hours each plan year; the prior year's dollar limit for services no longer applies.

Please see *Contact Information* on page 23 for NYSHIP addresses, teletypewriter (TTY) numbers and other important contact information.

Quick Reference

The NYSHIP Student Employee Health Plan is a health insurance plan for CUNY and SUNY graduate and teaching assistant employees and their families. The Plan has six main parts:

1 Hospital Program

administered by Empire BlueCross BlueShield

Provides coverage for inpatient and outpatient services provided by a hospital or birthing center and for hospice care. Also provides inpatient Benefits Management Program services for preadmission certification of scheduled hospital admissions or within 48 hours after an emergency or urgent admission.

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans.

2 Medical/Surgical Program

administered by UnitedHealthcare

Provides coverage for medical services, such as office visits, surgery and diagnostic testing under the network and non-network programs. Coverage for chiropractic care and physical therapy is provided through the Managed Physical Medicine Program. Home care services provided in lieu of hospitalization and diabetic supplies provided by the Home Care Advocacy Program (HCAP). Benefits Management Program services for Prospective Procedure Review for MRI, MRA, CT, PET scan and Nuclear Medicine tests.

3 Mental Health and Substance Abuse Program

administered by ValueOptions

Provides coverage for inpatient and outpatient mental health and substance abuse services. Also provides certification of inpatient and outpatient services, concurrent reviews, case management and discharge planning.

4 Prescription Drug Program

administered by CVS Caremark

Provides coverage for prescription drugs dispensed through Empire Plan participating pharmacies, the mail service pharmacy and non-participating pharmacies.

5 Dental Program

administered by EmblemHealth 1-800-947-0101

Provides coverage for dental examinations, cleaning and bitewing X-rays. Also provides discounts on other services.

6 Vision Program

administered by Davis Vision 1-888-588-4823

Provides coverage for routine eye examinations, eyeglasses or contact lenses.

2014 Network Copayments at a Glance

Medical/Surgical Program

Participating Provider Program*

$10 copayment - office visit, office surgery, urgent care visit, contraceptive drugs and devices (injections, insertions or other physician intervention provided during visit subject to additional copayment), infertility treatment visit, allergy testing, mammography, cervical cytology screening

$10 copayment - diagnostic laboratory tests and radiology (not performed during an office visit)

Chiropractic Treatment or Physical Therapy Services (Managed Physical Medicine Program)

$10 copayment - office visit, up to 15 chiropractic visits per person per calendar year; up to 60 physical therapy visits per diagnosis

$10 copayment - diagnostic laboratory tests or radiology

***Note:** Some medically necessary services are paid in full; others are subject to copayment and/or a 15-visit per person per calendar year limit. For these services, non-network benefits apply for visits 16 and beyond.

Hospital Program

$15 copayment - surgery, diagnostic radiology, diagnostic laboratory tests, bone mineral density screening and administration of Desferal for Cooley's Anemia in the hospital outpatient department of a network hospital or an extension clinic (including outpatient surgical locations)

$25 copayment - emergency room care

$200 copayment - per admission for covered inpatient hospital stays

$10 copayment - per visit for medically necessary physical therapy (following related hospitalization or surgery); up to 60 visits

Mental Health and Substance Abuse Program

$10 copayment - office visit to network practitioner**

$25 copayment - emergency room care

$200 copayment - per admission for a covered inpatient mental health or substance abuse detoxification stay

$200 copayment + 20% coinsurance - per admission for network inpatient care in a residential treatment center, group home or halfway house (covered for up to 30 days per person per year)

****Note:** Office visits to a network practitioner are subject to a 15-visit annual limit per covered individual. For visits 16 and beyond, non-network coverage applies.

Prescription Drug Program***

Up to a 30-day supply from a participating retail pharmacy, mail service or designated specialty pharmacy:

$5 copayment - Level 1 or generic drug

$15 copayment - Level 2 or preferred brand-name drug

$40 copayment - Level 3 or non-preferred brand-name drug

31- to 90-day supply through the mail service or designated specialty pharmacy:

$5 copayment - Level 1 or generic drug

$20 copayment - Level 2 or preferred brand-name drug

$65 copayment - Level 3 or non-preferred brand-name drug

****Note:** Oral chemotherapy drugs for the treatment of cancer do not require a copayment.

Dental Program

$20 copayment - participating provider visit

$10 copayment - filling

Vision Program

$10 copayment - routine eye exam

Annual Benefit Maximum

Effective January 1, 2014, there is no annual benefit maximum for essential benefits under the Student Employee Health Plan.

Benefits Management Program

YOU MUST CALL *for preadmission certification*

If SEHP coverage is primary for you or your covered dependents:

You must call The Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Hospital Program:

- Before a scheduled (nonemergency) hospital admission.
- Before a maternity hospital admission.
- Within 48 hours, or as soon as reasonably possible, after an emergency or urgent hospital admission.

If you do not call, or if the Hospital Program does not certify the hospitalization, the Plan pays up to 50 percent of the allowable amount after your $200 copayment. If the Hospital Program does not certify the hospitalization, you will be responsible for the entire cost of care determined not to be medically necessary.

Empire BlueCross BlueShield also provides concurrent review, discharge planning, inpatient Medical Case Management and the Future Moms Program.

YOU MUST CALL *for Prospective Procedure Review – MRI, MRA, CT, PET scans or Nuclear Medicine tests*

If NYSHIP SEHP coverage is primary for you or your covered dependents:

You must call The Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical Program for prior authorization before having a scheduled (nonemergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scan or a Nuclear Medicine test, unless you are having the test or procedure as an inpatient in a hospital. If you do not call, you will pay a larger part of the cost. If the test is determined not to be medically necessary, you will be responsible for the entire cost.

UnitedHealthcare helps coordinate Voluntary Specialist Consultant Evaluation services and outpatient Medical Case Management for serious or chronic conditions.

Hospital Program

The Hospital Program pays for covered services provided in an inpatient or outpatient hospital setting or hospice organization. The covered services are the same for network and non-network hospitals, however network and non-network benefits differ, as described below. "Allowable amount" means the amount you actually paid for medically necessary services covered under SEHP, or the network allowance as determined by the carrier, whichever is lower. The Medical/Surgical Program provides benefits for certain medical and surgical care provided in a hospital setting when it is not covered by the Hospital Program.

Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Hospital Program if you have questions about your hospital benefits, coverage or an Explanation of Benefits (EOB) Statement. **Representatives are available Monday through Friday, 8 a.m. to 5 p.m. Eastern time.**

Network coverage applies when you receive emergency or urgent services in a non-network hospital, or when you use a non-network hospital because you do not have access to a network hospital. Call the Hospital Program to determine if you qualify for network coverage at a non-network hospital based on access.

Hospital Inpatient • *Semi-private room or Birthing Center*

YOU MUST CALL ***for preadmission certification***

Network Coverage

Copayment: $200 per person per admission; new copayment required if hospitalization occurs more than 90 days after previous discharge for the same illness or injury.

Coverage Level: The Plan pays 100 percent of allowable amount after you pay the copayment.

Unlimited days for covered medical or surgical care in a hospital, including inpatient detoxification.

Maternity Care: First 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section or first 96 hours following a cesarean section are presumed medically necessary and covered at the same copayment and coverage level as other inpatient admissions. If you choose early discharge following delivery, you may request one paid-in-full home care visit.

Non-network Coverage

Copayment: $200 per person per admission; new copayment required if hospitalization occurs more than 90 days after previous discharge for the same illness or injury.

Coverage Level: The Plan pays 80 percent of allowable amount after you pay the copayment. You are responsible for the balance.

Unlimited days for covered medical or surgical care in a hospital, including inpatient detoxification.

Maternity Care: First 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section or first 96 hours following a cesarean section are presumed medically necessary. The Plan pays 80 percent of the allowable amount after you pay the copayment. You are responsible for the balance.

Hospital Outpatient

Network Coverage	Non-network Coverage
Surgery, diagnostic radiology, diagnostic laboratory tests, bone mineral density screening and administration of Desferal for Cooley's Anemia or visits to a hospital outpatient Urgent Care facility are subject to one $15 copayment per visit. If you are admitted as an inpatient directly from the outpatient department, the outpatient copayment is waived and only the inpatient copayment applies.	**Annual Deductible:** The combined annual deductible is $100 per covered individual. **Coinsurance:** The Plan pays 80 percent of allowable amount after you meet the combined $100 deductible.
You must have prior authorization for an MRI, MRA, CT, PET scan or a Nuclear Medicine test (see page 3).	Same as network coverage.
$10 copayment per visit for up to 60 visits for medically necessary physical therapy following a related hospitalization or related inpatient or outpatient surgery.	Non-network physical therapy is subject to the combined annual deductible of $100 per covered individual.

Medically necessary physical therapy is covered under the Managed Physical Medicine Program when not covered under the Hospital Program. (See Medical/Surgical Program coverage.)

Emergency Care

Network Coverage	Non-network Coverage
Emergency room services, including use of the facility for emergency care and services of the attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services are subject to one copayment of $25 per visit. If you are admitted as an inpatient directly from the outpatient department or Emergency Room, the inpatient copayment applies (see page 4).	Network coverage applies to non-network hospital emergency room services.
Emergency is defined as the sudden onset of symptoms of sufficient severity, including severe pain, that a prudent layperson could reasonably expect the absence of immediate care to put the person's life in jeopardy or cause serious impairment of bodily functions.	

Infertility

Network Coverage

The following services provided in the inpatient or outpatient departments of a hospital are covered: artificial/intra-uterine insemination, inpatient and/or outpatient surgical or medical procedures, performed in the hospital, which would correct malfunction, disease or dysfunction resulting in infertility and associated diagnostic tests and procedures including, but not limited to, those described in New York State Insurance Law as set forth in Chapter 82 of the Laws of 2002.

Non-network Coverage

Outpatient Infertility Treatment: The Plan pays 80 percent of the allowable amount after you pay the $100 combined annual deductible.

Inpatient Infertility Treatment: The Plan pays 80 percent of the allowable amount after you pay the $200 copayment.

Hospice Care

Network Coverage

Paid-in-full benefit for up to 210 days when provided by an approved hospice program.

Non-network Coverage

The Plan pays up to 100 percent of allowable amount for up to 210 days.

Medical/Surgical Program

Benefits for covered medical/surgical services are available by physicians and other covered providers under network coverage when you use a provider that participates with The Empire Plan or under or non-network coverage when a provider is non-participating. Some medically necessary services are paid-in-full; others are subject to copayment and a 15-visit per person annual limit. **Note:** Any visit you make to your SUNY Campus Student Health Center (which is not a network provider), does not count toward the 15-visit per person limit. (This does not apply to CUNY SEHP enrollees). Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical Program if you have questions about the status of a provider, Plan coverage or your benefits. **Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time.**

Network Coverage

Some covered services received from a network provider are paid-in-full and others are subject to a copayment as described below.

The Plan does not guarantee that network providers are available in all specialties or geographic locations.

To learn whether a provider participates, check with the provider directly, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical Program or visit the New York State Department of Civil Service web site at https://www.cs.ny.gov. Select Benefit Programs, then follow the prompts to the NYSHIP Online homepage. Then click on Find a Provider.

Always confirm the provider's participation **before** you receive services.

Non-network Coverage

Annual Deductible: The combined annual deductible is $100 per covered individual.

Coinsurance: The Plan pays 80 percent of allowable amount for covered services after you meet the combined $100 deductible.

"Allowable amount" means the amount you actually paid for medically necessary services covered under SEHP, or the network allowance as determined by the carrier, whichever is lower.

Inpatient in a Hospital or Birthing Center

Network Coverage	Non-network Coverage
Covered services received from a network provider while you are an inpatient are paid-in-full and do not count toward the 15-visit per person limit.	For covered services by a non-network provider, the Plan pays 80 percent of the allowable amount for covered services after you meet the combined $100 deductible.
Paid-in-full benefit for preadmission and/or presurgical testing for radiology, anesthesiology and pathology.	Network coverage applies.

Outpatient Department of a Hospital

Network Coverage	Non-network Coverage
Paid-in-full benefits for covered outpatient services provided in the outpatient department of a hospital by a network provider.	For covered services by a non-network provider, the Plan pays 80 percent of the allowable amount for covered services after you meet the combined $100 deductible.
For medical emergency: paid-in-full benefits for attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services when these services are not covered by the Hospital Program. Services of other participating physicians are also paid in full.	For medical emergency: paid-in-full benefits for attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services when these services are not covered under the Hospital Program. Services of other physicians who are non-network are subject to the deductible but not coinsurance. Charges above the allowable amount are not covered.
Paid-in-full benefit for preadmission testing and/or presurgical testing prior to an inpatient admission, chemotherapy, anesthesiology, radiology, pathology or dialysis when not covered by Empire BlueCross BlueShield; does not count toward 15-visit per person limit.	The Plan pays up to 100 percent of allowable amount.

Doctor's Office Visit, Office Surgery; Laboratory and Radiology

Network Coverage

You have network coverage for up to 15 visits per person per calendar year to a network provider, subject to a $10 copayment per visit. The copayment includes diagnostic laboratory tests and radiology done during the office visit.

Office-based surgery visits are subject to a $10 copayment and the 15-visit per person annual limit for network benefits.

Prenatal and postnatal office visits that are not included in the delivery charge are subject to a $10 copayment but are not subject to the 15-visit per person annual limit for network benefits.

Diagnostic laboratory tests and radiology not performed during an office visit, including interpretation of mammograms and analysis of cervical cytology screening, are covered subject to a separate $10 copayment, but do not count toward the 15-visit per person annual limit for network benefits.

Visits to a non-hospital Urgent Care Center are subject to a $10 copayment, but do not count toward the 15-visit per person annual limit for network benefits.

The following types of office visits and services are paid in full and do not count toward the 15-visit per person annual limit: dialysis, chemotherapy and radiation therapy, well-child care and prenatal and postnatal office visits included in your provider's delivery charge.

You must have prior authorization for an MRI, MRA, CT, PET scan or a Nuclear Medicine test (see page 3).

Contraceptive Drugs and Devices: $10 copayment for required injections, insertion or other physician intervention provided during an office visit. (This copayment is in addition to your $10 copayment for the office visit.)

Infertility Treatment: $10 copayment for covered services such as artificial/intrauterine insemination (see Infertility on page 6) provided during an office visit.

Non-network Coverage

The Plan pays 80 percent of the allowable amount after you meet the combined $100 deductible for covered services received from non-network providers or after the 15th visit to a network provider (for those services that are subject to the limit).

Contraceptive Drugs and Devices: Covered drugs and devices are the same as under network coverage. The Plan pays 80 percent of the allowable amount after you meet the combined $100 deductible.

Infertility Treatment: The Plan pays 80 percent of the allowable amount after you meet the combined $100 deductible (covered services only, see page 6).

Network Coverage	Non-network Coverage
Second Surgical Opinion: $10 copayment for one out-of-hospital specialist consultation in each specialty field per condition per calendar year; subject to the 15-visit per person annual limit. One paid-in-full in-hospital consultation in each field per confinement.	**Second Surgical Opinion:** Same limits apply as under network coverage. The Plan pays 80 percent of the allowable amount after you meet the combined $100 deductible.
Second Opinion for Cancer Diagnosis: $10 copayment for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommended course of treatment for cancer.	**Second Opinion for Cancer Diagnosis:** Covered services are the same as under network coverage. The Plan pays 80 percent of the allowable amount after you meet the combined $100 deductible.

Routine Health Exams

Network Coverage	Non-Network Coverage
Non-network coverage applies.	Routine physicals are covered once every two years for the active employee under age 40, or annually for the active employee over age 40. The Plan pays 80 percent of the allowable amount for covered services. There is no coverage for routine health exams for a spouse or domestic partner. This benefit is not subject to copayment, deductible or the 15-visit per person annual limit. Covered services, such as laboratory tests and screenings provided during the office visit for a routine exam, that fall outside the scope of a routine exam are subject to deductible and coinsurance. For further information contact The Empire Plan toll free at**1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical Program or go to the New York State Department of Civil Service web site at https://www.cs.ny.gov.

Allergy Care

Network Coverage	Non-Network Coverage
Office visits are covered subject to a $10 copayment and the 15-visit per person annual limit for network benefits. No separate copayment for basic skin tests done during an office visit. Tests provided on different date or different location require a separate $10 copayment, but do not count toward the 15-visit per person limit. Allergy injections and extracts are not covered; see *Exclusions*, page 20.	Not covered

Routine Well-Child Care

Network Coverage

Paid-in-full benefit for children up to age 19 including examinations and immunizations administered pursuant to pediatric guidelines. Well-child care visits do not count toward the 15-visit per person annual limit for network benefits.

Non-Network Coverage

The Plan pays 100 percent of allowable amount. This benefit is not subject to deductible or coinsurance.

Mammograms and Cervical Cytology Screening

Network Coverage

$10 copayment for mammography received from a network provider following recommended guidelines; $10 copayment for cervical cytology screening. (Also see Hospital Outpatient, page 5.)

Non-Network Coverage

The Plan pays 80 percent of allowable amount after you meet the combined $100 deductible.

Pregnancy Termination

Network Coverage

Paid-in-full benefit; does not count toward 15-visit per person annual limit for network benefits.

Non-Network Coverage

The Plan pays 80 percent of allowable amount after you meet the combined $100 deductible.

Ambulatory Surgical Center

Network Coverage

$10 copayment covers facility, same-day on-site testing and anesthesiology charges for covered services at a network surgical center.

Non-Network Coverage

The Plan pays 80 percent of allowable amount after you meet the combined $100 deductible.

Ambulance Service

Network Coverage

The Plan pays for local commercial ambulance charges for emergency transportation, subject to a $15 copayment.

Non-Network Coverage

Network coverage applies.

Emergency Ambulance Transportation is covered when the service is provided by a licensed ambulance service to the nearest hospital where emergency care can be performed and ambulance transportation is required because of an emergency condition.

Enteral Formulas; Modified Solid Food Products

Network Coverage

Non-network coverage applies.

Non-Network Coverage

For prescribed enteral formulas, the Plan pays up to 80 percent of allowable amount after you meet the combined annual deductible. For certain prescribed modified solid food products, the Plan pays up to 80 percent of allowable amount after you meet the combined annual deductible, up to a total maximum reimbursement of $2,500 per covered person per calendar year.

Managed Physical Medicine Program

This program is administered by Managed Physical Network (MPN).

Chiropractic Treatment and Physical Therapy

Network Coverage
(when you use MPN)

You pay a $10 copayment for each office visit to an MPN provider. You pay an additional $10 copayment for related radiology and diagnostic laboratory services billed by the MPN provider.

Chiropractic Treatment: Up to 15 visits per person per calendar year.

Physical Therapy: Up to 60 visits per diagnosis, if determined by MPN to be medically necessary.

Access to network benefits is guaranteed for chiropractic treatment and physical therapy. If there is no network provider in your area, call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical Program.

Non-network Coverage
(when you don't use MPN)

Annual Deductible: Subject to $100 deductible per covered individual. This deductible is separate from other plan deductibles.

Coinsurance: The Plan pays up to 80 percent of allowable amount after you meet the annual deductible. Non-network benefits apply for covered services received from non-network providers, or after the 15th chiropractic visit per year, or after the 60th physical therapy visit per diagnosis, by a network provider.

"Allowable amount" means the amount you actually paid for medically necessary services covered under SEHP, or the network allowance as determined by the carrier, whichever is lower.

Program requirements apply even if Medicare or another health plan is primary.

All benefits apply to treatment determined medically necessary by MPN.

Home Care Advocacy Program (HCAP)

Diabetic Equipment/Supplies, Home Care Services and Durable Medical Equipment and Supplies provided in Lieu of Hospitalization

for prior authorization

Network Coverage *(when you use HCAP)*	Non-network Coverage *(when you don't use HCAP)*
Diabetic equipment and supplies, including insulin pumps and Medijectors are paid-in-full. To receive diabetic equipment and supplies, (except insulin pumps and Medijectors) call The Empire Plan Diabetic Supplies Pharmacy at **1-888-306-7337**. For insulin pumps and Medijectors you must use a network provider. Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical Program, then the Benefits Management Program for prior authorization.	Diabetic equipment and supplies are covered up to 100 percent of the allowable amount; not subject to deductible or coinsurance. "Allowable amount" means the amount you actually paid for medically necessary services covered under SEHP, or the network allowance as determined by the carrier, whichever is lower.
Home care services provided in lieu of hospitalization are paid-in-full for 365 visits. To receive this benefit, you must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical Program then HCAP for prior authorization.	Home care services are not covered unless precertified. If precertified, the Plan pays 80 percent of allowable amount after you meet the combined annual deductible.
Durable medical equipment and supplies (other than diabetic equipment or supplies) is covered in lieu of hospitalization when precertified. To receive this benefit, you must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical Program then HCAP for prior authorization. Important: If Medicare is your primary coverage, and you do not use a Medicare contracted provider, your benefits will be further reduced.	Not covered.

Program requirements apply even if Medicare or another health plan is primary.

All benefits apply to treatment determined medically necessary by UnitedHealthcare.

Important: *If Medicare is your primary coverage and you live in an area or need supplies while visiting an area that participates in the Medicare Durable Medical Equipment, Prosthetics and Orthotics Supply (DMEPOS) Competitive Bidding Program, you must use a Medicare-approved supplier. Most regions of New York State are affected by DMEPOS. To locate a Medicare contract supplier, visit www.medicare.gov/supplierdirectory or contact The Empire Plan toll free at* ***1-877-7-NYSHIP (1-877-769-7447)*** *and choose the Medical Program, then Benefits Management Program.*

Mental Health and Substance Abuse Program

to ensure the highest level of benefits

Call the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Mental Health and Substance Abuse Program before seeking any treatment for mental health or substance abuse, including alcoholism. **The ValueOptions Clinical Referral Line is available 24 hours a day, every day of the year.** By following the Program requirements for network coverage, you will receive the highest level of benefits. Access to network benefits is guaranteed.

In an emergency, the Mental Health and Substance Abuse Program will either arrange for an appropriate provider to call you back (usually within 30 minutes) or direct you to an appropriate facility for treatment. In a life-threatening situation, go to the emergency room. If you are admitted as an inpatient, you or someone acting on your behalf should call the Mental Health and Substance Abuse Program within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization.

Program requirements apply even if Medicare or another health plan is primary.

Only treatment determined medically necessary by ValueOptions is covered.

If you are in treatment for mental health or alcohol/substance abuse at the time your NYSHIP SEHP coverage begins, please contact ValueOptions for help in making the transition to your NYSHIP SEHP coverage.

Inpatient Facilities

Network Coverage

Mental Health: Inpatient and partial hospitalization, intensive outpatient and day treatment programs, 23-hour extended and 72-hour crisis beds are covered for mental health care in an approved general acute or psychiatric hospital or clinic. The Plan pays up to 100 percent of the network allowance after you pay the $200 copayment. New copayment is required if admission occurs more than 90 days after the previous admission.

Inpatient care in an approved residential treatment center, group home or halfway house is covered for up to 30 days per person per year for mental health care. The Plan pays 80 percent of the network allowance after you pay the $200 copayment. New copayment required if admission occurs more than 90 days after the previous admission.

Substance Abuse: Inpatient care for medically necessary detoxification admissions is covered. The Plan pays 100 percent of the network allowance after you pay the $200 copayment. New copayment is required if admission occurs more than 90 days after the previous admission.

Non-network Coverage

Mental Health: Inpatient and partial hospitalization, intensive outpatient and day treatment programs, 23-hour extended and 72-hour crisis beds are covered for mental health care in an approved general acute or psychiatric hospital or clinic. The Plan pays 80 percent of the allowable amount after you pay the $200 copayment. New copayment required if admission occurs more than 90 days after the previous admission.

No coverage for inpatient care in a residential treatment center, group home or halfway house.

"Allowable amount" means the amount you actually paid for medically necessary services covered under SEHP, or the network allowance as determined by the carrier, whichever is lower.

Substance Abuse: Medically necessary inpatient detoxification admissions in an approved facility are covered. The Plan pays 80 percent of the allowable amount after you pay the $200 copayment. New copayment required if hospitalization occurs more than 90 days after the previous admission.

Hospital Emergency Room

Network Coverage

You pay a $25 copayment. If you are admitted as an inpatient directly from the outpatient department or Emergency Room, the inpatient copayment applies (see page 13).

Non-network Coverage

Network coverage applies.

Practitioner Visits

Network Coverage

Office visits to a network practitioner for mental health and/or substance abuse care are subject to a $10 copayment and the 15-visit per person annual limit for network benefits. For visit 16 and beyond, non-network coverage applies.

Non-network Coverage

Non-network benefits apply for covered services received from non-network practitioners or after the 15th visit to a network practitioner. Services are subject to the $100 combined annual deductible per covered individual. The Plan pays 80 percent of the allowable amount for covered services after you pay the deductible.

Psychological Testing and Neuropsychological Testing:
Network and non-network psychological testing and evaluations will be reviewed for medical necessity; only medically necessary services are covered. Therefore; precertification by ValueOptions is required before testing or evaluation begins.

Neuropsychological network or non-network testing and evaluations will be reviewed for medical necessity; only medically necessary services are covered. Therefore, precertification by ValueOptions is required before testing or evaluation begins.

Note: Neuropsychological testing with a medical diagnosis is also covered under the Medical Program. These services will be reviewed by UnitedHealthcare for medical necessity. Precertification by UnitedHealthcare is required before testing or evaluation begins.

Applied Behavioral Analysis services: There is an annual maximum of 680 hours for Applied Behavioral Analysis (ABA) Services, network and non-network combined.

Prescription Drug Program

Copayments

You have the following copayments for drugs purchased from a participating pharmacy or through the Mail Service Pharmacy or designated Specialty Pharmacy.

Up to a 30-day supply from a Participating Pharmacy, Mail Service Pharmacy, or designated Specialty Pharmacy	**31- to 90-day supply through the Mail Service Pharmacy, or designated Specialty Pharmacy**
Level 1 or **Generic** Drugs.....$5	Level 1 or **Generic** Drugs.....$5
Level 2 or **Preferred Brand-Name** Drug $15	Level 2 or **Preferred Brand-Name** Drug $20
Level 3 or **Non-preferred Brand-Name** Drug $40	Level 3 or **Non-preferred Brand-Name** Drug $65

Note: Oral chemotherapy drugs for the treatment of cancer do not require a copayment.

When you fill a prescription for a covered brand-name drug that has a generic equivalent, you pay the Level 3 non-preferred brand-name copayment plus the difference in cost between the brand-name drug and the generic (ancillary charge), not to exceed the full retail cost of the drug. Certain drugs are excluded from this requirement. You pay only the applicable copayment for these brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol, and Tegretol XR.

You have coverage for prescriptions for more than a 30-day supply through the mail service pharmacy or designated specialty pharmacy. Prescriptions may be refilled for up to one year.

Note: At certain SUNY Campus Student Health Centers, SUNY SEHP enrollees and/or their enrolled dependents are able to fill prescriptions for a $7 copayment for up to a 30-day supply. See your Health Benefits Administrator for more information. (This does not apply to CUNY SEHP enrollees.)

Flexible Formulary

The Student Employee Health Plan uses The Empire Plan Flexible Formulary for prescription drugs. The Empire Plan Flexible Formulary drug list is designed to provide enrollees and the Plan with the best value in prescription drug spending.

This is accomplished by:

- Excluding coverage for certain brand-name or generic drugs, if the drug has no clinical advantage over other covered medications in the same therapeutic class.
- Placing a brand-name drug on Level 1 or excluding or placing a generic drug on Level 3, subject to the appropriate copayment. These placements may be revised mid-year when such changes are advantageous to The Empire Plan. Enrollees will be notified in advance of such changes.
- Applying the highest copayment to non-preferred drugs that provide no clinical advantage over two or more Level 1 drug alternatives in the same therapeutic class. This may result in no Level 2 brand-name drugs.

Certain drugs have been added to the list of drugs excluded from coverage under the 2014 Flexible Formulary. A list of suggested alternatives to these excluded drugs, along with a complete list of all excluded drugs, is available online. Visit the New York State Department of Civil Service web site at https://www.cs.ny.gov. Select Benefit Programs, then follow the prompts to the NYSHIP Online homepage. Click on Using Your Benefits and then 2014 Empire Plan Flexible Formulary.

Flexible Formulary, continued

New prescription drugs may be subject to exclusion when they first become available on the market. Check the web site for current information regarding exclusions of newly launched prescription drugs. Coverage for prescription drugs excluded under the benefit plan design are not subject to exception. This includes prescription medications excluded from coverage under The Empire Plan Flexible Formulary.

Newly Excluded Drugs for 2014

A list of newly excluded drugs for 2014 is included in the 2014 Empire Plan Flexible Formulary Drug List.

An excluded drug is not subject to any type of appeal or coverage review, including a medical necessity appeal.

Prior Authorization

You must have prior authorization for the following drugs, including generic equivalents:

- Abstral
- Actemra
- Actiq
- Adcirca
- Ampyra
- Aranesp
- Aubagio
- Avonex
- Botox
- Cayston
- Cimzia
- Copaxone
- Dysport
- Egrifta
- Enbrel
- Epogen/Procrit
- Extavia
- Fentora
- Flolan
- Forteo
- Gilenya
- Growth Hormones
- Humira
- Immune Globulins
- Incivek
- Increlex
- Infergen
- Intron A
- Kalydeco
- Kineret
- Korlym
- Kuvan
- Lamisil
- Lazanda
- Letairis
- Makena
- modafanil
- Myobloc
- Nuvigil
- Onmel
- Onsolis
- Orencia
- Pegasys
- PegIntron
- Rebif
- Remicade
- Remodulin
- Revatio
- Simponi
- Sporanox
- Stelara
- Subsys
- Synagis
- Tazorac
- Tecfidera
- Tracleer
- Tysabri
- Tyvaso
- Veletri
- Ventavis
- Victrelis
- Weight Loss Drugs
- Xeljanz
- Xeomin
- Xolair
- Xyrem

Certain medications that require prior authorization based on age, gender or quantity limit specifications are not listed here. Compound Drugs that have a claim cost to the Program that exceeds $200 will also require prior authorization under this Program. The above list of drugs is subject to change as drugs are approved by the Food and Drug Administration and introduced into the market. For information about prior authorization requirements, or the current list of drugs requiring authorization, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)**. Choose the Prescription Drug Program, and select the 2014 benefits option. **Representatives are available 24 hours a day, seven days a week.** Or, go to the New York State Department of Civil Service web site at https://www.cs.ny.gov. Select Benefit Programs, then follow the prompts to the NYSHIP Online homepage. Select Find a Provider and scroll to Prescription Drug Program and click The Empire Plan: Drugs that Require Prior Authorization.

Specialty Pharmacy Program

The Empire Plan Specialty Pharmacy Program offers individuals using specialty drugs enhanced services including disease and drug education, compliance management, side-effect management and safety management. Also included with this Program are expedited, scheduled delivery of your medications at no additional charge, refill reminder calls and all necessary supplies such as needles and syringes applicable to the medication.

For a complete list of specialty medications included in the Specialty Pharmacy Program, visit the New York State Department of Civil Service web site at https://www.cs.ny.gov. Select Benefit Programs, then follow the prompts to the NYSHIP Online homepage. Click on Find a Provider, scroll down to Prescription Drug Program and then select Specialty Drug Program to see a complete list of specialty medications included in the Specialty Pharmacy Program. Specialty medications must be ordered through the Specialty Pharmacy Program using the CVS Caremark Mail Order Pharmacy. Prior authorization is required for some specialty medications.

To request mail service envelopes, refills or to speak to a specialty-trained pharmacist or nurse regarding the Specialty Pharmacy Program, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447).** Choose The Empire Plan Prescription Drug Program, and select the 2014 benefits option.

Mail Order Pharmacy

You may fill your prescription by mail through the CVS Caremark Mail Order Pharmacy by using the mail service envelope. For envelopes and refill orders, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447),** choose Prescription Drug Program, and select the 2014 benefits option. To refill a prescription on file with the mail order pharmacy, you may order by phone or download order forms online at the New York State Department of Civil Service web site at https://www.cs.ny.gov. Select Benefit Programs, then NYSHIP Online and follow the prompts to the NYSHIP Online homepage. Click on Find a Provider and scroll down to CVS Caremark Pharmacy Mail Order Form.

Non-Network Pharmacy

If you do not use your benefit card at a network or non-network pharmacy and pay the full retail cost of your prescription, you must submit a claim for reimbursement to The Empire Plan Prescription Drug Program, c/o CVS Caremark, P.O. Box 52136, Phoenix, AZ 85072-2136. If your prescription was filled with a generic drug or a covered brand-name drug with no generic equivalent, you will be reimbursed up to the amount the program would reimburse a network pharmacy for that prescription. If your prescription was filled with a covered brand-name drug that has a generic equivalent, you will be reimbursed up to the amount the program would reimburse a network pharmacy for filling the prescription with that drug's generic equivalent. In most cases, you will not be reimbursed the total amount you paid for the prescription.

Dental Program

The Student Employee Health Plan Dental Program (through EmblemHealth) provides coverage for dental care. Visits to a participating Dental Program provider for covered services are subject to a $20 copayment and limited to two visits per 12-month period per covered individual.

Covered Services

- Initial examination, including charting
- Periodic examination
- Cleaning
- Bitewing X-rays, maximum four X-rays per year

Up to two fillings per 12-month period are covered subject to a $10 copayment per filling when you visit a SEHP dental program participating provider. Certain guidelines apply based on the type of material (e.g. amalgam, composite resin) used in the filling. In some cases, additional out-of-pocket costs may apply.

Participating Provider: To locate a SEHP Dental Program participating provider, you can link to the EmblemHealth web site by accessing https://www.cs.ny.gov. From the homepage, click on Other Benefits and then choose Dental, or call **1-800-947-0101** for a list identifying EmblemHealth Discounted Dental Access Program participating providers.

EmblemHealth's Discounted Dental Access Program

As part of the SEHP dental program, you will be automatically enrolled in EmblemHealth's Discounted Dental Access Program. If you utilize a provider who participates in the EmblemHealth Discounted Dental Access Program (and receive services other than the covered services above), you are required to pay the provider directly for all care received, and your liability is reduced to a prearranged discounted access rate. You are not subject to precertification or eligibility verification when you utilize the discounted program.

Participating Provider: To locate a participating provider in the EmblemHealth Discounted Dental Access Program, please call EmblemHealth's Dedicated Customer Service Center at **1-800-947-0101** for a list identifying EmblemHealth Discounted Dental Access Program participating providers.

Administration

For **Eligibility** questions, please contact the Health Benefits Administrator (HBA) on your campus.

For **Customer Service**, please contact EmblemHealth's Dedicated Customer Services Center at **1-800-947-0101** after you have enrolled.

Correspondence: Please direct your correspondence to:

EmblemHealth
Attn: NYS Dental Customer Service
P.O. Box 12365
Albany, NY 12212-2365

Please be sure to include your identification number on all correspondence.

ID Card: You will receive a separate identification card from EmblemHealth. Present this EmblemHealth identification card before you receive services from a provider who participates in the SEHP Dental Program and/or an EmblemHealth Discounted Dental Access Program provider.

Vision Program

Network Benefits

You are covered for a routine eye exam, subject to a $10 copayment once in any 24-month period (based on your last date of service).

A limited selection of frames and lenses or daily wear, disposable or planned replacement contact lenses offered by a participating provider at the time and place of an eye exam will be paid in full. This benefit is available only once in any 24-month period. There is no coverage for services received from a non-participating provider.

To Confirm Eligibility or Locate a Network Provider

Contact Davis Vision, the plan administrator, at **1-888-588-4823** or link to their web site by accessing https://www.cs.ny.gov. Choose Benefit Programs then NYSHIP Online, and choose your group, if prompted. From the homepage, click on Other Benefits and then choose Vision.

To Receive Services from a Network Provider

- Contact the network provider and schedule an appointment.
- Identify yourself as covered under the SEHP vision care program available through the NYS Vision Plan, which is administered by Davis Vision.
- Give the provider your name and date of birth, or member ID number.

The provider will confirm your eligibility and obtain an authorization to provide services. At the time of your appointment, you are responsible for a $10 copayment for vision services.

Exclusions

Services not covered under SEHP include, but are not limited to, the following:

- Adult immunizations (except as part of a covered routine health exam)
- Allergy extracts and injections
- Cardiac rehabilitation
- Care that is not medically necessary
- Cosmetic surgery
- Custodial care
- Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease
- Durable medical equipment and supplies unless provided in lieu of hospitalization and precertified under the Home Care Advocacy Program (HCAP)
- Experimental or investigative procedures
- Hearing aids
- Occupational therapy
- Orthotics
- Prosthetics (except breast prostheses, which are paid in full)
- Reversal of sterilization; assisted reproductive technology and other infertility services (except artificial/intra-uterine insemination and other services for which coverage is mandated by New York State Insurance Law); cloning
- Routine foot care
- Sex change
- Skilled nursing facility care including rehabilitation
- Speech therapy
- TMJ treatment (except when caused by a medical condition)
- Weight loss treatment (except for otherwise covered medical care and prescription drugs for treatment of morbid obesity)

Benefits On the Web

You'll find NYSHIP Online, the Employee Benefits Division homepage, on the New York State Department of Civil Service web site at https://www.cs.ny.gov. Select Benefit Programs, then follow the prompts to the NYSHIP Online homepage.

On your first visit, you will be asked what group and benefit plan you have. Thereafter, you will not be prompted to enter this information if you have your cookies enabled. Cookies are simple text files stored on your web browser to provide a way to identify and distinguish the users of this site. If enabled, cookies will customize your visit to the site and group-specific pages will then display each time you visit unless you select Change Your Group on a toolbar near the top left of the page.

Without enabling cookies, when you select your group and health benefits plan to view your group-specific health insurance benefits, you will be required to reselect your group and benefits plan each time you navigate the health benefits section of the web site or revisit the site from the same computer at another time.

NYSHIP Online is a complete resource for your health insurance benefits, including up-to-date publications. You'll also find links to select Empire Plan program administrator web sites. These web sites include the most current list of providers. You can search by location, specialty or name. Announcements, an event calendar, prescription drug information and handy contact information are only a click or two away.

Federal Health Care Reform

Grandfathered Health Plan

The Empire Plan benefit package provided to your group is a grandfathered plan, and as such is not required to implement certain features of health care reform that apply to non-grandfathered health plans.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the New York State Department of Civil Service, Employee Benefits Division, Albany, NY 12239. You may also contact the U.S. Department of Health and Human Services at http://www.hhs.gov/healthcare/insurance/grandfather/index.html.

Contact Information

Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447). Listen carefully to your choices and make your selection at any time. Check the list below.

Hospital Program
Empire BlueCross BlueShield
New York State Service Center
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Representatives are available Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

Medical/Surgical Program
UnitedHealthcare
P.O. Box 1600
Kingston, NY 12402-1600

Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time.

Mental Health and Substance Abuse Program
ValueOptions
P.O. Box 1800
Latham, NY 12110

Representatives are available 24 hours a day, seven days a week.

Prescription Drug Program
CVS Caremark
Customer Care Correspondence
P.O. Box 6590
Lee's Summit, MO 64064-6590

Representatives are available 24 hours a day, seven days a week.

Empire Plan NurseLine$_{SM}$
Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose The Empire Plan NurseLine$_{SM}$ for health information and support.

Representatives are available 24 hours a day, seven days a week.

Teletypewriter (TTY) numbers for callers who use a TTY because of a hearing or speech disability:

Hospital Program ..... TTY only 1-800-241-6894

Medical/Surgical Program.....TTY only 1-888-697-9054

Mental Health and Substance Abuse Program.....TTY only 1-855-643-1476

Prescription Drug Program.....TTY only 1-800-863-5488

The *NYSHIP Student Employee Health Plan (SEHP) At A Glance* is published by the Employee Benefits Division of the State of New York Department of Civil Service. The Employee Benefits Division administers the New York State Health Insurance Program (NYSHIP). NYSHIP provides your health insurance benefits. If you have questions, call 1-877-7-NYSHIP (1-877-769-7447) and choose the program you need.

New York State
Department of Civil Service
Employee Benefits Division
Albany, NY 12239

518-457-5754 (Albany area) 1-800-833-4344
(U.S., Canada, Puerto Rico, Virgin Islands)
https://www.cs.ny.gov

This document provides a brief look at SEHP medical, dental and vision care benefits. If you have any questions or need claim forms, call the appropriate benefits carrier.

New York State
Department of Civil Service
Employee Benefits Division
P.O. Box 1068
Schenectady, New York 12301-1068
https://www.cs.ny.gov

Address Service Requested

! Please do not send mail or correspondence to the return address above. See boxed address on page 23.

Save this document

NYSHIP
New York State Health Insurance Program

Information for the Enrollee, Enrolled Spouse/ Domestic Partner and Other Enrolled Dependents

SEHP At A Glance– January 2014 – Revised

Notice of Access to Women's Health Services

This notice is provided in accordance with the NYS Women's Health and Wellness Act. The Plan provides direct access to primary and preventive obstetric and gynecologic services for no fewer than two examinations annually. The Plan covers services required as a result of such examinations. The Plan covers services required as a result of an acute gynecologic condition. The Plan covers all care related to pregnancy. Benefits for these services are paid according to the terms of network or non-network coverage.

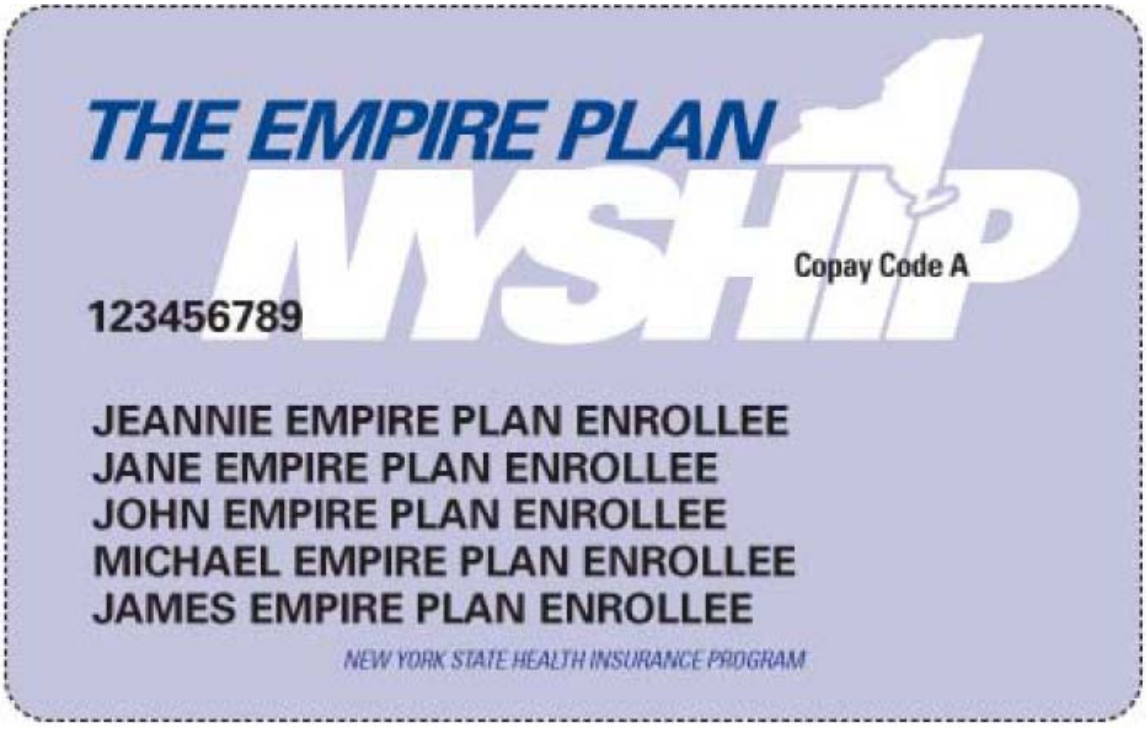
Benefits Management Program requirements apply. See page 3.

Annual Notice of Mastectomy and Reconstructive Surgery Benefits

The Plan covers inpatient hospital care for lymph node dissection, lumpectomy and mastectomy for treatment of breast cancer for as long as the physician and patient determine hospitalization is medically necessary. The Plan covers all stages of reconstructive breast surgery following mastectomy, including surgery of the other breast to produce a symmetrical appearance. The Plan also covers treatment for complications of mastectomy, including lymphedema and breast prostheses.

Benefits Management Program requirements apply. See page 3.

EMPIRE PLAN MENTAL HEALTH/SUBSTANCE ABUSE PROGRAM FOR THE EMPIRE PLAN BENEFIT CARD



Mental Health and Substance Abuse Program for the Empire Plan,
Student Employee Health Plan RFP, Student Employee Health Plan Card

NYSHIP

Student Employee Health Plan

1-877-7-NYSHIP (1-877-769-7447)

JOHN SAMPLE
890490011

Effective until 08/31/14 or when coverage ends, whichever is sooner

Hospital benefits

- $200 copayment per admission / inpatient hospital stays
- $15 copayment / outpatient hospital services
- $25 copayment / emergency room
- $10 copayment / physical therapy

Medical benefits

- $10 copayment / office visit, office surgery, laboratory services, radiology, chiropractic treatment, physical therapy

Mental Health / Substance Abuse benefits

- $200 copayment per admission / Mental Health or substance abuse detoxification stay
- $25 copayment / emergency room
- $10 copayment / outpatient visit

Rx benefits

Network Pharmacy 30 days/ Mail Service or Specialty Pharmacy 90 days*

- $5/$5* Level 1 or generic
- $15/$20* Level 2 or preferred brand-name
- $40/$65* Level 3 or nonpreferred brand-name

You must call

Toll Free
1-877-7-NYSHIP
1-877-769-7447

Precertification required for:
Admission to a hospital or birthing center: Select the Hospital Program. For an emergency admission, call within 48 hours.

Outpatient MRI, MRA, CT, PET and nuclear medicine tests: Select the Medical Program

Mental Health and/or Substance Abuse Services: non-emergency admissions, ABA therapy, psychological testing, electro-convulsive treatment. For emergency admissions, call within 48 hours. Select Mental Health and Substance Abuse Program.

Home Care and Diabetic Supplies/Equipment: Select the Medical Program

This card represents but does not guarantee enrollment in the New York State Health Insurance Program. It is insurance fraud for an enrollee or dependent to use the card to obtain services after eligibility for coverage ends.

Submit hospital and hospice claims to your local Blue Cross and/or Blue Shield Plan. Hospital and related services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent BlueCross and BlueShield Plans.

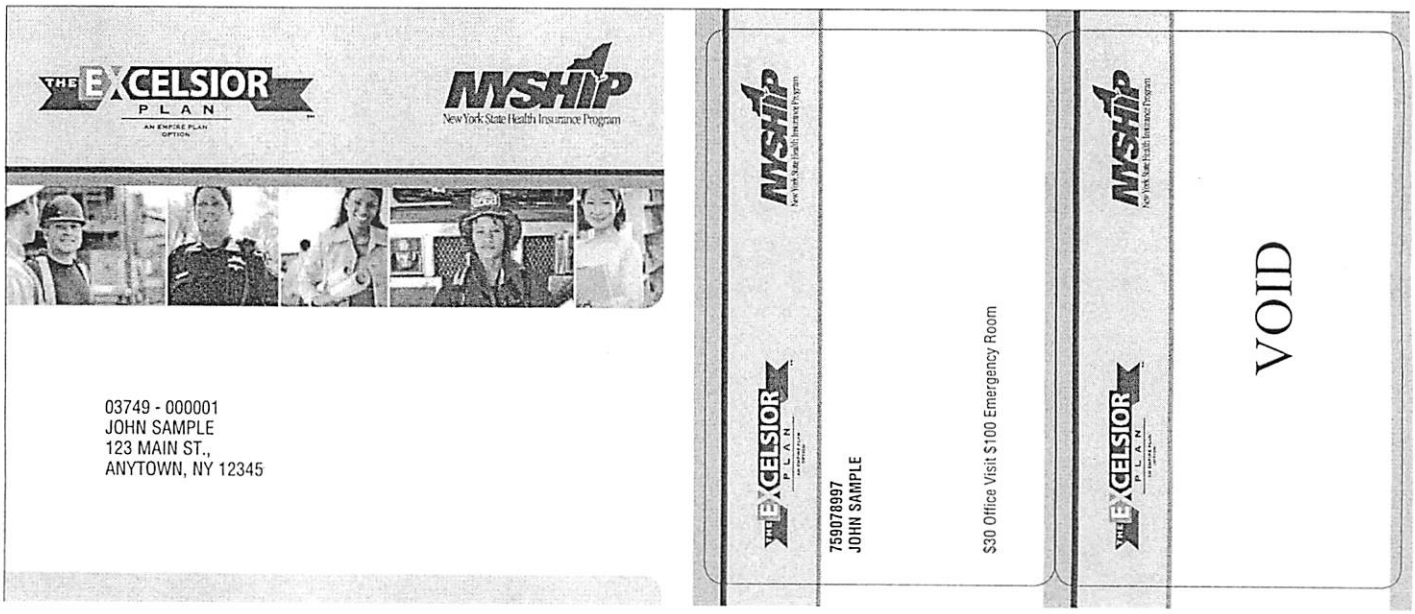
PPO
HOSPITAL ONLY

BLUE CROSS
PLAN 303

Blue Cross Prefix: YLS

Administered by the New York State Department of Civil Service

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan
Student Employee Health Plan RFP, Excelsior Benefit Card



For enrollee services, precertification & provider relations, please call:
1-877-7-NYSHIP
(1-877-769-7447)

Providers: This card represents but does not guarantee enrollment in the New York State Health Insurance Program (NYSHIP) for Government Employees.

Submit hospital, skilled nursing facility and hospice claims to your local Blue Cross and/or Blue Shield Plan.

Hospital and related services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

PPO HOSPITAL ONLY BLUE CROSS PLAN 393 Blue Cross PreEx YLS

Submit medical provider claims in accordance with your participating provider agreement.

UnitedHealthcare®

Group# UH0712959

All other non-hospital providers call 1-877-769-7447 for information about eligibility, benefits and claims submission.

Administered by the New York State Department of Civil Service.

- Attached is your Excelsior Plan benefit card(s). If you have family coverage and our records indicate that your dependent(s) resides at an address different from your address, a separate card with the name(s) of that dependent(s) will be mailed to the other address.
- This carrier holds two benefit cards. If you have individual coverage, you will receive one card. The second card will be blank. If you have family coverage, you will receive up to two carriers and four cards in this envelope.
- Each card may contain up to five names. Additional dependents will appear on a separate card, mailed in the same envelope. Check to be sure that all names are listed on the card(s).
- If you have questions, contact your current or former (if retiree) agency.

IMPORTANT NOTICE: The Excelsior Plan benefit card with the name of the individual receiving the service must be presented to the doctor or other health care provider (including pharmacies, if applicable) before receiving services. If you do not bring the card, services may be denied.

Receipt of the benefit card(s) does not mean that coverage is in effect. Do not use your card before coverage begins or after coverage ends. It is insurance fraud to knowingly use the card to obtain services when coverage is not effective. If it was determined later that you were not eligible for benefits at the time services were provided, you may be responsible for any amount paid on your behalf.

Q42712000001

Exhibit II.F

"Mental Health & Substance Abuse Program for the Empire Plan, Excelsior Plan, and Student Employee Health Plan RFP"
Reports Due Dates

Report Name	Brief Description	Frequency	Due Date(s)
Contract Management Reports			
Utilization	Quarterly summary of utilization trends for I/P, ALOC, and O/P services, as well as compliance with performance standards.	Quarterly	60 days from the end of the quarter
Performance Guarantees	Quarterly summary of compliance with performance standards.	Quarterly	60 days from the end of the quarter
Annual Report	Annual summary of utilization, performance, and future direction of the program	Annual	March 15th
Financial Management Reports			
Annual Financial Statement	Financial Settlement for the Plan Year just ended	Annually	March 15th
Annual Premium Renewal	Proposal for Forthcoming Plan Year Premium Rates and Retention charges	Annually	September 1st
Quarterly Statement of Experience	Plan Year financial experience through the quarter just ended plus projected financial experience for the entire Plan Year (also includes projected rate development for the forthcoming Plan Year and Qtrly Trend Statistics)	Quarterly	15th day after end of quarter
Monthly Paid Claims by Month of Incurral	Paid claims by core, enhancements, and benefit program	Monthly	15th day after end of month
Quarterly Paid Claims by Type of Service	Paid Claims ($ amt and # of svcs) during the quarter just ended by Type of Sevice; broken out by BP, EE/DEP, Year of Incurral, In/Out Network, Core/Enhancements	Quarterly	15th day after end of quarter
PA Mediprime Claims	Paid Claims ($ amt and # of svcs) per PA during the quarter just ended; broken out by Coverage Type, Year of Incurral, In/Out Network, EE/DEP, Medicare/No Medicare, Core/Enhancements	Quarterly	15th day after end of quarter
Claim Production Report	Summary of claims processed for the month just ended (also aging of claims): paid, declined, deductible not satisfied, other and # outstanding	Monthly	15th day after end of month
Coordination of Benefits Report	Medicare and Other COB Savings for the month just ended (and all prior current calendar year months)	Monthly	15th day after end of month
Copayment Savings Report	Outpatient Participating Provider Paid Claim Dollars per Month and Related Per Month Co-Payment Dollars	Monthly	15th day after end of month
In-Network Triangle Report	Total Paid In-Network claims per month of incurral; separate triangles for Empire, Excelsior and SEHP.	Monthly	15th day after end of month
Out-Network Triangle Report	Total Paid Out-of-Network claims per month of incurral; separate triangles for Empire, Excelsior and SEHP.	Monthly	15th day after end of month
Claims Paid by Agency	Enrollee and Dependent Paid Claims per agency for the Plan Year just ended	Annually	January 31st
Audit Reports			
Claim Data	Individual claim transactions	Monthly	

Empire Plan Mental Health & Substance Abuse

Financial Reports Specifications and Due Dates

REQUIRED DATA FIELDS FOR MHSA MIS REPORTS

	Report		Description	Field Name
(a)	IA. Monthly Paid Claims by Month of Incurral	1	Month Paid	MONTH PAID
		2	Year Paid	YEAR PAID
		3	Month Incurred	MONTH INC
		4	Year Incurred	YEAR INC
		5	Benefit Program Code	PROGRAM/BPI
		6	Benefit Type (Core, NY Enhancement or PA Enhancement)	BENEFIT TYPE
		7	Network (In-Network or Non-Network)	NETWORK
		8	Medicare Primary (Yes or No)	MEDICARE
		9	# of Services: Enrollees	EE SERVICES
		10	$ Amount Paid: Enrollees	EE PAID
		11	# of Services: Dependents	DEP SERVICES
		12	$ Amount Paid: Dependents	DEP PAID
		13	# of Services: Total	TOTAL SERVICES
		14	$ Amount Paid: Total	TOTAL PAID
(b)	IIA. Quarterly Paid Claims by Type of Service	1	Quarter and Year Paid	QTR PAID
		2	Year Incurred	YEAR INC
		3	Benefit Program Code	PROGRAM/BPI
		4	Benefit Type (Core, NY Enhancement or PA Enhancement)	BENEFIT TYPE
		5	Network (In-Network or Non-Network)	NETWORK
		6	Type of Service & Type for GAUC	TOS
		7	# of Services: Enrollees	EE SERVICES
		8	$ Amount Covered: Enrollees	EE COVERED
		9	$ Amount Paid: Enrollees	EE PAID
		10	# of Services: Dependents	DEP SERVICES
		11	$ Amount Covered: Dependents	DEP COVERED
		12	$ Amount Paid: Dependents	DEP PAID
		13	# of Services: Total	TOTAL SERVICES
		14	$ Amount Covered: Total	TOTAL COVERED
		15	$ Amount Paid: Total	TOTAL PAID
(c)	IB. PA Claims (Medicare/Non Medicare)	1	Quarter and Year Paid	QTR PAID
		2	Year Incurred	YEAR INC
		3	Benefit Type (Core, NY Enhancement or PA Enhancement)	BENEFIT TYPE
		4	Network (In-Network or Non-Network)	NETWORK
		5	Agency Code	AGNCYCD
		6	Coverage (Individual or Family)	COV
		7	Medicare Primary (Yes or No)	MEDICARE
		8	# of Services: Enrollees	EE SERVICES
		9	$ Amount Paid: Enrollees	EE PAID
		10	# of Services: Dependents	DEP SERVICES
		11	$ Amount Paid: Dependents	DEP PAID
		12	# of Services: Total	TOTAL SERVICES
		13	$ Amount Paid: Total	TOTAL PAID
(d)	IVG. Annual Claims & Credits Paid by Agency	1	Year Paid	YEARPD
		2	Year Incurred	YEARINC
		3	Network (In-Network or Non-Network)	NETWORK
		4	Agency Code	AGNCYCD
		5	Enrollee or Dependent Claim	EEDEP
		6	Enrollee Type (Active, Retiree or Other)	EE Type
		7	Number of Claims	CLAIMS
		8	Amount Paid	AMTPD
		9	Name of MHSA Progam Carrier	CARRIER

Empire Plan MHSA Program Selected Utilization Data **Exhibit II.F2**

Year 2009

Participating

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	1,434,671	68,624	1,062,551	1350.21	20.91
	SA	65,232	2,817	1,062,551	61.39	23.16

	MH/SA	Admits Authorized	Unique Members
Inpatient	MH	2,792	2,176
	SA	926	771

	MH/SA	Admits Authorized	Unique Members
Partial Hospitalization	MH	583	486
	SA	78	77

	MH/SA	Admits Authorized	Unique Members
Residential	MH	64	54
	SA	385	365

Subtotal- Participating	1,504,731	75,370

Non-Participating

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	479,168	23,932	1,062,551	450.96	20.02
	SA	17,980	920	1,062,551	16.92	19.54

	MH/SA	Admits Authorized	Unique Members
Inpatient	MH	508	422
	SA	127	117

	MH/SA	Admits Authorized	Unique Members
Partial Hospitalization	MH	54	45
	SA	56	54

	MH/SA	Admits Authorized	Unique Members
Residential	MH	5	2
	SA	29	27

Subtotal-Non-Participating	497,927	25,519
Total -2009	2,002,658	100,889

Year 2010

Exhibit II.F2

Participating

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	1,209,337	63,774	1,077,271	1122.59	18.96
	SA	79,626	3,279	1,077,271	73.91	24.28

	MH/SA	Admits Authorized	Unique Members
Inpatient	MH	2,661	2,071
	SA	712	600

	MH/SA	Admits Authorized	Unique Members
Partial Hospitalization	MH	586	489
	SA	150	140

	MH/SA	Admits Authorized	Unique Members
Residential	MH	52	47
	SA	262	243

Subtotal - Participating	1,293,386	70,643

Non-Participating

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	278,358	14,024	1,077,271	258.39	19.85
	SA	4,784	329	1,077,271	4.44	14.54

	MH/SA	Admits Authorized	Unique Members
Inpatient	MH	410	362
	SA	227	205

	MH/SA	Admits Authorized	Unique Members
Partial Hospitalization	MH	34	32
	SA	89	77

	MH/SA	Admits Authorized	Unique Members
Residential	MH	0	0

	SA	23	23
Subtotal - Non-Participating		283,925	15,052
Total-2010		1,577,311	85,695

Year 2011

Exhibit II.F2

Participating

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	1,316,823	65,604	1,100,707	1196.34	20.07
	SA	101,388	3,809	1,100,707	92.11	26.62

	MH/SA	Admits Authorized	Unique Members
Inpatient	MH	2,612	2,082
	SA	568	511

	MH/SA	Admits Authorized	Unique Members
Partial Hospitalization	MH	540	459
	SA	200	185

	MH/SA	Admits Authorized	Unique Members
Residential	MH	52	44
	SA	382	361

Subtotal - Participating 1,422,565 73,055

Non-Participating

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	303,589	13,425	1,100,707	275.81	22.61
	SA	5,018	296	1,100,707	4.56	16.95

	MH/SA	Admits Authorized	Unique Members
Inpatient	MH	337	299
	SA	661	530

	MH/SA	Admits Authorized	Unique Members
Partial Hospitalization	MH	41	38

Hospitalization	SA	197	172

	MH/SA	Admits Authorized	Unique Members
Residential	MH	2	2
	SA	20	20

Subtotal- Non-Participating	309,865	14,782
Total -2011	1,732,430	87,837

Year 2012 (through November 2012)

Exhibit II.F2

Participating

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	1,053,628	55,362	1,098,064	959.53	19.03
	SA	96,163	3,542	1,098,064	87.58	27.15

	MH/SA	Admits Authorized	Unique Members
Inpatient	MH	2,512	1,973
	SA	592	523

	MH/SA	Admits Authorized	Unique Members
Partial Hospitalization	MH	534	456
	SA	144	133

	MH/SA	Admits Authorized	Unique Members
Residential	MH	38	30
	SA	529	496

Subtotal - Participating 1,154,140 62,515

Non-Participating

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	244,435	10,701	1,098,064	222.61	22.84
	SA	3,442	206	1,098,064	3.13	16.71

	MH/SA	Admits Authorized	Unique Members
Inpatient	MH	324	286
	SA	646	536

	MH/SA	Admits Authorized	Unique Members
Partial Hospitalization	MH	51	42
	SA	285	224

	MH/SA	Admits Authorized	Unique Members
Residential	MH	0	0
	SA	13	13
Subtotal- Non-Participating		249,196	12,008
Total - 2012		1,403,336	74,523

Year 2013 (through December 2013)

Exhibit II.F2

Participating

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	1,272,193	49,555	1,096,200	1160.55	25.67
	SA	98,716	3,154	1,096,200	90.05	31.30

	MH/SA	Admits Authorized	Unique Members
Inpatient	MH	2,662	2,091
	SA	727	621

	MH/SA	Admits Authorized	Unique Members
Partial Hospitalization	MH	537	467
	SA	169	154

	MH/SA	Admits Authorized	Unique Members
Residential	MH	60	43
	SA	641	581

Subtotal - Participating 1,375,705 56,666

Non-Participating

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	251,771	8,556	1,096,200	229.68	29.43
	SA	2,579	136	1,096,200	2.35	18.96

	MH/SA	Admits Authorized	Unique Members
Inpatient	MH	333	282
	SA	795	627

	MH/SA	Admits Authorized	Unique Members
Partial Hospitalization	MH	51	48
	SA	457	376

	MH/SA	Admits Authorized	Unique Members
Residential	MH	4	3
	SA	8	8
Subtotal- Non-Participating		255,998	10,036
Total - 2013		1,631,703	66,702

Empire Plan Mental Health / Substance Abuse Program **Exhibit II.F3**
Abbreviated Sample of a Quarterly Performance Guarantee Report

PERFORMANCE GUARANTEE CATEGORY	PERFORMANCE GUARANTEE STANDARD	1st QTR	2nd QTR	3rd QTR	4th QTR
Network Access Facility	**NYS Urban:** The Contractor guarantees at least ninety-five percent (95%) of Enrollees in urban areas will have access to a Network Facility. The minimum access guarantee for Enrollees in urban areas is at least one (1) Network Facility within five (5) miles of an Enrollee's home.				
	NYS Suburban: The Contractor guarantees at least ninety-five percent (95%) of Enrollees in suburban areas will have access to a Network Facility. The minimum access guarantee for Enrollees in suburban areas is at least one (1) Network Facility within fifteen (15) miles of an Enrollee's home.				
	NYS Rural: The Contractor guarantees at least ninety-five percent (95%) of Enrollees in rural areas will have access to a Network Facility. The minimum access guarantee for Enrollees in rural areas is at least one (1) Network Facility within forty (40) miles of an Enrollee's home.				
Network Access Practitioner	**NYS Urban:** The Contractor guarantees at least ninety-five percent (95%) of Enrollees in urban areas will have access to a Network Practitioner. The minimum access guarantee for Enrollees in urban areas is at least one (1) Network Practitioner within three (3) miles of an Enrollee's home.				
	NYS Suburban: The Contractor guarantees at least ninety-five percent (95%) of Enrollees in suburban areas will have access to a Network Practitioner. The minimum access guarantee for Enrollees in suburban areas is at least one (1) Network Practitioner within fifteen (15) miles of an Enrollee's home.				
	NYS Rural: The Contractor guarantees at least ninety-five percent (95%) of Enrollees in rural areas will have access to a Network Practitioner. The minimum access guarantee for Enrollees in rural areas is at least one (1) Network Practitioner within forty (40) miles of an Enrollee's home.				
Provider Credentialing	The Contractor guarantees that within sixty (60) Days of receipt of a complete Provider application to join the Empire Plan Network, the review, including credentialing, will be completed and the Practitioner, program or facility notified of the determination.				

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Mental Health & Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan
Shared Accumulator file layout

Header Record

Seq	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required?	Outbound (From UHG)	Inbound (To UHG)
1	Record Code	N	1	1	1	Always a zero (0) - indicating file header record.	9(1)		Yes	'1'	'1'
2	Sender ID	A/N	2	11	10	Indicates sender of file	X(10)	Left Justified	Yes	UHG	
3	Processor Name	A/N	12	31	20	Vendor Name	X(20)	Left Justified	Yes	UNITEDHEALTH GROUP	
4	Processor Address	A/N	32	51	20	Vendor Address	X(20)	Left Justified	Yes	9900 BREN ROAD EAST	
5	Processor City	A/N	52	69	18	Vendor City	X(18)	Left Justified	Yes	HOPKINS	
6	Processor State	A/N	70	71	2	Vendor State	X(2)	Left Justified	Yes	MN	
7	Processor Zip	A/N	72	80	9	Vendor Zip Code	X(9)	Left Justified	Yes	55343	
8	Processor Phone	N	81	90	10	Format: AAAEEENNNN	AAAEEENNNN	Right Justified	Yes	9529361300	
9	Receiver ID	A/N	91	100	10	Indicates receiver of file. (Vendor assigned Id to indicate UHG)	X(10)	Left Justified	Yes	TBD	UHG
10	Run Date	N	101	108	8	Date on which File was generated by processor.	CCYYMMDD		Yes	Date as of the beginning of processing	Date as of the beginning of processing
11	Run Time	A/N	109	116	8	Time the file was generated by processor.	HH:MM:SS		Yes	Time as of the beginning of processing	Time as of the beginning of processing
12	File Content Type	A/N	117	117	1	T - Test, P - Production	X(1)		Yes	'T' OR 'P'	'T' OR 'P'
13	Version Number	A/N	118	120	3	Indicates the Claim Detail Layout version number of the file. (Current verion = 001)	X(3)		Yes	Always 001	Always 001

14	Filler	A/N	121	600	480	Filler			Yes		

Detail Record

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
1	Record Code	N	1	1	1	Always a four (4) - indicates that this record is a detail record.	9(1)		Yes	'4'	
2	Batch Number	N	2	6	5	Assigned by the processor, Julian Date Format YYDDD.	YYDDD		Yes	For a weekly file, the batch number will be the end of the week date in Julian format.	
3	Transaction ID	A/N	7	26	20	Number assigned by vendor to uniquely identify the transaction.	x(20)	Right Justified	NO		
4	Record Type Code	A/N	27	27	1	Identifies the type of Claim 1 - Pharmacy Claim 2 - Medical Claim 3 - Mental Health/Substance Abuse Claim 4 - Durable Medical Equipment Claim 5 - Dental Claim 6 - Vision Claim ? - Future Values	X(1)		Yes		
5	Carrier Number	A/N	28	35	8	Account Number assigned by vendor during installation.	X(8)	Left Justified - Trailing Spaces	Yes	UHG POLICY NUMBER (FIRST 6 POSITIONS POPULATED)	
6	Adjustment Type	A/N	36	36	1	Type of adjustment: 1 - Claim 2 - Adjustment	X(1)		Yes	If adjustment is negative, the claim amounts sent need to be negative.	

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
7	Adjustment Code	A/N	37	38	2	A two position field representing the type of adjustment: AJ - Supplement CR - Credit	X(2)		NO	BLANK	
8	Adjustment Reason Code	A/N	39	41	3	Reason for adjustment Values TBD - Future Reporting	X(3)	Left Justified	NO	BLANK	
9	Group ID	A/N	42	57	16	To indicate which Plan Eligibility/Benefit is applicable for the claim.	X(16)	Left Justified with trailing spaces.	NO	BLANK	
10	Prescription/ Service Reference Number	A/N	58	66	9	Number assigned to uniquely identify the claim.	X(9)	Left Justified with trailing spaces.	NO	BLANK	
11	Fill Number	N	67	68	2	Code identifying whether the prescription is an original (00) or by refill number (01-99) 00 - New 01-99 - Refill Number This field represents the Fill Number as submittetd by the pharmacy. The "Fill Number Calculated" field provides the Fill Number	9(2)	Right Justified	NO	BANK	
12	Adjudication Date	N	69	76	8	Indicates the date the transaction was processed by vendor.	CCYYMMDD		NO		
13	First Date Of Service	N	77	84	8	Indicates the first date that the prescription/service was dispensed/provided as submitted by the dispensing pharmacy, or source documents for direct claims.	CCYYMMDD		Yes		

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
14	Last Date Of Service	N	85	92	8	Indicates the last date that the prescription/service was dispensed/provided as submitted by the dispensing pharmacy, or source documents for direct claims.	CCYYMMDD		Yes		
15	Cardholder ID	A/N	93	112	20	Cardholder Id number as submitted by vendor or provided on direct claim.	X(20)	Left Justified	Yes	ID USED TO ADJUDICATE THE CLAIM. COULD BE ALT ID OR SSN.	
16	Cardholder Id Qualifier	A/N	113	114	2	Code qualifying the 'Cardholder ID' field. Values: Blank - Not Specified 01 - Social Security Number 99 - Other	X(2)	Left Justified	NO		
17	Patient Id	A/N	115	134	20	ID assigned to the patient as provided in eligibility.	X(20)	Left Justified	NO	BLANK	
18	Patient First Name	A/N	135	159	25	Patient's first name as it appears in eligibility data provided to vendor.	X(25)	Left Justified	Yes		
19	Patient Middle Initial	A/N	160	184	25	Patient's middle name as it appears in eligibility or submitted by member for direct claims.	X(25)	Left Justified	NO	BLANK	
20	Patient Last Name	A/N	185	219	35	Patient's last name as provided in eligibility data if available.	X(35)	Left Justified	Yes		
21	Patient Gender	N	220	220	1	Gender of patient based on eligibility data Values: 0 - Unknown 1 - Male 2 - Female	9(1)		Yes		

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
22	Patient Date of Birth	N	221	228	8	Patient's birth date as provided in eligibility data.	CCYYMMDD		Yes		
23	Patient Relationship Code	A/N	229	229	1	The relationship code as defined by NCPDP indicating the patient's relationship to the subscriber. Values: 1 - Cardholder 2 - Spouse 3 - Child 4 - Other	X(1)		Yes		
24	Service Provider ID Qualifier	A/N	230	231	2	Identifies the type of data being submitted in the Service Provider ID field. Values: Blank - Not Specified 01 - National Provider Identifier (NPI) 02 - Blue Cross 03 - Blue Shield 04 - Medicare 05 - Medicaid 06 - UPIN 07 - NCPDP Provider ID 08 - State	X(2)	Left Justified	NO	BLANK	
25	Service Provider ID	A/N	232	241	10	Code assigned to identify the provider as qualified by the Service Provider ID Qualifier.	X(10)	Left Justified	NO	BLANK	
26	Pharmacy Chain/Region	A/N	242	245	4	PBM assigned number used to link pharmacies that are part of a chain.	X(4)	Left Justified	NO	BLANK	
27	Provider Name	A/N	246	280	35	Name of Provider	X(35)	Left Justified	NO		

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
28	Provider Address	A/N	281	335	55	Address of Provider	X(55)	Left Justified	NO		
29	Provider City	A/N	336	365	30	City of Provider	X(30)	Left Justified	NO		
30	Provider State	A/N	366	367	2	State Abbreviation of Provider	X(2)	Left Justified	NO		
31	Provider Zip	A/N	368	382	15	Zip code of Provider	X(15)	Left Justified	NO		
32	Provider Phone Number	A/N	383	392	10	Phone Number of Provider	X(10)	Left Justified	NO		
33	Provider TAX ID Number	A/N	393	401	9	Provider Tax ID Number	X(9)	Left Justify	NO		
34	Pharmacy County Code	A/N	402	404	3	Indicates the county of the pharmacy using the FIPS codeset (Federal Information Processing Standards). Values: A full list of values can be found at: http://www.itl.nist.gov/fipspubs/co-codes/states.txt	X(3)	Left Justified	NO	BLANK	
35	Pharmacy Class Code	A/N	405	405	1	Indicates class of the pharmacy: Values: 1 - Class 1 Pharmacy 2 - Class 2 Pharmacy 3 - Mail Service Pharmacy 4 - Home Health Care (Class 1) 5 - Home Health Care (Class 2) 6 - Nursing Home (Class 1) 7 - Nursing Home (Class 2) 8 - Medicaid Agency 9 - Dept	X(1)		NO	BLANK	
36	IN/OUT of Network Indicator	A/N	406	406	1	Indicates whether the amount was applied to the In or Out of Network benefits. Values: I - In Network O - Out of Network	X(1)	Left Justifified	Yes		

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
37	Client Amount Due	N	407	414	8	Amount to be paid to the provider representing the cost of the product\service less patient/other payer amounts.	s9(6)v9(2)	Right Justified	NO	For future expansion.	
38	Other Payer Amount Paid	N	415	422	8	Amount paid by another payer (Primary, coupon, major medical, Medicare, Medicaid). If multiple other payers exist, this field represents the total of all payments.	s9(6)v9(2)	Right Justified	NO	For future expansion.	
39	COINS	N	423	430	8	Amount to be collected from the patient that is included in 'Patient Paid Amount' that is due to a per prescription copay/coinsurance.	s9(6)v9(2)	Right Justified	YES	COINSURANCE	
40	Deductible	N	431	438	8	Portion of Patient Paid Amount applied to deductible.	s9(6)v9(2)	Right Justified	Yes	DEDUCT ATTACHED TO THE CLAIM	
41	Deductible Total Remaining Amount	N	439	448	10	Indicates the updated accumulated deductible total amount for the patient.	s9(8)v9(2)	Right Justified	NO	TOTAL DEDUCT FOR THE PROCESS DATE	
42	Deductible Remaining Amount/Limit	N	449	458	10	From UHG to the vendor, indicates amount of deductible remaining until deductible limit is reached for the patient. From vendor to UHG, indicates the deductible limit.	s9(8)v9(2)	Right Justified	NO	TOTAL REMAINING DEDUCT (LIMIT – YTD DEDUCT DOLLARS)	
43	Out Of Pocket Apply Amount	N	459	466	8	Amount applied to out of pocket expense.	s9(6)v9(2)	Right Justified	Yes	OOP ATTACHED TO THE CLAIM	

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
44	Out of Pocket Total Accumulated Amount	N	467	476	10	Indicates the updated accumulated out of pocket total amount for the patient.	s9(8)v9(2)	Right Justified	NO	TOTAL OOP FOR THE PROCESS DATE	
45	Out of Pocket Remaining Amount/Limit	N	477	486	10	From UHG to the vendor, indicates the amount of OOP remaining until out of pocket maximum is reached for the patient. From vendor to UHG, indicates the OOPM limit.	s9(8)v9(2)	Right Justified	NO	TOTAL REMAINING OOP (LIMIT – YTD OOP DOLLARS)	
46	Plan Year	N	487	494	8	Plan year in which the claim is effective.	CCYYMMDD		Yes	EFFECTIVE DATE	
47	Filler	A/N	495	600	106	Default to Spaces	X(106)	Left Justified - Trailing Spaces	Optional	For future expansion - default to spaces.	

Trailer Record

Seq	Field Name	Data Type	Start	End	Length	Descripton	Format	Justification	Outbound (From UHG)	Inbound (To UHG)
1	Record Code	N	1	1	1	Always an eight (8) - indicating a file trailer record.	9(1)		'8'	'8'
2	Sender ID	A/N	2	11	10	Indicates sender of file	X(10)	Left Justified	UHG	
	Transaction Count		12	21	10	Sum of all Record Code "4" transactions included on file.	9(10)	Right Justified	9999999999	
3	Total Record Count	N	22	31	10	Sum of all records (including header, detail and trailer) on file.	9(10)	Right Justified	9999999999	
4	Filler	N	32	600	569	Filler		Right Justified		

Exhibit II.G

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Paid Claims by Benefit Type

Calendar Years 2009, 2010, 2011, 2012 and 2013

		Enrollee		Dependent		Total	
Year	**Type**	**# of Services (1)**	**Amount Paid**	**# of Services (1)**	**Amount Paid**	**# of Services (1)**	**Amount Paid**
2009	Core	507,279	$ 39,430,701	451,764	$ 47,107,454	959,044	$ 86,538,155
	NY Enhancement	11,304	$ 1,588,364	9,394	$ 1,430,754	20,698	$ 3,019,118
	PA Enhancement	11,892	$ 1,388,504	9,647	$ 1,248,322	21,539	$ 2,636,826
	Total	530,475	$ 42,407,569	470,805	$ 49,786,529	1,001,280	$ 92,194,098
2010	Core	607,432	$ 46,329,585	533,515	$ 53,619,442	1,140,947	$ 99,949,027
	NY Enhancement	14,980	$ 2,755,713	12,450	$ 2,649,805	27,429	$ 5,405,518
	PA Enhancement	16,235	$ 2,380,864	14,507	$ 2,532,391	30,742	$ 4,913,255
	Total	638,647	$ 51,466,163	560,472	$ 58,801,638	1,199,119	$ 110,267,801
2011	Core	639,257	$ 51,099,105	622,428	$ 68,865,728	1,261,686	$ 119,964,833
	NY Enhancement	17,331	$ 3,396,977	17,794	$ 4,853,832	35,125	$ 8,250,808
	PA Enhancement	18,635	$ 3,060,269	20,957	$ 5,181,635	39,592	$ 8,241,904
	Total	675,223	$ 57,556,350	661,179	$ 78,901,196	1,336,402	$ 136,457,546
2012	Core	623,588	$ 46,124,975	652,404	$ 70,333,254	1,275,992	$ 116,458,229
	NY Enhancement	13,485	$ 3,261,292	16,233	$ 5,869,040	29,718	$ 9,130,333
	PA Enhancement	13,085	$ 2,325,046	19,862	$ 6,266,701	32,947	$ 8,591,747
	Total	650,158	$ 51,711,313	688,499	$ 82,468,995	1,338,657	$ 134,180,309
2013	Core	600,752	$ 44,040,870	659,112	$ 69,981,297	1,259,865	$ 114,022,167
	NY Enhancement	12,002	$ 4,239,992	17,292	$ 8,295,794	29,294	$ 12,535,785
	PA Enhancement	10,899	$ 2,425,039	18,350	$ 7,525,506	29,248	$ 9,950,545
	Total	623,653	$ 50,705,901	694,754	$ 85,802,597	1,318,407	$ 136,508,498

(1) Represents days/visits

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

Selected Financial Data

Empire Plan Monthly Premium Rates: Groups With Plan Changes/Ratified Contracts (1)

Effective Date	Individual			Family		
	Core	NY Enhancement	PA Enhancement	Core	NY Enhancement	PA Enhancement
1/1/2009	$ 7.94	$ 0.50	$ 0.79	$ 25.58	$ 1.88	$ 2.32
1/1/2010	$ 9.15	$ 0.54	$ 0.85	$ 29.49	$ 1.78	$ 2.35
1/1/2011	$ 9.25	$ 0.64	$ 0.80	$ 29.29	$ 1.83	$ 2.43
1/1/2012	$ 9.92	$ 1.13	$ 1.59	$ 33.79	$ 3.65	$ 5.61
1/1/2013	$ 9.36	$ 0.84	$ 1.25	$ 38.53	$ 4.18	$ 7.49
1/1/2014	$ 8.97	$ 0.87	$ 1.38	$ 38.00	$ 4.06	$ 7.32

Empire Plan Monthly Premium Rates: Groups Not With Plan Changes/Not With Ratified Contracts (2)

Effective Date	Individual		Family	
	Core	NY Enhancement	Core	NY Enhancement
1/1/2009	$ 8.02	$ 0.50	$ 25.84	$ 1.90
1/1/2010	$ 9.29	$ 0.55	$ 29.95	$ 1.82
1/1/2011	$ 9.39	$ 0.65	$ 29.73	$ 1.86
1/1/2012	$ 10.36	$ 1.18	$ 35.29	$ 3.81
1/1/2013	$ 9.78	$ 0.88	$ 40.25	$ 4.37
1/1/2014	$ 9.37	$ 0.91	$ 39.68	$ 4.24

Excelsior Plan Monthly Premium Rates

Effective Date	Individual	Family
1/1/2009	$ 7.34	$ 23.55
1/1/2010	$ 8.45	$ 27.04
1/1/2011	$ 8.37	$ 26.52
1/1/2012	$ 10.02	$ 34.40
1/1/2013	$ 9.23	$ 40.19
1/1/2014	$ 8.64	$ 37.84

Student Employee Health Plan Monthly Premium Rates

Effective Date	Individual	Family
1/1/2009	$ 9.05	$ 20.91
1/1/2010	$ 15.88	$ 22.02
1/1/2011	$ 17.87	$ 32.15
1/1/2012	$ 23.60	$ 49.30
1/1/2013	$ 26.18	$ 63.26
1/1/2014	$ 29.38	$ 47.69

Empire Plan Average Enrollment

	Active		Retired		Total
Period	Individual	Family	Individual	Family	Contracts

Jan 2010 through Dec 2010	115,770	192,728	125,406	97,645	531,549
Jan 2011 through Dec 2011	105,792	191,109	129,535	102,628	529,064
Jan 2012 through Dec 2012	100,384	187,065	131,213	104,030	522,692
Jan 2013 through Dec 2013	99,282	184,641	133,006	103,959	520,888

Excelsior Plan Average Enrollment

Period	Active		Retired		Total
	Individual	Family	Individual	Family	Contracts
Jan 2010 through Dec 2010	68	76	28	8	180
Jan 2011 through Dec 2011	20	15	21	5	61
Jan 2012 through Dec 2012	37	51	90	66	244
Jan 2013 through Dec 2013	36	52	80	56	224

Student Employee Health Plan Average Enrollment

Period	Individual	Family	Total
Jan 2010 through Dec 2010	4,665	674	5,339
Jan 2011 through Dec 2011	4,688	754	5,442
Jan 2012 through Dec 2012	4,667	767	5,434
Jan 2013 through Dec 2013	4,617	772	5,389

NYS MHSA Experience

	2009	2010	2011	2012	2013 (1)
Premium	$ 120,763,967	$ 137,726,119	$ 139,059,341	$ 166,428,136	$ 182,983,268
Paid Claims (2)	93,709,449	112,247,862	139,245,444	136,258,401	138,450,961
Change in Reserves	22,604,882	(2,915,874)	1,845,503	(3,441,338)	5,409,686
(Credits)	(582,147)	-	-	-	-
Net Incurred Claim Cost	$ 115,732,184	$ 109,331,988	$ 141,090,947	$ 132,817,063	$ 143,860,647
Net Retention	18,130,019	19,674,973	20,599,446	19,297,100	23,072,241
Dividend/(Loss)	$ (13,098,236)	$ 8,719,158	$ (22,631,052)	$ 14,313,973	$ 16,050,380

(1) Represents CSEA, PEF, M/C's and Unrepresented Enrollees for each of these years. At various points in time during 2011 and 2012 N
(2) Represents UUP, PBA Troopers, PBA Supervisors, PIA and DC-37
(3) Represents preliminary/projected final experience for 2013 as of January 4, 2014 (2013 Fourth Quarter Report)
(4) Includes Paid Bad Debt and Charity

lYSCOPBA, APSU and Council-82 became part of this group.

Empire Plan Mental Health/Substance Abuse Program (1)
2011 Incurred Claims By Type of Service - Paid through December 31, 2013

IN-NETWORK

	Enrollees		Dependents		Total	
Type of Service Category	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**
Mental Health Acute Inpatient (2)	9,628	$6,329,007	17,908	$15,561,080	27,536	$21,890,087
Substance Abuse Acute Inpatient (2)	2,947	$1,565,112	3,496	$1,933,741	6,443	$3,498,853
Alcohol Rehab Acute Inpatient	487	$215,761	219	$132,997	706	$348,758
Day Treatment	2,372	$745,213	6,469	$2,413,158	8,841	$3,158,371
Residential	2,029	$729,765	2,846	$1,217,436	4,875	$1,947,201
Recovery Home	-	$0	-	$0	-	$0
Professional Services: Physician (3)	7,085	$242,517	5,598	$339,856	12,683	$582,373
Professional Services: Psychologist	7,186	$113,439	906	$22,468	8,092	$135,908
Professional Services: Other	518	$21,540	275	$24,946	793	$46,486
Outpatient & Med Mgt: Physician	132,479	$7,514,951	159,313	$9,038,396	291,792	$16,553,346
Outpatient & Med Mgt: Psychologist	138,241	$8,093,474	126,281	$7,887,792	264,522	$15,981,266
Outpatient & Med Mgt: Other	222,489	$9,888,387	200,985	$11,124,770	423,474	$21,013,157
Substance Abuse & Structured Outpatient	5,131	$755,566	8,898	$1,415,252	14,029	$2,170,818
Mental Health Structured Outpatient	2,015	$229,690	3,048	$619,459	5,063	$849,149
Electro Convulsive Therapy	827	$213,357	828	$312,418	1,655	$525,775
Ancillary Services	1,370	-$60,348	846	-$110,450	2,216	-$170,799
Total	534,804	$36,597,432	537,916	$51,933,319	1,072,720	$88,530,750

(1) Data is inclusive of the Empire Plan, the Excelsior Plan and the Student Employee Health Plan

(2) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(3) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(4) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

Empire Plan Mental Health/Substance Abuse Program (1)
2011 Incurred Claims By Type of Service - Paid through December 31, 2013

OUT-OF-NETWORK

	Enrollees		Dependents		Total	
Type of Service Category	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**
Mental Health Acute Inpatient (2)	2,427	$1,563,815	3,807	$3,492,583	6,234	$5,056,398
Substance Abuse Acute Inpatient (2)	736	$858,056	1,219	$1,386,748	1,955	$2,244,804
Alcohol Rehab Acute Inpatient	49	$57,964	125	$71,679	174	$129,643
Day Treatment	1,172	$820,193	2,710	$1,975,347	3,882	$2,795,540
Residential	19	$20,417	122	$125,445	141	$145,861
Recovery Home	-	$0	-	$0	-	$0
Professional Services: Physician (3)	8,800	$1,028,234	7,871	$1,974,339	16,671	$3,002,573
Professional Services: Psychologist	2,777	$78,650	445	$20,543	3,222	$99,194
Professional Services: Other	250	$24,657	185	$50,802	435	$75,459
Outpatient & Med Mgt: Physician	23,263	$3,247,048	22,907	$3,518,362	46,170	$6,765,410
Outpatient & Med Mgt: Psychologist	34,811	$3,379,693	37,579	$4,110,701	72,390	$7,490,394
Outpatient & Med Mgt: Other	52,926	$5,495,613	44,379	$6,238,882	97,305	$11,734,495
Substance Abuse & Structured Outpatient	942	$627,227	2,907	$1,980,075	3,849	$2,607,302
Mental Health Structured Outpatient	695	$95,989	545	$255,850	1,240	$351,839
Electro Convulsive Therapy	397	$79,917	263	$115,672	660	$195,589
Ancillary Services	5,762	$1,127,320	6,168	$2,254,340	11,930	$3,381,660
Total	135,026	$18,504,793	131,232	$27,571,368	266,258	$46,076,161

(1) Data is inclusive of the Empire Plan, the Excelsior Plan and the Student Employee Health Plan

(2) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(3) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(4) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

Empire Plan Mental Health/Substance Abuse Program (1)
2011 Incurred Claims By Type of Service - Paid through December 31, 2013

COMBINED: IN-NETWORK PLUS OUT-OF-NETWORK

	Enrollees		Dependents		Total	
Type of Service Category	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**
Mental Health Acute Inpatient (2)	12,055	$7,892,822	21,715	$19,053,664	33,770	$26,946,485
Substance Abuse Acute Inpatient (2)	3,683	$2,423,168	4,715	$3,320,489	8,398	$5,743,657
Alcohol Rehab Acute Inpatient	536	$273,725	344	$204,676	880	$478,401
Day Treatment	3,544	$1,565,406	9,179	$4,388,505	12,723	$5,953,911
Residential	2,048	$750,182	2,968	$1,342,881	5,016	$2,093,062
Recovery Home	-	$0	-	$0	-	$0
Professional Services: Physician (3)	15,885	$1,270,751	13,469	$2,314,195	29,354	$3,584,946
Professional Services: Psychologist	9,963	$192,089	1,351	$43,012	11,314	$235,101
Professional Services: Other	768	$46,197	460	$75,747	1,228	$121,945
Outpatient & Med Mgt: Physician	155,742	$10,761,999	182,220	$12,556,758	337,962	$23,318,757
Outpatient & Med Mgt: Psychologist	173,052	$11,473,168	163,860	$11,998,493	336,912	$23,471,661
Outpatient & Med Mgt: Other	275,415	$15,384,000	245,364	$17,363,653	520,779	$32,747,652
Substance Abuse & Structured Outpatient	6,073	$1,382,793	11,805	$3,395,327	17,878	$4,778,120
Mental Health Structured Outpatient	2,710	$325,679	3,593	$875,309	6,303	$1,200,988
Electro Convulsive Therapy	1,224	$293,274	1,091	$428,090	2,315	$721,364
Ancillary Services	7,132	$1,066,972	7,014	$2,143,890	14,146	$3,210,861
Total	669,830	$55,102,224	669,148	$79,504,686	1,338,978	$134,606,911

(1) Data is inclusive of the Empire Plan, the Excelsior Plan and the Student Employee Health Plan

(2) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(3) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(4) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

Empire Plan Mental Health/Substance Abuse Program (1)
2012 Incurred Claims By Type of Service - Paid through December 31, 2013

IN-NETWORK

	Enrollees		Dependents		Total	
Type of Service Category	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**
Mental Health Acute Inpatient (2)	11,093	$6,517,821	18,862	$17,978,704	29,955	$24,496,525
Substance Abuse Acute Inpatient (2)	2,097	$1,084,815	4,256	$2,237,777	6,353	$3,322,592
Alcohol Rehab Acute Inpatient	2,068	$1,055,122	1,069	$565,980	3,137	$1,621,101
Day Treatment	2,222	$795,014	5,653	$2,219,245	7,875	$3,014,259
Residential	1,943	$921,265	4,017	$1,913,573	5,960	$2,834,838
Recovery Home	23	$1,060	-	$0	23	$1,060
Professional Services: Physician (3)	8,359	$286,638	6,895	$465,207	15,254	$751,845
Professional Services: Psychologist	7,237	$77,746	737	$13,424	7,974	$91,170
Professional Services: Other	429	$26,210	225	$13,760	654	$39,970
Outpatient & Med Mgt: Physician	135,074	$7,233,745	180,127	$9,626,697	315,201	$16,860,443
Outpatient & Med Mgt: Psychologist	133,695	$7,557,792	127,828	$7,878,041	261,523	$15,435,833
Outpatient & Med Mgt: Other	223,243	$8,657,442	205,666	$8,751,445	428,909	$17,408,887
Substance Abuse & Structured Outpatient	2,623	$431,908	5,782	$908,038	8,405	$1,339,946
Mental Health Structured Outpatient	1,621	$258,084	2,881	$610,309	4,502	$868,393
Electro Convulsive Therapy	1,036	$220,873	1,041	$377,664	2,077	$598,538
Ancillary Services	1,111	$39,547	671	$177,251	1,782	$216,798
Total	533,874	$35,165,082	565,710	$53,737,114	1,099,584	$88,902,196

(1) Data is inclusive of the Empire Plan, the Excelsior Plan and the Student Employee Health Plan

(2) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(3) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(4) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

Empire Plan Mental Health/Substance Abuse Program (1)
2012 Incurred Claims By Type of Service - Paid through December 31, 2013

OUT-OF-NETWORK

	Enrollees		Dependents		Total	
Type of Service Category	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**
Mental Health Acute Inpatient (2)	2,267	$1,653,178	2,757	$3,391,648	5,024	$5,044,825
Substance Abuse Acute Inpatient (2)	391	$483,397	1,485	$1,911,928	1,876	$2,395,324
Alcohol Rehab Acute Inpatient	415	$421,985	289	$312,861	704	$734,846
Day Treatment	1,063	$945,720	3,716	$3,308,136	4,779	$4,253,856
Residential	-	$0	-	$0	-	$0
Recovery Home	23	$8,777	76	$75,290	99	$84,067
Professional Services: Physician (3)	8,966	$1,325,977	9,203	$2,733,197	18,169	$4,059,174
Professional Services: Psychologist	1,402	$36,354	270	$14,840	1,672	$51,194
Professional Services: Other	236	$21,911	165	$48,313	401	$70,224
Outpatient & Med Mgt: Physician	17,695	$2,669,255	18,852	$3,136,790	36,547	$5,806,046
Outpatient & Med Mgt: Psychologist	27,925	$2,947,477	32,173	$3,715,958	60,098	$6,663,436
Outpatient & Med Mgt: Other	40,210	$3,818,835	34,839	$3,516,917	75,049	$7,335,752
Substance Abuse & Structured Outpatient	771	$599,070	3,382	$2,501,979	4,153	$3,101,049
Mental Health Structured Outpatient	393	$53,913	509	$169,419	902	$223,333
Electro Convulsive Therapy	391	$81,637	214	$80,468	605	$162,105
Ancillary Services	7,166	$1,400,919	7,438	$2,781,631	14,604	$4,182,550
Total	109,314	$16,468,404	115,368	$27,699,376	224,682	$44,167,781

(1) Data is inclusive of the Empire Plan, the Excelsior Plan and the Student Employee Health Plan

(2) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(3) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(4) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

Empire Plan Mental Health/Substance Abuse Program (1)
2012 Incurred Claims By Type of Service - Paid through December 31, 2013

COMBINED: IN-NETWORK PLUS OUT-OF-NETWORK

	Enrollees		Dependents		Total	
Type of Service Category	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**
Mental Health Acute Inpatient (2)	13,360	$8,170,999	21,619	$21,370,352	34,979	$29,541,351
Substance Abuse Acute Inpatient (2)	2,488	$1,568,212	5,741	$4,149,704	8,229	$5,717,916
Alcohol Rehab Acute Inpatient	2,483	$1,477,107	1,358	$878,841	3,841	$2,355,948
Day Treatment	3,285	$1,740,734	9,369	$5,527,380	12,654	$7,268,114
Residential	1,943	$921,265	4,017	$1,913,573	5,960	$2,834,838
Recovery Home	46	$9,837	76	$75,290	122	$85,127
Professional Services: Physician (3)	17,325	$1,612,616	16,098	$3,198,403	33,423	$4,811,019
Professional Services: Psychologist	8,639	$114,100	1,007	$28,264	9,646	$142,364
Professional Services: Other	665	$48,121	390	$62,073	1,055	$110,194
Outpatient & Med Mgt: Physician	152,769	$9,903,001	198,979	$12,763,487	351,748	$22,666,488
Outpatient & Med Mgt: Psychologist	161,620	$10,505,269	160,001	$11,594,000	321,621	$22,099,269
Outpatient & Med Mgt: Other	263,453	$12,476,277	240,505	$12,268,361	503,958	$24,744,638
Substance Abuse & Structured Outpatient	3,394	$1,030,977	9,164	$3,410,017	12,558	$4,440,995
Mental Health Structured Outpatient	2,014	$311,997	3,390	$779,728	5,404	$1,091,725
Electro Convulsive Therapy	1,427	$302,510	1,255	$458,133	2,682	$760,643
Ancillary Services	8,277	$1,440,466	8,109	$2,958,882	16,386	$4,399,348
Total	643,188	$51,633,486	681,078	$81,436,491	1,324,266	$133,069,977

(1) Data is inclusive of the Empire Plan, the Excelsior Plan and the Student Employee Health Plan

(2) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(3) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(4) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

Empire Plan Mental Health/Substance Abuse Program (1)
2013 Incurred Claims By Type of Service - Paid through December 31, 2013

IN-NETWORK

	Enrollees		Dependents		Total	
Type of Service Category	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**
Mental Health Acute Inpatient (2)	7,746	$5,373,799	13,983	$14,063,508	21,729	$19,437,307
Substance Abuse Acute Inpatient (2)	634	$316,673	3,164	$1,686,820	3,798	$2,003,493
Alcohol Rehab Acute Inpatient	2,134	$1,074,752	1,590	$788,311	3,724	$1,863,063
Day Treatment	1,375	$520,776	4,837	$1,923,031	6,212	$2,443,807
Residential	-	$0	-	$0	-	$0
Recovery Home	1,768	$868,653	5,491	$2,839,010	7,259	$3,707,663
Professional Services: Physician (3)	12,764	$563,387	17,386	$1,120,070	30,150	$1,683,457
Professional Services: Psychologist	607	$21,401	379	$20,730	986	$42,131
Professional Services: Other	2,277	$136,517	1,807	$119,753	4,084	$256,270
Outpatient & Med Mgt: Physician	112,840	$6,424,448	153,357	$8,369,090	266,197	$14,793,537
Outpatient & Med Mgt: Psychologist	124,598	$6,607,988	122,448	$7,343,556	247,046	$13,951,545
Outpatient & Med Mgt: Other	195,527	$7,555,992	195,583	$8,155,697	391,110	$15,711,689
Substance Abuse & Structured Outpatient	2,261	$347,661	4,595	$703,675	6,856	$1,051,337
Mental Health Structured Outpatient	1,415	$195,661	2,710	$627,837	4,125	$823,499
Electro Convulsive Therapy	876	$286,952	773	$278,496	1,649	$565,448
Ancillary Services	659	$77,656	629	$88,431	1,288	$166,087
Total	467,481	$30,372,317	528,732	$48,128,014	996,213	$78,500,332

(1) Data is inclusive of the Empire Plan, the Excelsior Plan and the Student Employee Health Plan

(2) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(3) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(4) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

Empire Plan Mental Health/Substance Abuse Program (1)
2013 Incurred Claims By Type of Service - Paid through December 31, 2013

OUT-OF-NETWORK

	Enrollees		Dependents		Total	
Type of Service Category	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**
Mental Health Acute Inpatient (2)	1,685	$1,190,129	3,097	$3,783,843	4,782	$4,973,972
Substance Abuse Acute Inpatient (2)	368	$415,276	1,668	$2,357,720	2,036	$2,772,996
Alcohol Rehab Acute Inpatient	862	$1,144,530	746	$1,028,618	1,608	$2,173,149
Day Treatment	1,215	$1,110,154	3,899	$3,805,720	5,114	$4,915,874
Residential	24	$20,610	68	$78,004	92	$98,614
Recovery Home	-	$0	-	$0	-	$0
Professional Services: Physician (3)	6,898	$879,990	7,543	$2,012,699	14,441	$2,892,689
Professional Services: Psychologist	302	$18,006	381	$45,086	683	$63,092
Professional Services: Other	321	$40,490	296	$52,504	617	$92,994
Outpatient & Med Mgt: Physician	11,435	$2,107,543	13,776	$2,546,957	25,211	$4,654,499
Outpatient & Med Mgt: Psychologist	22,177	$2,363,567	25,374	$3,000,852	47,551	$5,364,419
Outpatient & Med Mgt: Other	28,613	$2,777,399	25,025	$2,465,089	53,638	$5,242,488
Substance Abuse & Structured Outpatient	1,148	$846,879	4,352	$3,826,165	5,500	$4,673,045
Mental Health Structured Outpatient	218	$44,245	556	$220,272	774	$264,518
Electro Convulsive Therapy	236	$88,257	135	$75,007	371	$163,263
Ancillary Services	4,855	$970,582	5,634	$2,664,554	10,489	$3,635,136
Total	80,357	$14,017,657	92,550	$27,963,091	172,907	$41,980,747

(1) Data is inclusive of the Empire Plan, the Excelsior Plan and the Student Employee Health Plan

(2) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(3) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(4) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

Empire Plan Mental Health/Substance Abuse Program (1)
2013 Incurred Claims By Type of Service - Paid through December 31, 2013

COMBINED: IN-NETWORK PLUS OUT-OF-NETWORK

	Enrollees		Dependents		Total	
Type of Service Category	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**	**Services (2)**	**Amount Paid**
Mental Health Acute Inpatient (2)	9,431	$6,563,927	17,080	$17,847,351	26,511	$24,411,279
Substance Abuse Acute Inpatient (2)	1,002	$731,949	4,832	$4,044,540	5,834	$4,776,489
Alcohol Rehab Acute Inpatient	2,996	$2,219,282	2,336	$1,816,929	5,332	$4,036,212
Day Treatment	2,590	$1,630,930	8,736	$5,728,751	11,326	$7,359,681
Residential	24	$20,610	68	$78,004	92	$98,614
Recovery Home	1,768	$868,653	5,491	$2,839,010	7,259	$3,707,663
Professional Services: Physician (3)	19,662	$1,443,377	24,929	$3,132,769	44,591	$4,576,146
Professional Services: Psychologist	909	$39,407	760	$65,816	1,669	$105,223
Professional Services: Other	2,598	$177,007	2,103	$172,257	4,701	$349,264
Outpatient & Med Mgt: Physician	124,275	$8,531,990	167,133	$10,916,046	291,408	$19,448,036
Outpatient & Med Mgt: Psychologist	146,775	$8,971,555	147,822	$10,344,408	294,597	$19,315,964
Outpatient & Med Mgt: Other	224,140	$10,333,391	220,608	$10,620,786	444,748	$20,954,177
Substance Abuse & Structured Outpatient	3,409	$1,194,540	8,947	$4,529,841	12,356	$5,724,381
Mental Health Structured Outpatient	1,633	$239,907	3,266	$848,110	4,899	$1,088,016
Electro Convulsive Therapy	1,112	$375,208	908	$353,503	2,020	$728,711
Ancillary Services	5,514	$1,048,238	6,263	$2,752,985	11,777	$3,801,223
Total	547,838	$44,389,974	621,282	$76,091,105	1,169,120	$120,481,079

(1) Data is inclusive of the Empire Plan, the Excelsior Plan and the Student Employee Health Plan

(2) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(3) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(4) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

Mental Health and Substance Abuse Program for the Empire Plan
In-Network Claims Paid
Paid Through December 31, 2013

2010 Incurreds

	Month Incurred												
Month Paid	**Jan-10**	**Feb-10**	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Total**
Jan-10	$ 1,094,816												**$ 1,094,816**
Feb-10	$ 2,976,667	$ 887,870											**$ 3,864,537**
Mar-10	$ 1,592,709	$ 2,825,767	$ 1,349,225										**$ 5,767,701**
Apr-10	$ 524,561	$ 1,303,233	$ 3,316,925	$ 1,166,391									**$ 6,311,110**
May-10	$ 210,796	$ 408,235	$ 1,311,501	$ 3,152,892	$ 1,085,815								**$ 6,169,240**
Jun-10	$ 101,580	$ 154,162	$ 416,616	$ 1,508,648	$ 3,058,046	$ 1,312,137							**$ 6,551,189**
Jul-10	$ 106,099	$ 130,278	$ 199,704	$ 486,387	$ 1,573,218	$ 3,493,413	$ 1,221,723						**$ 7,210,823**
Aug-10	$ 18,658	$ 45,129	$ 108,497	$ 229,326	$ 363,903	$ 1,210,317	$ 3,047,484	$ 1,398,400					**$ 6,421,715**
Sep-10	$ 33,039	$ 22,440	$ 34,953	$ 72,611	$ 128,430	$ 357,524	$ 860,449	$ 3,230,385	$ 1,376,863				**$ 6,116,694**
Oct-10	$ 46,732	$ 52,495	$ 59,296	$ 71,960	$ 142,391	$ 146,415	$ 338,400	$ 862,196	$ 2,985,778	$ 1,343,275			**$ 6,048,937**
Nov-10	$ 20,859	$ 14,159	$ 33,201	$ 118,959	$ 75,180	$ 84,419	$ 162,625	$ 376,504	$ 1,113,072	$ 3,048,378	$ 1,256,371		**$ 6,303,728**
Dec-10	$ 36,959	$ 10,080	$ 25,787	$ 24,970	$ 57,814	$ 51,109	$ 102,667	$ 124,274	$ 374,866	$ 1,167,885	$ 3,235,935	$ 1,295,837	**$ 6,508,182**
Jan-11	$ 12,086	$ 3,190	$ 34,360	$ 39,762	$ 22,432	$ 37,060	$ 36,861	$ 82,903	$ 179,917	$ 466,166	$ 1,168,273	$ 3,095,949	**$ 5,178,960**
Feb-11	$ 9,542	$ 14,027	$ 16,006	$ 30,165	$ 30,533	$ 21,167	$ 111,208	$ 136,705	$ 277,940	$ 134,368	$ 566,841	$ 1,022,166	**$ 2,370,668**
Mar-11	$ 11,234	$ 6,756	$ 22,207	$ 20,887	$ 23,132	$ 47,565	$ 51,905	$ 46,184	$ 79,340	$ 72,540	$ 293,468	$ 447,718	**$ 1,122,935**
Apr-11	$ 3,804	$ 7,043	$ 12,434	$ 12,726	$ 17,917	$ 25,153	$ 17,745	$ 37,459	$ 62,694	$ 58,252	$ 120,480	$ 207,833	**$ 583,540**
May-11	$ (210)	$ 5,067	$ (2,546)	$ 27,691	$ 12,652	$ 8,814	$ 12,185	$ 21,990	$ 35,239	$ 15,779	$ 51,587	$ 96,701	**$ 284,950**
Jun-11	$ 1,665	$ 3,160	$ 778	$ 8,785	$ 4,265	$ 2,018	$ 4,571	$ 3,464	$ 17,895	$ 9,542	$ 15,027	$ 27,480	**$ 98,650**
Jul-11	$ 259	$ 30,169	$ 6,965	$ 10,711	$ 35,498	$ 7,617	$ 2,331	$ (7,538)	$ 5,936	$ 12,120	$ 21,592	$ 64,959	**$ 190,620**
Aug-11	$ 3,264	$ 1,672	$ 8,766	$ 8,001	$ 5,319	$ 5,873	$ 3,339	$ 27,515	$ 2,760	$ 27,034	$ 10,404	$ 15,857	**$ 119,803**
Sep-11	$ (8,516)	$ (2,763)	$ 1,325	$ 421	$ 231	$ 659	$ 6,232	$ 619	$ 2,551	$ 2,768	$ 7,368	$ 28,200	**$ 39,096**
Oct-11	$ 666	$ (794)	$ 7,349	$ 288	$ (1,494)	$ 6,799	$ 4,734	$ 3,879	$ 995	$ 5,026	$ 16,792	$ 34,851	**$ 79,092**
Nov-11	$ 1,045	$ 585	$ 441	$ 369	$ 781	$ 2,414	$ 3,212	$ 3,641	$ 7,774	$ 369	$ 2,000	$ 682	**$ 23,311**
Dec-11	$ 8,402	$ 1,119	$ 4,228	$ 475	$ 105	$ 12	$ (1,360)	$ 287	$ 603	$ 4,087	$ (4,095)	$ (3,472)	**$ 10,391**
Jan-12	$ 435	$ (109)	$ 1,152	$ 701	$ 235	$ 1,669	$ 9,231	$ 492	$ 9,671	$ 960	$ (59)	$ 1,486	**$ 25,862**
Feb-12	$ 111	$ (1,534)	$ (5,367)	$ 4,403	$ (235)	$ 1,574	$ (48)	$ 128	$ 269	$ 4,735	$ 15,940	$ 975	**$ 20,951**
Mar-12	$ 1,086	$ (36)	$ (332)	$ 966	$ 23	$ 1,048	$ (145)	$ 927	$ 190	$ 180	$ 133	$ 55	**$ 4,094**
Apr-12			$ 131	$ 46	$ (42)	$ (691)	$ 79	$ (1,497)	$ 15	$ 647	$ (1,081)	$ 4,323	**$ 1,931**
May-12	$ 265	$ 184	$ 434	$ 100	$ 24,040	$ 65	$ (1,283)	$ (1,998)	$ 365	$ 26,260	$ 170	$ (1,864)	**$ 46,738**
Jun-12	$ 634	$ 251	$ 181	$ 160	$ 762	$ 200	$ 1,398	$ 1,015	$ 27,646	$ 140	$ 5,460	$ 251	**$ 38,099**
Jul-12	$ 118	$ 28	$ 5,097	$ 1,514	$ 221	$ 752	$ 255	$ 82	$ 182	$ 272	$ 466	$ 152	**$ 9,139**
Aug-12	$ (373)	$ 104	$ (402)	$ 285	$ 770	$ 37	$ 1,734	$ 77	$ (585)	$ 771	$ (106)	$ (97)	**$ 2,214**
Sep-12	$ (723)	$ (1,150)	$ 190	$ (405)	$ (781)	$ 2,389	$ (16)	$ (799)	$ (628)	$ (35)	$ (543)	$ 351	**$ (2,148)**
Oct-12	$ (627)	$ (1,317)	$ (1,403)	$ (565)	$ (863)	$ (1,003)	$ (695)	$ (434)	$ (301)	$ (291)	$ (286)	$ 92	**$ (7,692)**
Nov-12	$ (850)	$ (1,690)	$ (1,061)	$ (1,633)	$ (38)	$ (815)	$ (890)	$ (560)	$ (1,066)	$ (519)	$ 115	$ (818)	**$ (9,825)**
Dec-12	$ 67	$ 80	$ (5)	$ (105)	$ (1,263)	$ (1,840)	$ (678)	$ (240)	$ (46)	$ 33	$ (180)	$ 50	**$ (4,126)**
Jan-13	$ 35	$ (104)	$ (4,405)	$ (28)	$ (20)	$ (105)	$ (60)	$ 122	$ 73	$ (105)	$ (536)	$ (170)	**$ (5,302)**
Feb-13		$ (156)	$ (15)	$ 1,011		$ 188					$ 2,036	$ 460	**$ 3,523**
Mar-13		$ (180)	$ (165)	$ (10)	$ (55)	$ (362)	$ (266)		$ (3,177)	$ (1)	$ 2,512	$ 14,587	**$ 12,884**
Apr-13		$ (40)	$ (110)	$ (108)	$ 115	$ (217)	$ (28)	$ 7	$ 11	$ (9)	$ 46		**$ (333)**
May-13	$ 120	$ (51)	$ (177)	$ (26)		$ 990	$ (154)	$ 16,835	$ 95	$ 210	$ 55	$ 160	**$ 18,057**
Jun-13					$ (690)		$ (335)	$ (2,310)	$ 105				**$ (3,229)**
Jul-13	$ (85)	$ 85			$ -	$ (38)	$ (760)	$ 620	$ 120	$ (205)	$ (215)	$ 120	**$ (358)**
Aug-13		$ -	$ (300)	$ 8,119		$ 380	$ -	$ -	$ (2,965)	$ (115)	$ (160)	$ (425)	**$ 4,535**
Sep-13	$ (959)	$ (17)	$ (17)	$ 14,980		$ (675)	$ 626		$ (60)	$ 118	$ (75)	$ (55)	**$ 13,867**
Oct-13		$ (130)			$ (60)				$ (40)	$ 688	$ (293)	$ (7,040)	**$ (6,875)**
Nov-13		$ (75)					$ (5)		$ (83)		$ 168	$ (264)	**$ (259)**
Dec-13	$ (170)								$ (83)		$ (14)	$ (60)	**$ (327)**

Total	$ 6,805,802	$ 5,917,222	$ 6,961,446	$ 7,021,829	$ 6,658,290	$ 6,824,031	$ 5,994,270	$ 6,361,336	$ 6,553,932	$ 6,401,324	$ 6,785,596	$ 6,347,029	$ 78,632,106

Mental Health and Substance Abuse Program for the Empire Plan
In-Network Claims Paid
Paid Through December 31, 2013

2011 Incurreds

	Month Incurred												
Month Paid	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Total**
Jan-11	$ 1,202,527												**$ 1,202,527**
Feb-11	$ 3,467,297	$ 1,104,123											**$ 4,571,420**
Mar-11	$ 2,012,035	$ 3,444,049	$ 1,549,011										**$ 7,005,096**
Apr-11	$ 484,230	$ 1,046,184	$ 3,782,975	$ 1,199,248									**$ 6,512,637**
May-11	$ 191,463	$ 385,165	$ 1,591,126	$ 3,260,034	$ 1,164,805								**$ 6,592,593**
Jun-11	$ 107,216	$ 209,142	$ 443,052	$ 1,740,938	$ 3,091,776	$ 1,169,374							**$ 6,761,497**
Jul-11	$ 115,636	$ 95,466	$ 265,609	$ 681,178	$ 2,387,903	$ 3,847,748	$ 1,110,959						**$ 8,504,500**
Aug-11	$ 32,341	$ 91,770	$ 177,545	$ 241,689	$ 649,201	$ 1,939,903	$ 3,871,074	$ 1,809,371					**$ 8,812,896**
Sep-11	$ 14,595	$ 29,901	$ 39,369	$ 106,945	$ 102,630	$ 338,559	$ 838,344	$ 3,276,880	$ 1,301,023				**$ 6,048,246**
Oct-11	$ 5,073	$ 28,164	$ 31,834	$ 51,764	$ 63,596	$ 298,144	$ 433,993	$ 1,400,453	$ 3,484,473	$ 1,505,903			**$ 7,303,396**
Nov-11	$ 24,440	$ 13,054	$ 20,768	$ 20,145	$ 36,793	$ 95,474	$ 95,598	$ 331,232	$ 1,531,803	$ 3,928,041	$ 1,398,710		**$ 7,496,057**
Dec-11	$ 17,962	$ 13,130	$ 64,102	$ 32,595	$ 35,454	$ 87,538	$ 93,729	$ 210,349	$ 411,698	$ 1,349,780	$ 4,147,232	$ 1,623,136	**$ 8,086,707**
Jan-12	$ 18,528	$ 13,550	$ 11,992	$ 6,038	$ 25,895	$ 40,725	$ 40,949	$ 127,301	$ 139,822	$ 471,924	$ 1,115,185	$ 3,581,701	**$ 5,593,609**
Feb-12	$ 64,569	$ 6,363	$ 9,876	$ 14,422	$ 30,240	$ 22,132	$ 73,927	$ 61,022	$ 80,051	$ 158,451	$ 494,293	$ 948,731	**$ 1,964,078**
Mar-12	$ 759	$ 7,212	$ 15,188	$ 30,174	$ 14,363	$ 14,698	$ 21,415	$ 31,144	$ 52,006	$ 69,056	$ 217,077	$ 313,358	**$ 786,451**
Apr-12	$ 23,254	$ 8,062	$ 8,553	$ 6,895	$ 11,688	$ 35,621	$ 18,320	$ 56,600	$ 29,845	$ 27,777	$ 120,839	$ 127,110	**$ 474,565**
May-12	$ (14,893)	$ 10,050	$ 4,136	$ (5,521)	$ (8,200)	$ 10,748	$ 6,173	$ 6,553	$ 11,521	$ 44,315	$ 27,405	$ 43,697	**$ 135,983**
Jun-12	$ 415	$ (2,584)	$ (2,097)	$ (10,451)	$ 8,040	$ 4,485	$ 10,526	$ (5,344)	$ 20,832	$ 13,031	$ 13,059	$ 38,289	**$ 88,202**
Jul-12	$ (4,349)	$ (3,804)	$ (3,232)	$ (12,332)	$ 1,378	$ (8,277)	$ 9,477	$ 5,017	$ (7,021)	$ (5,443)	$ 2,065	$ 7,712	**$ (18,811)**
Aug-12	$ (1,135)	$ 17,665	$ (15,643)	$ 14,779	$ (3,180)	$ (5,501)	$ 1,566	$ 816	$ 2,350	$ (10,857)	$ 985	$ 7,236	**$ 9,081**
Sep-12	$ (467)	$ (8,240)	$ (6,494)	$ 3,427	$ (7,155)	$ (42)	$ 234	$ (15,217)	$ 519	$ (4,252)	$ 72,766	$ 6,740	**$ 41,818**
Oct-12	$ 522	$ 4,074	$ (8,834)	$ (8,561)	$ (8,087)	$ (3,792)	$ (5,353)	$ 15,036	$ 6,022	$ (10,472)	$ (1,802)	$ 3,549	**$ (17,698)**
Nov-12	$ 131	$ 318	$ (9,709)	$ 7,827	$ (215)	$ (4,341)	$ (472)	$ (4,140)	$ (3,839)	$ 4,748	$ 1,929	$ (9,055)	**$ (16,818)**
Dec-12	$ (2)	$ (19,138)	$ (2,287)	$ (4,980)	$ (12,151)	$ (4,311)	$ (7,122)	$ (4,797)	$ (2,834)	$ (35,136)	$ (24,224)	$ 5,361	**$ (111,620)**
Jan-13	$ (27,093)	$ (4,986)	$ (9,693)	$ (2,725)	$ (3,059)	$ 9,535	$ (11,367)	$ (2,928)	$ 6,585	$ 1,908	$ 4,533	$ 6,487	**$ (32,802)**
Feb-13	$ (17,029)	$ 70	$ 897	$ (833)	$ (3,166)	$ (12,778)	$ (7,429)	$ (2,950)	$ 16,921	$ (30,763)	$ (811)	$ (369)	**$ (58,239)**
Mar-13	$ 5,923	$ (15)	$ 200	$ (298)	$ 545	$ (4,613)	$ (4,764)	$ 477	$ (54)	$ (6,906)	$ (281)	$ (5,857)	**$ (15,644)**
Apr-13	$ 57	$ 40	$ (860)	$ 180	$ 485	$ (100)	$ -	$ 40	$ -	$ (2,351)	$ 2,352	$ (27)	**$ (183)**
May-13	$ 2,034	$ 225	$ 101	$ (206)	$ 175	$ 255	$ 572	$ 17,783	$ 2,360	$ 366	$ (56)	$ (93)	**$ 23,518**
Jun-13	$ 35	$ 200	$ (70)	$ 463	$ 235	$ 540	$ 200	$ 366	$ 260	$ 263	$ 1,791	$ 256	**$ 4,539**
Jul-13	$ 13	$ (220)	$ 81,155	$ (15)	$ 110	$ (60)	$ (1,024)	$ (130)	$ (15,003)	$ (60)	$ (20)	$ 190	**$ 64,937**
Aug-13	$ 30	$ (245)	$ (294)	$ (336)	$ (1,409)	$ 220	$ (706)	$ 275	$ 300	$ 1,152	$ 684	$ 3,259	**$ 2,928**
Sep-13	$ (4,595)	$ (2,585)	$ (511)	$ (3,482)	$ (1,054)	$ (1,120)	$ (515)	$ (145)	$ (468)	$ (490)	$ 8,976	$ 186	**$ (5,802)**
Oct-13	$ (637)	$ (729)	$ (626)	$ (1,561)	$ (914)	$ (1,016)	$ (1,254)	$ (696)	$ (1,005)	$ (1,757)	$ (490)	$ (170)	**$ (10,855)**
Nov-13	$ (260)	$ (124)	$ (255)	$ (159)	$ (218)	$ (4,337)	$ (111)	$ 10,264	$ 78	$ (340)	$ (412)	$ (94)	**$ 4,033**
Dec-13	$ (60)	$ (85)	$ (15)	$ 45	$ (172)	$ (16)	$ 60	$ 17	$ (24)		$ (190)		**$ (441)**
Total	**$ 7,720,564**	**$ 6,485,223**	**$ 8,036,871**	**$ 7,367,328**	**$ 7,576,331**	**$ 7,865,399**	**$ 6,586,999**	**$ 7,324,649**	**$ 7,068,221**	**$ 7,467,888**	**$ 7,601,595**	**$ 6,701,333**	**$ 87,802,401**

Mental Health and Substance Abuse Program for the Empire Plan
In-Network Claims Paid
Paid Through December 31, 2013

2012 Incurreds

	Month Incurred												
Month Paid	**Jan-12**	**Feb-12**	**Mar-12**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Total**
Jan-12	$ 1,907,449												**$ 1,907,449**
Feb-12	$ 4,387,334	$ 1,670,267											**$ 6,057,601**
Mar-12	$ 1,244,937	$ 4,056,300	$ 2,012,632										**$ 7,313,869**
Apr-12	$ 633,153	$ 953,843	$ 3,764,733	$ 1,680,653									**$ 7,032,382**
May-12	$ 229,922	$ 368,661	$ 1,126,871	$ 3,920,347	$ 1,752,686								**$ 7,398,487**
Jun-12	$ 196,415	$ 188,031	$ 447,249	$ 1,113,179	$ 4,326,630	$ 1,550,416							**$ 7,821,920**
Jul-12	$ 51,877	$ 50,999	$ 104,961	$ 308,965	$ 1,087,306	$ 4,007,768	$ 1,479,199						**$ 7,091,075**
Aug-12	$ 10,480	$ 6,893	$ 139,863	$ 148,903	$ 377,885	$ 1,230,869	$ 4,084,586	$ 1,937,598					**$ 7,937,077**
Sep-12	$ 24,959	$ 21,875	$ 43,556	$ 47,085	$ 146,890	$ 219,425	$ 736,702	$ 3,606,157	$ 1,472,684				**$ 6,319,334**
Oct-12	$ 65,412	$ 48,978	$ 38,413	$ 52,300	$ 55,241	$ 113,100	$ 373,481	$ 988,210	$ 3,266,102	$ 1,894,212			**$ 6,895,450**
Nov-12	$ 11,693	$ 11,394	$ 19,787	$ 10,941	$ 32,854	$ 42,046	$ 177,820	$ 319,054	$ 824,636	$ 3,508,957	$ 1,428,489		**$ 6,387,670**
Dec-12	$ 2,619	$ 11,730	$ 34,344	$ 16,453	$ 45,562	$ 54,151	$ 71,383	$ 132,063	$ 501,177	$ 1,026,483	$ 3,890,211	$ 1,601,862	**$ 7,388,040**
Jan-13	$ 41,704	$ 18,568	$ 11,249	$ 12,808	$ 18,282	$ 56,091	$ 66,733	$ 89,211	$ 170,485	$ 377,734	$ 879,748	$ 3,402,206	**$ 5,144,819**
Feb-13	$ 11,122	$ 9,410	$ 18,673	$ 51,478	$ 37,597	$ 16,954	$ 34,619	$ 36,007	$ 69,025	$ 125,310	$ 291,298	$ 526,338	**$ 1,227,830**
Mar-13	$ 17,366	$ 764	$ 7,862	$ 1,824	$ 9,451	$ 25,429	$ 61,164	$ 22,678	$ 58,218	$ 243,122	$ 210,848	$ 333,438	**$ 992,164**
Apr-13	$ 5,017	$ 6,390	$ 24,772	$ 8,291	$ 48,827	$ 27,639	$ 55,324	$ 10,944	$ 49,090	$ 68,312	$ 130,898	$ 125,247	**$ 560,751**
May-13	$ 1,697	$ 11,315	$ 1,960	$ 12,594	$ 7,779	$ 7,139	$ 9,304	$ 10,958	$ 28,991	$ 33,702	$ 25,512	$ 44,583	**$ 195,534**
Jun-13	$ 2,642	$ 989	$ 516	$ 3,355	$ 11,486	$ 1,150	$ 2,924	$ 466	$ 1,479	$ 14,203	$ 7,352	$ 26,425	**$ 72,987**
Jul-13	$ 62	$ 287	$ (9,301)	$ 1,901	$ 7,417	$ 2,103	$ 2,886	$ 5,372	$ 21,170	$ 6,684	$ 3,851	$ 37,600	**$ 80,032**
Aug-13	$ 230	$ 473	$ 42,924	$ 860	$ 6,424	$ 47,896	$ 20,093	$ 2,488	$ 19,306	$ 5,456	$ 5,269	$ 14,067	**$ 165,485**
Sep-13	$ 3,701	$ 354	$ 38,951	$ 6,225	$ 1,740	$ 2,963	$ 1,467	$ 747	$ 2,328	$ 5,198	$ 7,064	$ 14,065	**$ 84,804**
Oct-13	$ 1,912	$ 61	$ 247	$ 164	$ 560	$ 1,558	$ 509	$ 824	$ 9,231	$ 34,584	$ 12,343	$ 5,302	**$ 67,296**
Nov-13	$ 4,859	$ 995	$ 1,232	$ 191	$ 2	$ 81	$ (190)	$ 208	$ 710	$ 969	$ 787	$ 1,162	**$ 11,007**
Dec-13	$ 65	$ -	$ 67	$ (148)	$ (114)	$ 360	$ 192	$ 1,918	$ 161	$ 2,225	$ 4,087	$ 4,828	**$ 13,641**
Total	**$ 8,856,627**	**$ 7,438,579**	**$ 7,871,562**	**$ 7,398,371**	**$ 7,974,506**	**$ 7,407,136**	**$ 7,178,195**	**$ 7,164,903**	**$ 6,494,794**	**$ 7,347,152**	**$ 6,897,757**	**$ 6,137,123**	**$ 88,166,704**

Mental Health and Substance Abuse Program for the Empire Plan
In-Network Claims Paid
Paid Through December 31, 2013

2013 Incurreds

	Month Incurred												
Month Paid	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Total**
Jan-13	$ 1,551,306												**$ 1,551,306**
Feb-13	$ 4,128,753	$ 1,221,633											**$ 5,350,386**
Mar-13	$ 1,742,062	$ 3,697,592	$ 1,493,286										**$ 6,932,940**
Apr-13	$ 694,803	$ 1,235,494	$ 3,875,181	$ 1,719,591									**$ 7,525,070**
May-13	$ 234,355	$ 360,379	$ 1,048,119	$ 3,745,741	$ 1,614,110								**$ 7,002,705**
Jun-13	$ 177,794	$ 166,227	$ 280,707	$ 1,088,115	$ 3,882,176	$ 1,364,883							**$ 6,959,902**
Jul-13	$ 107,827	$ 124,190	$ 126,265	$ 400,984	$ 1,298,330	$ 3,817,455	$ 1,537,565						**$ 7,412,615**
Aug-13	$ 34,018	$ 38,999	$ 104,905	$ 180,510	$ 376,216	$ 1,080,317	$ 3,835,853	$ 1,603,378					**$ 7,254,195**
Sep-13	$ 48,075	$ 52,129	$ 46,921	$ 66,743	$ 177,748	$ 219,229	$ 969,753	$ 3,451,290	$ 1,379,952				**$ 6,411,840**
Oct-13	$ 33,016	$ 20,735	$ 40,053	$ 96,221	$ 181,572	$ 156,394	$ 414,165	$ 894,151	$ 3,752,879	$ 1,751,242			**$ 7,340,428**
Nov-13	$ (584)	$ 50,430	$ 18,471	$ 25,262	$ 67,629	$ 80,608	$ 183,833	$ 362,005	$ 934,110	$ 3,776,770	$ 1,368,056		**$ 6,866,590**
Dec-13	$ 14,381	$ 24,347	$ 22,861	$ 51,781	$ 58,420	$ 42,398	$ 70,693	$ 118,360	$ 313,236	$ 1,239,714	$ 3,821,479	$ 1,447,085	**$ 7,224,754**

Total	**$ 8,765,805**	**$ 6,992,154**	**$ 7,056,769**	**$ 7,374,949**	**$ 7,656,202**	**$ 6,761,283**	**$ 7,011,861**	**$ 6,429,184**	**$ 6,380,176**	**$ 6,767,726**	**$ 5,189,535**	**$ 1,447,085**	**$ 77,832,730**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Empire Plan
Paid Through December 31, 2013

2010 Incurreds

	Month Incurred												
Month Paid	**Jan-10**	**Feb-10**	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Total**
Jan-10	$ 8,372												**$ 8,372**
Feb-10	$ 398,671	$ 36,155											**$ 434,826**
Mar-10	$ 447,321	$ 773,843	$ 118,144										**$ 1,339,308**
Apr-10	$ 166,870	$ 455,658	$ 1,194,532	$ 112,186									**$ 1,929,245**
May-10	$ 81,676	$ 174,464	$ 634,153	$ 1,045,159	$ 82,502								**$ 2,017,953**
Jun-10	$ 119,444	$ 128,659	$ 315,298	$ 874,589	$ 1,094,866	$ 153,939							**$ 2,686,795**
Jul-10	$ 62,453	$ 168,348	$ 357,288	$ 333,164	$ 724,186	$ 1,118,792	$ 166,816						**$ 2,931,046**
Aug-10	$ 51,890	$ 59,639	$ 209,856	$ 208,367	$ 408,918	$ 511,694	$ 1,083,401	$ 280,499					**$ 2,814,265**
Sep-10	$ 37,352	$ 35,567	$ 67,135	$ 86,135	$ 169,366	$ 228,370	$ 477,006	$ 1,008,450	$ 249,780				**$ 2,359,160**
Oct-10	$ 20,153	$ 32,464	$ 53,043	$ 60,060	$ 118,592	$ 175,123	$ 246,702	$ 474,382	$ 1,066,926	$ 281,394			**$ 2,528,839**
Nov-10	$ 69,387	$ 16,614	$ 38,698	$ 50,930	$ 91,211	$ 168,983	$ 145,631	$ 230,476	$ 564,859	$ 1,135,866	$ 300,848		**$ 2,813,502**
Dec-10	$ 39,558	$ 15,617	$ 15,207	$ 45,935	$ 59,756	$ 69,997	$ 103,190	$ 151,940	$ 271,910	$ 559,442	$ 1,160,452	$ 244,089	**$ 2,737,092**
Jan-11	$ 10,953	$ 20,122	$ 96,229	$ 129,104	$ 35,315	$ 52,105	$ 74,422	$ 95,064	$ 213,035	$ 334,079	$ 630,619	$ 1,114,967	**$ 2,806,014**
Feb-11	$ 22,663	$ 11,960	$ 27,262	$ 52,106	$ 41,718	$ 46,083	$ 62,585	$ 61,852	$ 129,536	$ 187,627	$ 397,446	$ 568,322	**$ 1,609,160**
Mar-11	$ 11,313	$ 16,302	$ 19,060	$ 37,212	$ 38,189	$ 62,885	$ 114,900	$ 108,731	$ 97,101	$ 120,602	$ 232,795	$ 301,943	**$ 1,161,035**
Apr-11	$ 50,233	$ 35,823	$ 44,870	$ 36,740	$ 49,059	$ 36,001	$ 55,183	$ 48,166	$ 89,294	$ 102,667	$ 143,689	$ 210,759	**$ 902,481**
May-11	$ 2,790	$ 5,510	$ 11,418	$ 9,613	$ 6,513	$ 44,739	$ 15,790	$ 35,464	$ 15,940	$ 36,296	$ 59,627	$ 69,267	**$ 312,968**
Jun-11	$ 6,245	$ 18,124	$ 4,708	$ 5,264	$ 11,634	$ 7,434	$ 9,218	$ 10,995	$ 11,300	$ 25,902	$ 24,460	$ 47,368	**$ 182,651**
Jul-11	$ 1,694	$ 17,531	$ 3,289	$ 10,790	$ 10,121	$ 12,622	$ 39,286	$ 10,847	$ 19,885	$ 41,758	$ 28,812	$ 31,867	**$ 228,503**
Aug-11	$ 4,772	$ 6,167	$ 8,650	$ 4,266	$ 2,554	$ 5,036	$ 12,644	$ 4,563	$ 15,989	$ 9,792	$ 60,090	$ 18,692	**$ 153,217**
Sep-11	$ 20,654	$ (7,719)	$ 723	$ 1,736	$ 9,533	$ 1,148	$ 3,359	$ 4,335	$ 3,932	$ 4,220	$ 10,399	$ 43,924	**$ 96,243**
Oct-11	$ 361	$ 7,241	$ 2,881	$ 12,099	$ 1,591	$ 9,204	$ 8,477	$ 2,014	$ (620)	$ 18,714	$ 3,656	$ 5,490	**$ 71,108**
Nov-11	$ 1,934	$ 2,860	$ 224	$ 571	$ 408	$ 1,763	$ 18,956	$ 1,151	$ 1,709	$ 4,448	$ 3,709	$ 3,153	**$ 40,885**
Dec-11	$ 824	$ 749	$ 1,918	$ 2,365	$ 3,357	$ 7,210	$ 1,285	$ 18,601	$ 1,504	$ 3,612	$ 1,847	$ 3,413	**$ 46,685**
Jan-12	$ 395	$ 1,385	$ 1,309	$ 291	$ 305	$ 1,370	$ 691	$ 582	$ 308	$ 2,145	$ 4,353	$ 4,052	**$ 17,186**
Feb-12	$ 686	$ (243)	$ (107)	$ -	$ (339)	$ 2,057	$ 339	$ 213	$ 10,256	$ 660	$ 487	$ 2,807	**$ 16,816**
Mar-12	$ 2,771	$ 116	$ 667	$ 1,250	$ 541	$ 1,127	$ 971	$ 2,951	$ 2,330	$ 327	$ 198	$ 139	**$ 13,386**
Apr-12	$ (103)	$ (238)	$ (105)	$ 108	$ 189	$ (1,236)	$ (1,000)	$ (1,320)	$ 1,506	$ (30)	$ 122	$ (158)	**$ (2,265)**
May-12	$ (133)	$ (256)	$ (157)	$ 912	$ (9,551)	$ (12,069)	$ 192	$ 1,619	$ 870	$ 950	$ 565	$ (128)	**$ (17,185)**
Jun-12	$ 440	$ 276	$ 139	$ 3,859	$ 358	$ 696	$ (120)		$ 1,110	$ (26)	$ 862	$ 155	**$ 7,749**
Jul-12	$ -	$ (162)	$ (121)	$ (272)	$ -	$ 432	$ (40)	$ 363	$ 510		$ 1,100	$ 42	**$ 1,853**
Aug-12	$ (511)	$ 654	$ 1,348	$ (1,160)	$ (345)	$ (1,341)	$ (60)	$ 1,488	$ (754)	$ 540	$ 936	$ 33	**$ 827**
Sep-12	$ 84	$ (152)		$ (31)	$ (60)	$ (385)	$ (1,128)	$ (197)	$ 116	$ 732	$ (80)		**$ (1,102)**
Oct-12	$ (255)	$ (410)	$ (1,045)	$ (893)	$ 21,587	$ (911)	$ (1,357)	$ (698)	$ 801	$ 1,642	$ (291)	$ 64	**$ 18,235**
Nov-12	$ (4,886)	$ (376)	$ (3,769)	$ (2,709)	$ (1,116)	$ (320)		$ (468)	$ (384)	$ -	$ (200)		**$ (14,228)**
Dec-12	$ (123)	$ 18	$ (657)	$ (206)	$ (136)	$ (96)	$ (130)			$ 221	$ -	$ (1,156)	**$ (2,266)**
Jan-13	$ (37)	$ (354)		$ (35)	$ (489)	$ (313)	$ (585)	$ 131	$ 208	$ 503	$ (716)		**$ (1,687)**
Feb-13	$ 175	$ 348	$ 142	$ 133			$ (388)	$ 822	$ (630)	$ 120	$ 236	$ 15	**$ 972**
Mar-13		$ 441		$ (491)		$ (103)	$ (895)	$ (105)	$ (201)	$ (472)	$ (336)	$ 409	**$ (1,753)**
Apr-13	$ (40)	$ 288	$ (235)	$ 168	$ 252	$ 553	$ 9,585	$ (576)	$ 182	$ 90	$ (215)	$ 634	**$ 10,687**
May-13	$ (60)	$ (160)			$ -	$ -	$ 960		$ (540)	$ 450	$ 900	$ 250	**$ 1,800**
Jun-13		$ (180)	$ 75	$ (101)	$ -	$ -	$ 575	$ (264)	$ (357)	$ (96)	$ (98)	$ 272	**$ (175)**
Jul-13	$ (2)	$ (4,221)	$ (91)	$ (362)	$ (272)	$ (274)	$ (120)	$ (1,761)	$ (249)	$ -	$ 1,871	$ (1,346)	**$ (6,826)**
Aug-13		$ (104)			$ (169)	$ (20)	$ (216)	$ (94)	$ 192	$ (45)	$ -	$ (28)	**$ (484)**
Sep-13	$ 61	$ (416)	$ (150)					$ (24)		$ (230)	$ (363)	$ (234)	**$ (1,357)**
Oct-13		$ (167)		$ (86)	$ (359)		$ 20			$ (750)	$ (200)	$ (748)	**$ (2,289)**
Nov-13				$ (1,471)	$ (140)	$ -		$ (72)	$ -	$ (140)	$ -	$ (300)	**$ (2,123)**
Dec-13								$ (600)	$ (120)	$ (3,060)	$ (94)	$ (174)	**$ (4,047)**

Total	**$ 1,636,041**	**$ 2,027,785**	**$ 3,221,830**	**$ 3,117,292**	**$ 2,969,647**	**$ 2,702,295**	**$ 2,646,145**	**$ 2,549,522**	**$ 2,767,234**	**$ 2,869,949**	**$ 3,067,485**	**$ 2,667,853**	**$ 32,243,078**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Empire Plan
Paid Through December 31, 2013

2011 Incurreds

	Month Incurred												
Month Paid	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Total**
Jan-11	$ 73,669												**$ 73,669**
Feb-11	$ 920,767	$ 140,862											**$ 1,061,628**
Mar-11	$ 534,552	$ 1,222,900	$ 242,438										**$ 1,999,889**
Apr-11	$ 374,876	$ 548,235	$ 1,397,443	$ 173,659									**$ 2,494,212**
May-11	$ 153,785	$ 263,347	$ 885,245	$ 1,191,790	$ 184,018								**$ 2,678,184**
Jun-11	$ 114,348	$ 256,824	$ 467,344	$ 856,811	$ 1,438,992	$ 199,057							**$ 3,333,376**
Jul-11	$ 56,987	$ 186,802	$ 270,973	$ 460,399	$ 1,174,854	$ 1,728,665	$ 345,471						**$ 4,224,152**
Aug-11	$ 192,305	$ 150,338	$ 203,621	$ 224,795	$ 468,851	$ 1,016,530	$ 2,032,234	$ 585,781					**$ 4,874,455**
Sep-11	$ 28,844	$ 95,579	$ 62,899	$ 102,097	$ 262,626	$ 442,894	$ 606,949	$ 1,670,565	$ 425,011				**$ 3,697,463**
Oct-11	$ 65,422	$ 25,158	$ 42,811	$ 89,005	$ 207,675	$ 169,193	$ 264,616	$ 760,009	$ 1,854,121	$ 533,163			**$ 4,011,173**
Nov-11	$ 40,633	$ 37,205	$ 76,899	$ 7,754	$ 107,110	$ 114,839	$ 195,611	$ 326,314	$ 798,498	$ 2,081,021	$ 445,461		**$ 4,231,346**
Dec-11	$ 29,685	$ 25,183	$ 24,528	$ 35,415	$ 50,457	$ 89,391	$ 75,632	$ 205,417	$ 439,064	$ 982,694	$ 2,219,556	$ 705,425	**$ 4,882,448**
Jan-12	$ 43,243	$ 6,116	$ 24,561	$ 34,115	$ 42,006	$ 73,409	$ 100,223	$ 79,044	$ 142,519	$ 424,247	$ 770,484	$ 1,628,663	**$ 3,368,629**
Feb-12	$ 18,422	$ 12,507	$ 23,626	$ 36,813	$ 31,849	$ 39,000	$ 49,100	$ 71,812	$ 145,089	$ 206,123	$ 386,518	$ 816,204	**$ 1,837,064**
Mar-12	$ 11,975	$ 9,527	$ 20,936	$ 6,068	$ 25,215	$ 44,655	$ 67,430	$ 49,688	$ 68,301	$ 129,974	$ 189,676	$ 296,161	**$ 919,605**
Apr-12	$ 9,428	$ 15,006	$ 24,809	$ 45,866	$ 28,362	$ 20,911	$ 38,710	$ 37,313	$ 59,324	$ 81,539	$ 204,469	$ 141,591	**$ 707,327**
May-12	$ (815)	$ (6,455)	$ 395	$ 13,827	$ 6,862	$ 12,978	$ 31,348	$ 7,333	$ 19,830	$ 24,415	$ 46,897	$ 124,993	**$ 281,608**
Jun-12	$ 540	$ 3,242	$ 1,471	$ 6,006	$ 3,181	$ 2,636	$ 2,887	$ 20,684	$ 10,850	$ 16,440	$ 19,005	$ 21,459	**$ 108,403**
Jul-12	$ (1,841)	$ 769	$ (1,583)	$ 2,444	$ (4,587)	$ 730	$ 1,871	$ 5,082	$ 5,447	$ 44,375	$ 11,507	$ 12,838	**$ 77,052**
Aug-12	$ (4,391)	$ 536	$ 1,720	$ 728	$ 3,585	$ 3,446	$ 5,206	$ 10,008	$ 17,641	$ 5,528	$ 56,466	$ 34,000	**$ 134,473**
Sep-12	$ 4,294	$ 20,971	$ 14,331	$ 5,253	$ 786	$ 1,919	$ (5,726)	$ (4,556)	$ (24,236)	$ (11,015)	$ 2,308	$ 93,198	**$ 97,525**
Oct-12	$ (62)	$ 1,145	$ 505	$ 711	$ (6,199)	$ (12,055)	$ 2,523	$ (10,802)	$ 22,900	$ (2,813)	$ (8,568)	$ 1,442	**$ (11,272)**
Nov-12	$ (8,209)	$ 264	$ (3,482)	$ (5,502)	$ (4,420)	$ (408)	$ -	$ 312	$ 1,531	$ 345,772	$ 230	$ 2,989	**$ 329,077**
Dec-12	$ 61	$ (314)	$ 770	$ (8,493)	$ (3,058)	$ (11,103)	$ 14,129	$ 2,449	$ (3,758)	$ (38,442)	$ (32,899)	$ (13,050)	**$ (93,707)**
Jan-13	$ 231	$ 1,292	$ 2,737	$ (11,403)	$ 882	$ 13,541	$ 25,430	$ 980	$ 5,364	$ 1,110	$ 7,384	$ 6,811	**$ 54,358**
Feb-13	$ 148	$ (6,760)	$ 105	$ (8,028)	$ (6,090)	$ (7,663)	$ (7,002)	$ 270	$ (6,803)	$ (4,493)	$ (1,337)	$ 2,011	**$ (45,641)**
Mar-13			$ 2,467	$ (541)	$ 90	$ 14,588	$ 799	$ 679	$ (10,440)	$ 319	$ (1,947)	$ (55)	**$ 5,958**
Apr-13	$ 1,089	$ (470)	$ (49)	$ (46)	$ 522	$ (6)	$ (119)	$ 6,774	$ 114	$ (677)	$ 130	$ 372	**$ 7,632**
May-13	$ 120	$ 4,331	$ 3,243	$ (188)	$ 1,788	$ 1,223	$ 747	$ 919	$ 282	$ 1,665	$ 1,250	$ 868	**$ 16,250**
Jun-13	$ 8,579	$ 1,267	$ (7,703)	$ 52	$ 316	$ (1,038)	$ 1,184	$ (679)	$ (763)	$ 1,746	$ 2,850	$ (330)	**$ 5,480**
Jul-13	$ (495)	$ (165)	$ (155)	$ 19,804	$ 250	$ (116)	$ (653)	$ (672)	$ (1,494)	$ 30	$ (633)	$ 2,395	**$ 18,097**
Aug-13	$ (1,497)	$ (722)	$ 5,832	$ (430)	$ (490)	$ 37	$ (980)	$ (860)	$ 8	$ (742)	$ (3,666)	$ 432	**$ (3,078)**
Sep-13		$ (520)	$ 657	$ (315)	$ 680	$ (709)	$ (519)	$ (2,252)	$ (94)	$ (1,200)	$ (332)	$ (150)	**$ (4,753)**
Oct-13			$ (994)	$ (1,344)	$ (1,051)	$ (585)	$ (480)	$ (1,079)	$ (859)	$ (468)	$ (1,380)	$ (466)	**$ (8,705)**
Nov-13	$ -	$ -	$ (613)	$ (41)	$ -	$ (524)	$ (640)	$ (545)	$ (73)	$ 16,471	$ (102)	$ 169	**$ 14,101**
Dec-13	$ (36)	$ (72)	$ (240)	$ (136)	$ (254)	$ (482)	$ (160)	$ -	$ -	$ (391)	$ -	$ 135	**$ (1,636)**
Total	**$ 2,666,654**	**$ 3,013,927**	**$ 3,787,547**	**$ 3,276,943**	**$ 4,014,807**	**$ 3,954,952**	**$ 3,845,821**	**$ 3,819,992**	**$ 3,967,375**	**$ 4,836,393**	**$ 4,313,328**	**$ 3,878,105**	**$ 45,375,844**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Empire Plan
Paid Through December 31, 2013

2012 Incurreds

	Month Incurred												
Month Paid	**Jan-12**	**Feb-12**	**Mar-12**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Total**
Jan-12	$ 391,257												**$ 391,257**
Feb-12	$ 1,020,227	$ 459,579											**$ 1,479,806**
Mar-12	$ 438,427	$ 1,249,265	$ 560,513										**$ 2,248,205**
Apr-12	$ 122,675	$ 404,827	$ 1,482,484	$ 546,652									**$ 2,556,638**
May-12	$ 124,087	$ 174,025	$ 440,947	$ 1,449,295	$ 476,110								**$ 2,664,464**
Jun-12	$ 101,278	$ 196,185	$ 215,378	$ 858,083	$ 1,990,686	$ 512,875							**$ 3,874,484**
Jul-12	$ 37,345	$ 116,033	$ 139,961	$ 318,147	$ 667,627	$ 1,721,672	$ 518,863						**$ 3,519,647**
Aug-12	$ 75,411	$ 54,471	$ 128,881	$ 248,784	$ 327,670	$ 652,777	$ 1,850,102	$ 831,467					**$ 4,169,563**
Sep-12	$ 52,472	$ 21,053	$ 92,146	$ 62,766	$ 122,507	$ 389,343	$ 861,852	$ 2,059,053	$ 594,301				**$ 4,255,494**
Oct-12	$ 22,410	$ 58,470	$ 34,653	$ 139,198	$ 138,468	$ 173,676	$ 322,883	$ 682,129	$ 2,006,928	$ 810,208			**$ 4,389,022**
Nov-12	$ 123,232	$ 16,572	$ 36,059	$ 23,824	$ 63,953	$ 54,729	$ 82,782	$ 228,555	$ 385,890	$ 1,528,083	$ 588,242		**$ 3,131,920**
Dec-12	$ 5,811	$ 7,960	$ 29,937	$ 20,671	$ 46,931	$ 127,365	$ 103,729	$ 125,028	$ 238,508	$ 562,847	$ 1,672,010	$ 564,486	**$ 3,505,282**
Jan-13	$ 20,047	$ 19,325	$ 24,184	$ 38,781	$ 36,925	$ 106,643	$ 14,228	$ 213,387	$ 186,620	$ 351,139	$ 572,730	$ 1,492,548	**$ 3,076,557**
Feb-13	$ 6,209	$ 11,787	$ 33,265	$ 20,048	$ 28,126	$ 24,473	$ 52,376	$ 55,446	$ 107,180	$ 201,360	$ 287,136	$ 583,169	**$ 1,410,574**
Mar-13	$ 11,530	$ 15,576	$ 19,436	$ 22,901	$ 24,486	$ 137,877	$ (31,814)	$ 93,946	$ 79,923	$ 141,927	$ 214,168	$ 269,767	**$ 999,722**
Apr-13	$ 12,587	$ 9,448	$ 16,383	$ 63,389	$ 23,537	$ 23,954	$ 28,508	$ 32,500	$ 51,218	$ 81,587	$ 78,703	$ 150,684	**$ 572,499**
May-13	$ 11,172	$ 10,292	$ 11,571	$ 12,332	$ 19,486	$ 20,494	$ 36,682	$ 16,419	$ 23,466	$ 74,219	$ 70,336	$ 89,831	**$ 396,299**
Jun-13	$ 6,470	$ 3,194	$ 5,026	$ 3,516	$ 6,346	$ 9,419	$ 21,480	$ 28,027	$ 9,919	$ 25,115	$ 19,490	$ 36,269	**$ 174,271**
Jul-13	$ 2,910	$ 2,749	$ 1,504	$ 2,414	$ 9,520	$ 6,984	$ 6,307	$ 5,767	$ 3,969	$ 14,437	$ 16,380	$ 21,167	**$ 94,107**
Aug-13	$ 360	$ (564)	$ 671	$ 2,012	$ 1,132	$ 3,794	$ 3,010	$ 4,680	$ 7,621	$ 7,513	$ 13,482	$ 26,017	**$ 69,729**
Sep-13	$ 952	$ 1,801	$ 1,049	$ 285	$ 2,384	$ 1,990	$ 1,646	$ 6,484	$ 5,803	$ 4,845	$ 10,904	$ 25,702	**$ 63,846**
Oct-13	$ (6,541)	$ 1,291	$ 172	$ 793	$ 2,994	$ 2,517	$ 2,220	$ 4,354	$ 2,915	$ 4,718	$ 2,403	$ 8,471	**$ 26,307**
Nov-13	$ 437	$ 480	$ 230	$ 420	$ 755	$ 120	$ 41,226	$ 16,738	$ 1,842	$ 3,981	$ 2,989	$ 5,901	**$ 75,118**
Dec-13	$ 6,274	$ 3,474	$ (460)	$ 3,737	$ (936)	$ 7,656	$ 862	$ 708	$ 116,919	$ 644	$ (659)	$ 1,217	**$ 139,436**
Total	**$ 2,587,041**	**$ 2,837,292**	**$ 3,273,990**	**$ 3,838,047**	**$ 3,988,706**	**$ 3,978,356**	**$ 3,916,943**	**$ 4,404,687**	**$ 3,823,021**	**$ 3,812,623**	**$ 3,548,314**	**$ 3,275,228**	**$ 43,284,248**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Empire Plan
Paid Through December 31, 2013

2013 Incurreds

	Month Incurred												
Month Paid	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Total**
Jan-13	$ 521,350												**$ 521,350**
Feb-13	$ 1,239,322	$ 378,682											**$ 1,618,004**
Mar-13	$ 474,855	$ 1,452,190	$ 614,564										**$ 2,541,608**
Apr-13	$ 365,883	$ 593,498	$ 1,787,056	$ 664,898									**$ 3,411,334**
May-13	$ 228,179	$ 319,669	$ 418,676	$ 1,940,588	$ 615,352								**$ 3,522,463**
Jun-13	$ 193,218	$ 103,446	$ 317,316	$ 695,871	$ 2,087,966	$ 503,172							**$ 3,900,989**
Jul-13	$ 72,588	$ 110,763	$ 127,214	$ 291,646	$ 706,206	$ 2,056,053	$ 639,297						**$ 4,003,767**
Aug-13	$ 87,390	$ 73,112	$ 102,284	$ 171,131	$ 385,851	$ 608,143	$ 2,101,373	$ 581,519					**$ 4,110,803**
Sep-13	$ 51,349	$ 54,900	$ 106,899	$ 99,817	$ 224,450	$ 227,743	$ 495,214	$ 1,755,590	$ 633,504				**$ 3,649,465**
Oct-13	$ 60,264	$ 41,140	$ 90,591	$ 99,644	$ 142,521	$ 142,158	$ 306,179	$ 686,364	$ 2,346,744	$ 907,288			**$ 4,822,893**
Nov-13	$ 31,964	$ 41,242	$ 40,801	$ 62,266	$ 140,198	$ 145,951	$ 135,395	$ 205,549	$ 587,578	$ 2,426,244	$ 576,400		**$ 4,393,588**
Dec-13	$ 23,945	$ 26,761	$ 27,622	$ 49,386	$ 76,746	$ 85,121	$ 118,554	$ 161,420	$ 315,791	$ 813,332	$ 2,188,730	$ 634,697	**$ 4,522,106**

Total	**$ 3,350,305**	**$ 3,195,401**	**$ 3,633,023**	**$ 4,075,247**	**$ 4,379,291**	**$ 3,768,342**	**$ 3,796,011**	**$ 3,390,441**	**$ 3,883,617**	**$ 4,146,865**	**$ 2,765,130**	**$ 634,697**	**$ 41,018,370**

NYS Mental Health and Substance Abuse Program
In-Network Claims Paid - Excelsior Plan
Paid Through December 31, 2013

2010 Incurreds

	Month Incurred												
Month Paid	**Jan-10**	**Feb-10**	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Total**
Jan-10	$ 78												**$ 78**
Feb-10	$ 560	$ 203											**$ 763**
Mar-10	$ 125	$ 820	$ 60										**$ 1,005**
Apr-10			$ 3,090	$ 45									**$ 3,135**
May-10			$ 4,680	$ 505	$ 200								**$ 5,385**
Jun-10				$ 1	$ 430	$ 80							**$ 511**
Jul-10		$ 10		$ 80	$ 151	$ 3,818	$ 80						**$ 4,139**
Aug-10						$ 6,045	$ 470	$ 50					**$ 6,565**
Sep-10				$ 105			$ 3	$ 75					**$ 183**
Oct-10	$ 65	$ 130	$ 130	$ 75	$ 90	$ (2,749)	$ 396	$ 1	$ 95	$ 30			**$ (1,737)**
Nov-10			$ 130		$ 130	$ 95	$ 30		$ 4	$ 60	$ 5		**$ 454**
Dec-10						$ 90	$ 15			$ 19	$ 30	$ 22	**$ 176**
Jan-11							$ 7				$ 4	$ 30	**$ 41**
Feb-11												$ 4	**$ 4**
Mar-11													**$ -**
Apr-11													**$ -**
May-11													**$ -**
Jun-11													**$ -**
Jul-11													**$ -**
Aug-11													**$ -**
Sep-11													**$ -**
Oct-11													**$ -**
Nov-11													**$ -**
Dec-11													**$ -**
Jan-12													**$ -**
Feb-12													**$ -**
Mar-12													**$ -**
Apr-12													**$ -**
May-12													**$ -**
Jun-12													**$ -**
Jul-12													**$ -**
Aug-12													**$ -**
Sep-12													**$ -**
Oct-12													**$ -**
Nov-12													**$ -**
Dec-12													**$ -**
Jan-13													**$ -**
Feb-13													**$ -**
Mar-13													**$ -**
Apr-13													**$ -**
May-13													**$ -**
Jun-13													**$ -**
Jul-13													**$ -**
Aug-13													**$ -**
Sep-13													**$ -**
Oct-13													**$ -**
Nov-13													**$ -**
Dec-13													**$ -**

Total	$ 828	$ 1,163	$ 8,090	$ 811	$ 1,001	$ 7,379	$ 1,001	$ 126	$ 99	$ 109	$ 39	$ 56	$ 20,701

NYS Mental Health and Substance Abuse Program
In-Network Claims Paid - Excelsior Plan
Paid Through December 31, 2013

2011 Incurreds

	Month Incurred												
Month Paid	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Total**
Jan-11													**$ -**
Feb-11	$ 98												**$ 98**
Mar-11		$ 60											**$ 60**
Apr-11	$ 44	$ 44	$ 60	$ 20									**$ 168**
May-11			$ 3	$ 48									**$ 51**
Jun-11			$ 70		$ 60								**$ 130**
Jul-11						$ 30	$ 20						**$ 50**
Aug-11						$ 3	$ 58						**$ 61**
Sep-11								$ 30	$ 80				**$ 110**
Oct-11									$ 226	$ 113			**$ 339**
Nov-11									$ 90	$ 113			**$ 203**
Dec-11											$ 17		**$ 17**
Jan-12												$ 6	**$ 6**
Feb-12													**$ -**
Mar-12													**$ -**
Apr-12													**$ -**
May-12													**$ -**
Jun-12													**$ -**
Jul-12													**$ -**
Aug-12													**$ -**
Sep-12													**$ -**
Oct-12													**$ -**
Nov-12													**$ -**
Dec-12													**$ -**
Jan-13													**$ -**
Feb-13													**$ -**
Mar-13													**$ -**
Apr-13													**$ -**
May-13													**$ -**
Jun-13													**$ -**
Jul-13													**$ -**
Aug-13													**$ -**
Sep-13													**$ -**
Oct-13													**$ -**
Nov-13													**$ -**
Dec-13													**$ -**
Total	**$ 141**	**$ 104**	**$ 133**	**$ 68**	**$ 60**	**$ 33**	**$ 78**	**$ 30**	**$ 396**	**$ 226**	**$ 17**	**$ 6**	**$ 1,292**

NYS Mental Health and Substance Abuse Program
In-Network Claims Paid - Excelsior Plan
Paid Through December 31, 2013

2012 Incurreds

	Month Incurred												
Month Paid	**Jan-12**	**Feb-12**	**Mar-12**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Total**
Jan-12	$ 249												**$ 249**
Feb-12	$ 8,965	$ 290											**$ 9,255**
Mar-12	$ 170	$ 547	$ 100										**$ 817**
Apr-12		$ 127	$ 764	$ 140									**$ 1,031**
May-12			$ 173	$ 656	$ 1,415								**$ 2,244**
Jun-12					$ 2,003	$ 275							**$ 2,278**
Jul-12				$ 140	$ 39	$ 461	$ 205						**$ 845**
Aug-12				$ 90	$ 200	$ 183	$ 481	$ 310					**$ 1,265**
Sep-12							$ 50	$ 688	$ 174				**$ 912**
Oct-12						$ 19	$ 204	$ 151	$ 7,278	$ 1,156			**$ 8,808**
Nov-12				$ 175		$ 6	$ 14	$ 11	$ 3	$ 1,081	$ 255		**$ 1,544**
Dec-12						$ 90	$ 45		$ 110	$ 222	$ 616	$ 531	**$ 1,614**
Jan-13							$ 22				$ 3,081	$ 290	**$ 3,393**
Feb-13								$ 32				$ 130	**$ 162**
Mar-13								$ 3,786					**$ 3,786**
Apr-13													**$ -**
May-13							$ 45				$ 6	$ 90	**$ 141**
Jun-13													**$ -**
Jul-13													**$ -**
Aug-13									$ 10				**$ 10**
Sep-13													**$ -**
Oct-13													**$ -**
Nov-13													**$ -**
Dec-13													**$ -**
Total	**$ 9,384**	**$ 963**	**$ 1,037**	**$ 1,201**	**$ 3,657**	**$ 1,034**	**$ 1,065**	**$ 4,978**	**$ 7,575**	**$ 2,459**	**$ 3,958**	**$ 1,041**	**$ 38,355**

NYS Mental Health and Substance Abuse Program
In-Network Claims Paid - Excelsior Plan
Paid Through December 31, 2013

2013 Incurreds

	Month Incurred												
Month Paid	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Total**
Jan-13	$ 142												**$ 142**
Feb-13	$ 1,012	$ 312											**$ 1,324**
Mar-13	$ 125	$ 515	$ 311										**$ 950**
Apr-13		$ 16	$ 223	$ 118									**$ 358**
May-13	$ 62	$ 18	$ 64	$ 1,027	$ 214								**$ 1,385**
Jun-13			$ 80	$ 290	$ 599	$ 213							**$ 1,181**
Jul-13			$ 28	$ 60	$ 38	$ 297	$ 189						**$ 612**
Aug-13			$ 7		$ 7	$ 124	$ 2,491	$ 92					**$ 2,721**
Sep-13							$ 52	$ 288	$ 83				**$ 424**
Oct-13					$ 16			$ 25	$ 255	$ 55			**$ 352**
Nov-13							$ 12	$ 53	$ 142	$ 563	$ 39		**$ 808**
Dec-13										$ 77	$ 310	$ 163	**$ 550**

Total	**$ 1,341**	**$ 860**	**$ 713**	**$ 1,495**	**$ 875**	**$ 634**	**$ 2,744**	**$ 459**	**$ 480**	**$ 695**	**$ 349**	**$ 163**	**$ 10,807**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Excelsior Plan
Paid Through December 31, 2013

2010 Incurreds

	Month Incurred												
Month Paid	**Jan-10**	**Feb-10**	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Total**
Jan-10													**$ -**
Feb-10													**$ -**
Mar-10		$ 240											**$ 240**
Apr-10		$ 120	$ 1,880										**$ 2,000**
May-10			$ 100	$ 300									**$ 400**
Jun-10				$ 200	$ 960	$ 270							**$ 1,430**
Jul-10						$ 746	$ 100						**$ 846**
Aug-10						$ 400	$ 1,060						**$ 1,460**
Sep-10			$ 100	$ 200	$ 100		$ -						**$ 400**
Oct-10						$ 966							**$ 966**
Nov-10													**$ -**
Dec-10													**$ -**
Jan-11							$ -						**$ -**
Feb-11							$ 20						**$ 20**
Mar-11													**$ -**
Apr-11													**$ -**
May-11													**$ -**
Jun-11													**$ -**
Jul-11													**$ -**
Aug-11													**$ -**
Sep-11													**$ -**
Oct-11													**$ -**
Nov-11													**$ -**
Dec-11													**$ -**
Jan-12													**$ -**
Feb-12													**$ -**
Mar-12													**$ -**
Apr-12													**$ -**
May-12													**$ -**
Jun-12													**$ -**
Jul-12													**$ -**
Aug-12													**$ -**
Sep-12													**$ -**
Oct-12													**$ -**
Nov-12													**$ -**
Dec-12													**$ -**
Jan-13													**$ -**
Feb-13													**$ -**
Mar-13													**$ -**
Apr-13													**$ -**
May-13													**$ -**
Jun-13													**$ -**
Jul-13													**$ -**
Aug-13													**$ -**
Sep-13													**$ -**
Oct-13													**$ -**
Nov-13													**$ -**
Dec-13													**$ -**

Total	**$ -**	**$ 360**	**$ 2,080**	**$ 700**	**$ 1,060**	**$ 2,382**	**$ 1,180**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 7,762**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Excelsior Plan
Paid Through December 31, 2013

2011 Incurreds

	Month Incurred												
Month Paid	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Total**
Jan-11													**$ -**
Feb-11													**$ -**
Mar-11													**$ -**
Apr-11													**$ -**
May-11													**$ -**
Jun-11													**$ -**
Jul-11		$ 196											**$ 196**
Aug-11													**$ -**
Sep-11													**$ -**
Oct-11													**$ -**
Nov-11													**$ -**
Dec-11													**$ -**
Jan-12													**$ -**
Feb-12													**$ -**
Mar-12													**$ -**
Apr-12													**$ -**
May-12													**$ -**
Jun-12													**$ -**
Jul-12													**$ -**
Aug-12													**$ -**
Sep-12													**$ -**
Oct-12													**$ -**
Nov-12													**$ -**
Dec-12													**$ -**
Jan-13													**$ -**
Feb-13													**$ -**
Mar-13													**$ -**
Apr-13													**$ -**
May-13													**$ -**
Jun-13													**$ -**
Jul-13													**$ -**
Aug-13													**$ -**
Sep-13													**$ -**
Oct-13													**$ -**
Nov-13													**$ -**
Dec-13													**$ -**
Total	**$ -**	**$ 196**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 196**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Excelsior Plan
Paid Through December 31, 2013

2012 Incurreds

	Month Incurred												
Month Paid	**Jan-12**	**Feb-12**	**Mar-12**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Total**
Jan-12													**$ -**
Feb-12													**$ -**
Mar-12		$ 120	$ 360										**$ 480**
Apr-12			$ 120	$ 360									**$ 480**
May-12				$ 265	$ 240								**$ 505**
Jun-12					$ 240	$ 120							**$ 360**
Jul-12						$ 360							**$ 360**
Aug-12							$ 646						**$ 646**
Sep-12							$ 37	$ 360					**$ 397**
Oct-12									$ 360	$ 240			**$ 600**
Nov-12													**$ -**
Dec-12										$ 120	$ 1,247		**$ 1,367**
Jan-13				$ 96				$ 96				$ 588	**$ 780**
Feb-13													**$ -**
Mar-13													**$ -**
Apr-13													**$ -**
May-13													**$ -**
Jun-13													**$ -**
Jul-13													**$ -**
Aug-13													**$ -**
Sep-13													**$ -**
Oct-13													**$ -**
Nov-13													**$ -**
Dec-13													**$ -**
Total	**$ -**	**$ 120**	**$ 480**	**$ 721**	**$ 480**	**$ 480**	**$ 683**	**$ 456**	**$ 360**	**$ 360**	**$ 1,247**	**$ 588**	**$ 5,975**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Excelsior Plan
Paid Through December 31, 2013

2013 Incurreds

	Month Incurred												
Month Paid	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Total**
Jan-13													**$ -**
Feb-13	$ 230												**$ 230**
Mar-13		$ 120	$ 240										**$ 360**
Apr-13	$ 360		$ 120	$ 240									**$ 720**
May-13				$ 360	$ 120								**$ 480**
Jun-13					$ 360	$ 120							**$ 480**
Jul-13						$ 616	$ 280						**$ 896**
Aug-13							$ 258	$ 472					**$ 730**
Sep-13								$ 240	$ 480				**$ 720**
Oct-13									$ 320	$ 440			**$ 760**
Nov-13										$ 452	$ 280		**$ 732**
Dec-13											$ 819	$ 503	**$ 1,322**

Total	**$ 590**	**$ 120**	**$ 360**	**$ 600**	**$ 480**	**$ 736**	**$ 538**	**$ 712**	**$ 800**	**$ 892**	**$ 1,099**	**$ 503**	**$ 7,430**

NYS Mental Health and Substance Abuse Program
In-Network Claims Paid - Student Employee Health Plan (SEHP)
Paid Through December 31, 2013

2010 Incurreds

	Month Incurred												
Month Paid	**Jan-10**	**Feb-10**	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Total**
Jan-10	$ 9,881												**$ 9,881**
Feb-10	$ 31,802	$ 10,840											**$ 42,643**
Mar-10	$ 4,415	$ 32,949	$ 15,780										**$ 53,144**
Apr-10	$ 2,019	$ 8,360	$ 22,627	$ 12,937									**$ 45,943**
May-10	$ 302	$ 1,090	$ 4,375	$ 22,218	$ 10,453								**$ 38,439**
Jun-10	$ 1,115	$ 679	$ 2,097	$ 7,117	$ 20,091	$ 10,278							**$ 41,377**
Jul-10	$ 50	$ 692	$ 1,784	$ 1,268	$ 5,281	$ 18,118	$ 13,656						**$ 40,848**
Aug-10	$ 220	$ 295	$ 504	$ 1,369	$ 2,349	$ 5,562	$ 40,495	$ 11,489					**$ 62,283**
Sep-10					$ 655	$ 2,610	$ 4,396	$ 15,731	$ 12,150				**$ 35,541**
Oct-10	$ 130	$ 98	$ 108	$ (311)	$ 724	$ 987	$ 1,277	$ 35,943	$ 26,800	$ 14,010			**$ 79,766**
Nov-10		$ -	$ -		$ (74)	$ 118	$ 308	$ 1,269	$ 6,284	$ 29,465	$ 14,275		**$ 51,645**
Dec-10					$ -	$ 64	$ 424	$ (65)	$ 23,113	$ 4,737	$ 24,526	$ 15,235	**$ 68,033**
Jan-11	$ 48				$ 105	$ 120	$ 460	$ 1,587	$ 2,364	$ 1,315	$ 3,826	$ 21,165	**$ 30,989**
Feb-11	$ 884				$ -	$ -	$ -		$ 334	$ 818	$ 1,986	$ 4,452	**$ 8,474**
Mar-11					$ 29		$ 90	$ -	$ 210	$ 354	$ 472	$ 1,687	**$ 2,842**
Apr-11										$ 244	$ 375	$ 356	**$ 975**
May-11					$ 6				$ -	$ -	$ -		**$ 6**
Jun-11										$ 75	$ 150	$ 75	**$ 300**
Jul-11						$ (346)	$ 346	$ (356)	$ 340		$ (50)		**$ (66)**
Aug-11									$ (48)	$ (96)	$ 32	$ 218	**$ 106**
Sep-11													**$ -**
Oct-11							$ (133)	$ -					**$ (133)**
Nov-11										$ 96			**$ 96**
Dec-11													**$ -**
Jan-12													**$ -**
Feb-12													**$ -**
Mar-12													**$ -**
Apr-12													**$ -**
May-12													**$ -**
Jun-12					$ (35)								**$ (35)**
Jul-12													**$ -**
Aug-12													**$ -**
Sep-12													**$ -**
Oct-12													**$ -**
Nov-12													**$ -**
Dec-12													**$ -**
Jan-13													**$ -**
Feb-13													**$ -**
Mar-13													**$ -**
Apr-13													**$ -**
May-13													**$ -**
Jun-13													**$ -**
Jul-13													**$ -**
Aug-13													**$ -**
Sep-13													**$ -**
Oct-13													**$ -**
Nov-13													**$ -**
Dec-13													**$ -**

Total	**$ 50,866**	**$ 55,004**	**$ 47,276**	**$ 44,599**	**$ 39,584**	**$ 37,510**	**$ 61,319**	**$ 65,598**	**$ 71,547**	**$ 51,018**	**$ 45,592**	**$ 43,187**	**$ 613,098**

NYS Mental Health and Substance Abuse Program
In-Network Claims Paid - Student Employee Health Plan (SEHP)
Paid Through December 31, 2013

2011 Incurreds

	Month Incurred												
Month Paid	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Total**
Jan-11	$ 15,672												**$ 15,672**
Feb-11	$ 21,705	$ 14,103											**$ 35,808**
Mar-11	$ 9,145	$ 25,982	$ 18,237										**$ 53,364**
Apr-11	$ 8,235	$ 8,129	$ 31,480	$ 15,805									**$ 63,649**
May-11	$ 681	$ 15,078	$ 6,610	$ 26,776	$ 12,297								**$ 61,442**
Jun-11	$ 295	$ 410	$ 13,473	$ 11,601	$ 26,095	$ 10,593							**$ 62,467**
Jul-11	$ 56	$ 535	$ 1,143	$ 2,239	$ 10,096	$ 29,761	$ 8,738						**$ 52,568**
Aug-11	$ 133	$ 303	$ 323	$ 849	$ 16,586	$ 8,076	$ 19,794	$ 10,996					**$ 57,059**
Sep-11				$ (270)	$ 29,632	$ 579	$ 5,862	$ 19,989	$ 10,810				**$ 66,602**
Oct-11	$ 406	$ (315)	$ 215	$ (10)	$ 1,056	$ 605	$ 2,220	$ 6,432	$ 25,571	$ 10,832			**$ 47,011**
Nov-11			$ 1,156	$ 208	$ 203	$ 240	$ 203	$ 984	$ 4,921	$ 33,677	$ 11,685		**$ 53,277**
Dec-11			$ 75			$ 565	$ 6,635	$ 620	$ 1,601	$ 6,552	$ 25,353	$ 15,689	**$ 57,090**
Jan-12		$ (50)	$ (265)		$ 194	$ 64	$ 174		$ 639	$ 1,935	$ 13,566	$ 22,702	**$ 38,958**
Feb-12				$ 68	$ 340	$ 272	$ 370	$ 651	$ 211	$ 1,184	$ 3,023	$ 4,346	**$ 10,465**
Mar-12					$ 28,158	$ 136			$ 230	$ 90	$ 12,809	$ 1,905	**$ 43,328**
Apr-12	$ 377		$ 75	$ 588	$ 750	$ 448	$ 384	$ 144	$ 502	$ 530	$ 465	$ 1,351	**$ 5,614**
May-12				$ 48	$ 96	$ 48					$ 100	$ 50	**$ 342**
Jun-12										$ 120		$ (265)	**$ (145)**
Jul-12									$ 225	$ 455	$ 225	$ 494	**$ 1,399**
Aug-12													**$ -**
Sep-12													**$ -**
Oct-12													**$ -**
Nov-12													**$ -**
Dec-12											$ 68		**$ 68**
Jan-13							$ 96	$ 139	$ 164	$ 278	$ 186	$ 162	**$ 1,026**
Feb-13													**$ -**
Mar-13													**$ -**
Apr-13													**$ -**
May-13													**$ -**
Jun-13											$ 79		**$ 79**
Jul-13													**$ -**
Aug-13													**$ -**
Sep-13	$ (85)												**$ (85)**
Oct-13													**$ -**
Nov-13													**$ -**
Dec-13													**$ -**
Total	**$ 56,620**	**$ 64,174**	**$ 72,521**	**$ 57,902**	**$ 125,503**	**$ 51,387**	**$ 44,476**	**$ 39,954**	**$ 44,874**	**$ 55,653**	**$ 67,558**	**$ 46,434**	**$ 727,058**

NYS Mental Health and Substance Abuse Program
In-Network Claims Paid - Student Employee Health Plan (SEHP)
Paid Through December 31, 2013

2012 Incurreds

	Month Incurred												
Month Paid	**Jan-12**	**Feb-12**	**Mar-12**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Total**
Jan-12	$ 16,052												**$ 16,052**
Feb-12	$ 25,105	$ 14,811											**$ 39,917**
Mar-12	$ 7,102	$ 29,764	$ 14,814										**$ 51,681**
Apr-12	$ 1,970	$ 6,132	$ 29,595	$ 11,744									**$ 49,441**
May-12	$ 895	$ 2,595	$ 9,503	$ 36,512	$ 11,803								**$ 61,308**
Jun-12	$ 225	$ 200	$ 1,066	$ 5,271	$ 30,827	$ 10,975							**$ 48,564**
Jul-12	$ 560	$ 730	$ 1,340	$ 3,074	$ 7,681	$ 24,815	$ 9,630						**$ 47,830**
Aug-12	$ 140	$ 236	$ 75	$ 275	$ 2,286	$ 6,565	$ 24,427	$ 11,966					**$ 45,970**
Sep-12	$ 165	$ 337	$ 120	$ 60	$ 408	$ 1,869	$ 5,350	$ 33,412	$ 7,774				**$ 49,495**
Oct-12	$ 70	$ 70	$ 590	$ 225	$ 3,947	$ 900	$ 2,361	$ 6,051	$ 45,464	$ 13,930			**$ 73,608**
Nov-12		$ 68	$ 320	$ 136	$ 5,508	$ 246	$ 839	$ 1,815	$ 3,743	$ 30,673	$ 13,510		**$ 56,858**
Dec-12	$ 450	$ 361	$ 168	$ 616	$ 324	$ 730	$ 716	$ 986	$ 2,713	$ 11,271	$ 68,636	$ 12,788	**$ 99,760**
Jan-13	$ 203	$ 203	$ 225	$ 162	$ 162	$ 23	$ 110	$ 611	$ 1,935	$ 3,313	$ 7,854	$ 25,414	**$ 40,216**
Feb-13			$ 108	$ 196			$ 440	$ 683	$ 689	$ 672	$ 1,810	$ 3,538	**$ 8,136**
Mar-13			$ 88	$ 68	$ -		$ 96	$ 263	$ 96	$ 96	$ 1,121	$ 1,829	**$ 3,658**
Apr-13						$ 130	$ 150	$ 75			$ 266	$ 392	**$ 1,013**
May-13											$ 68	$ 150	**$ 218**
Jun-13											$ 1,686	$ 136	**$ 1,822**
Jul-13							$ 53			$ 136	$ 476		**$ 665**
Aug-13						$ 104					$ (200)	$ 110	**$ 14**
Sep-13								$ 70			$ 136	$ 682	**$ 888**
Oct-13			$ (7)	$ (20)	$ -	$ 52							**$ 25**
Nov-13													**$ -**
Dec-13													**$ -**
Total	**$ 52,938**	**$ 55,508**	**$ 58,005**	**$ 58,320**	**$ 62,946**	**$ 46,410**	**$ 44,172**	**$ 55,932**	**$ 62,413**	**$ 60,091**	**$ 95,363**	**$ 45,040**	**$ 697,137**

NYS Mental Health and Substance Abuse Program
In-Network Claims Paid - Student Employee Health Plan (SEHP)
Paid Through December 31, 2013

2013 Incurreds

	Month Incurred												
Month Paid	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Total**
Jan-13	$ 8,351												**$ 8,351**
Feb-13	$ 36,168	$ 9,711											**$ 45,878**
Mar-13	$ 10,680	$ 33,418	$ 11,744										**$ 55,842**
Apr-13	$ 3,347	$ 7,885	$ 50,998	$ 12,697									**$ 74,926**
May-13	$ 3,008	$ 3,750	$ 8,984	$ 47,419	$ 13,149								**$ 76,310**
Jun-13	$ 1,709	$ 1,565	$ 2,941	$ 42,990	$ 27,736	$ 9,135							**$ 86,076**
Jul-13	$ 171	$ 177	$ 908	$ 2,887	$ 6,734	$ 26,161	$ 15,116						**$ 52,154**
Aug-13	$ 182	$ 443	$ 443	$ 517	$ 3,626	$ 6,374	$ 25,714	$ 8,767					**$ 46,065**
Sep-13	$ 183	$ (301)	$ 199	$ 446	$ 1,104	$ 2,043	$ 6,001	$ 18,854	$ 8,603				**$ 37,131**
Oct-13	$ 673	$ 589	$ 691	$ 303	$ 606	$ 1,807	$ 3,577	$ 6,053	$ 25,793	$ 13,676			**$ 53,767**
Nov-13	$ 195		$ 224	$ 52	$ 1,438	$ 234	$ 1,028	$ 1,947	$ 6,522	$ 23,377	$ 10,465		**$ 45,483**
Dec-13	$ 412	$ 413	$ 266	$ 626	$ 742	$ 655	$ 1,161	$ 1,026	$ 23,814	$ 8,626	$ 23,200	$ 13,869	**$ 74,811**

Total	**$ 65,079**	**$ 57,649**	**$ 77,399**	**$ 107,936**	**$ 55,134**	**$ 46,410**	**$ 52,595**	**$ 36,647**	**$ 64,733**	**$ 45,679**	**$ 33,664**	**$ 13,869**	**$ 656,794**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Student Enrollee Health Plan (SEHP)
Paid Through December 31, 2013

2010 Incurreds

	Month Incurred												
Month Paid	**Jan-10**	**Feb-10**	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Total**
Jan-10	$ 1,046												**$ 1,046**
Feb-10	$ 9,037	$ 1,958											**$ 10,995**
Mar-10	$ 6,505	$ 14,087	$ 4,690										**$ 25,281**
Apr-10	$ 5,057	$ 9,466	$ 20,606	$ 3,664									**$ 38,793**
May-10	$ 1,404	$ 4,456	$ 9,276	$ 21,588	$ 2,595								**$ 39,319**
Jun-10	$ 344	$ 758	$ 1,635	$ 8,297	$ 21,461	$ 3,485							**$ 35,979**
Jul-10	$ -	$ 354	$ 2,407	$ 3,933	$ 7,918	$ 18,029	$ 3,027						**$ 35,669**
Aug-10	$ 977	$ 1,076	$ 922	$ 1,685	$ 2,483	$ 11,333	$ 17,438	$ 4,936					**$ 40,849**
Sep-10	$ 340	$ 1,024	$ 1,123	$ 2,093	$ 1,919	$ 5,375	$ 11,105	$ 17,964	$ 5,825				**$ 46,768**
Oct-10	$ (340)	$ (420)	$ (210)		$ 216	$ 3,868	$ 3,865	$ 10,608	$ 19,276	$ 4,739			**$ 41,601**
Nov-10		$ 760	$ 1,735	$ 1,564	$ 2,234	$ 1,434	$ 4,336	$ 3,232	$ 7,951	$ 20,093	$ 6,683		**$ 50,021**
Dec-10				$ 1,210	$ 1,680	$ 1,680	$ 3,108	$ 2,108	$ 4,829	$ 9,692	$ 21,791	$ 5,488	**$ 51,586**
Jan-11						$ 166	$ 117	$ 938	$ 8,605	$ 1,840	$ 7,765	$ 14,405	**$ 33,837**
Feb-11	$ 540	$ 412		$ 100	$ 1,000	$ 100		$ 172	$ 1,462	$ 3,454	$ 3,638	$ 11,046	**$ 21,924**
Mar-11	$ 240	$ -		$ 325		$ 320	$ 638	$ 100	$ 3,942	$ 760	$ 3,064	$ 4,203	**$ 13,592**
Apr-11	$ 184	$ 336	$ 176			$ 240	$ 475	$ 765	$ 1,314	$ 3,333	$ 1,292	$ 3,868	**$ 11,983**
May-11	$ 88	$ 200	$ 280	$ 280	$ 112		$ -	$ -	$ -	$ 296	$ 554	$ 660	**$ 2,470**
Jun-11		$ 724		$ 112	$ 168	$ 312	$ 300	$ 412	$ 568	$ 524	$ 368	$ 464	**$ 3,952**
Jul-11												$ 156	**$ 156**
Aug-11													**$ -**
Sep-11			$ (286)										**$ (286)**
Oct-11													**$ -**
Nov-11							$ 50						**$ 50**
Dec-11													**$ -**
Jan-12													**$ -**
Feb-12													**$ -**
Mar-12													**$ -**
Apr-12													**$ -**
May-12													**$ -**
Jun-12													**$ -**
Jul-12													**$ -**
Aug-12													**$ -**
Sep-12													**$ -**
Oct-12													**$ -**
Nov-12													**$ -**
Dec-12				$ (120)									**$ (120)**
Jan-13													**$ -**
Feb-13													**$ -**
Mar-13													**$ -**
Apr-13													**$ -**
May-13													**$ -**
Jun-13													**$ -**
Jul-13													**$ -**
Aug-13													**$ -**
Sep-13													**$ -**
Oct-13													**$ -**
Nov-13													**$ -**
Dec-13													**$ -**

Total	**$ 25,421**	**$ 35,190**	**$ 42,354**	**$ 44,731**	**$ 41,787**	**$ 46,342**	**$ 44,459**	**$ 41,235**	**$ 53,773**	**$ 44,731**	**$ 45,154**	**$ 40,290**	**$ 505,465**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Student Enrollee Health Plan (SEHP)
Paid Through December 31, 2013

2011 Incurreds

	Month Incurred												
Month Paid	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Total**
Jan-11	$ 836												**$ 836**
Feb-11	$ 15,075	$ 2,860											**$ 17,935**
Mar-11	$ 11,522	$ 21,049	$ 4,283										**$ 36,855**
Apr-11	$ 4,641	$ 9,511	$ 25,568	$ 2,959									**$ 42,679**
May-11	$ 2,097	$ 4,626	$ 10,018	$ 14,819	$ 1,244								**$ 32,804**
Jun-11	$ 1,068	$ 2,102	$ 8,193	$ 11,637	$ 24,434	$ 2,364							**$ 49,798**
Jul-11	$ 1,504	$ 533	$ 2,139	$ 7,895	$ 12,429	$ 26,968	$ 2,841						**$ 54,309**
Aug-11	$ 360	$ 451	$ 804	$ 4,232	$ 8,915	$ 18,391	$ 29,359	$ 7,534					**$ 70,046**
Sep-11	$ 949	$ 1,515	$ 601	$ 1,016	$ 3,545	$ 1,179	$ 4,388	$ 10,109	$ 5,497				**$ 28,801**
Oct-11	$ -	$ 200	$ 632	$ 1,456	$ 2,262	$ 2,942	$ 6,524	$ 8,611	$ 29,351	$ 6,835			**$ 58,813**
Nov-11	$ 256	$ 192	$ 1,248	$ 484	$ 692	$ 1,372	$ 4,090	$ 2,498	$ 14,571	$ 35,369	$ 7,392		**$ 68,164**
Dec-11	$ 1,800	$ 564	$ 897	$ 1,792	$ 944	$ 2,720	$ 1,079	$ 1,152	$ 15,950	$ 50,494	$ 33,631	$ 6,668	**$ 117,691**
Jan-12	$ 300	$ 200	$ 300	$ 508	$ 500	$ 866	$ 1,440	$ 1,220	$ 7,245	$ 6,970	$ 10,615	$ 21,344	**$ 51,509**
Feb-12					$ 560	$ 560		$ 200	$ 1,128	$ 2,393	$ 4,882	$ 16,103	**$ 25,826**
Mar-12		$ 464	$ 528	$ 1,004	$ 1,160	$ 348	$ 708	$ 364	$ 1,668	$ 1,236	$ 3,345	$ 5,419	**$ 16,244**
Apr-12		$ 150			$ 450	$ 936	$ 879	$ 879	2,336	$ 7,176	$ 1,302	$ 1,402	**$ 15,510**
May-12				$ (144)	$ 104		$ 104	$ 124	$ 104	$ 532	$ 979	$ 1,724	**$ 3,527**
Jun-12				$ 300	$ 150					$ 450			**$ 900**
Jul-12						$ 960	$ 720	$ 960	$ 240	$ 809		$ (174)	**$ 3,515**
Aug-12													**$ - **
Sep-12										$ 260	$ 260	$ 390	**$ 910**
Oct-12					$ 256	$ 256	$ 128		$ 192	$ 192	$ 502	$ 240	**$ 1,766**
Nov-12											$ 420	$ 560	**$ 980**
Dec-12													**$ - **
Jan-13											$ 190	$ 656	**$ 846**
Feb-13													**$ - **
Mar-13													**$ - **
Apr-13													**$ - **
May-13													**$ - **
Jun-13													**$ - **
Jul-13													**$ - **
Aug-13													**$ - **
Sep-13													**$ - **
Oct-13							$ (144)						**$ (144)**
Nov-13													**$ - **
Dec-13													**$ - **
Total	**$ 40,409**	**$ 44,417**	**$ 55,212**	**$ 47,958**	**$ 57,644**	**$ 59,864**	**$ 52,117**	**$ 33,652**	**$ 78,281**	**$ 112,716**	**$ 63,519**	**$ 54,332**	**$ 700,121**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Student Enrollee Health Plan (SEHP)
Paid Through December 31, 2013

2012 Incurreds

	Month Incurred												
Month Paid	**Jan-12**	**Feb-12**	**Mar-12**	**Apr-12**	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Total**
Jan-12	$ 5,986												**$ 5,986**
Feb-12	$ 29,517	$ 6,264											**$ 35,781**
Mar-12	$ 11,306	$ 37,783	$ 9,936										**$ 59,025**
Apr-12	$ 4,067	$ 10,460	$ 31,268	$ 8,194									**$ 53,989**
May-12	$ 1,091	$ 4,080	$ 16,976	$ 35,539	$ 8,653								**$ 66,338**
Jun-12	$ 2,092	$ 3,919	$ 6,175	$ 10,485	$ 32,452	$ 7,227							**$ 62,349**
Jul-12	$ 470	$ 3,385	$ 3,806	$ 9,342	$ 14,693	$ 20,788	$ 4,355						**$ 56,839**
Aug-12	$ 1,200	$ 1,440	$ 2,502	$ 1,870	$ 8,344	$ 17,229	$ 27,087	$ 6,162					**$ 65,835**
Sep-12	$ 620		$ 150	$ 360	$ 1,912	$ 3,778	$ 7,610	$ 17,117	$ 4,790				**$ 36,337**
Oct-12	$ 1,264	$ 1,692	$ 3,661	$ 4,592	$ 6,559	$ 4,960	$ 6,872	$ 9,932	$ 34,362	$ 10,187			**$ 84,081**
Nov-12	$ -		$ 1,200	$ 1,700	$ 1,982	$ 2,356	$ 3,304	$ 2,992	$ 59,189	$ 24,819	$ 5,693		**$ 103,235**
Dec-12	$ 80	$ 240	$ 520	$ 404	$ 536	$ 1,310	$ 2,396	$ 3,536	$ 5,776	$ 17,232	$ 37,167	$ 5,285	**$ 74,482**
Jan-13	$ 860	$ 280	$ 8	$ (140)	$ 1,992	$ 1,550	$ 2,880	$ 3,386	$ 8,686	$ 11,918	$ 16,498	$ 30,795	**$ 78,713**
Feb-13	$ 116		$ 560	$ 756	$ 408	$ 738	$ 1,250	$ 710	$ 15,893	$ 5,144	$ 7,870	$ 12,268	**$ 45,713**
Mar-13			$ 982	$ 448	$ 271	$ 336	$ 2,376	$ 1,515	$ 3,292	$ 5,766	$ 8,440	$ 5,801	**$ 29,227**
Apr-13	$ 70	$ 628	$ 600	$ 450	$ 600	$ 750	$ 234	$ 656	$ 422	$ 1,252	$ 1,652	$ 2,860	**$ 10,174**
May-13	$ 300	$ 200				$ 520	$ 570	$ 350	$ 100	$ 200	$ (56)	$ 2,070	**$ 4,254**
Jun-13					$ 179	$ (520)	$ (200)	$ 90	$ 187	$ 720		$ 300	**$ 756**
Jul-13								$ 160		$ 300	$ 80		**$ 540**
Aug-13													**$ -**
Sep-13								$ 768	$ 512	$ 128	$ 120	$ 180	**$ 1,708**
Oct-13						$ -	$ (160)		$ -	$ (52)	$ 1,550	$ 1,800	**$ 3,138**
Nov-13													**$ -**
Dec-13		$ (420)	$ (21)	$ (500)									**$ (941)**
Total	**$ 59,038**	**$ 69,950**	**$ 78,323**	**$ 73,500**	**$ 78,580**	**$ 61,022**	**$ 58,574**	**$ 47,374**	**$ 133,209**	**$ 77,614**	**$ 79,014**	**$ 61,359**	**$ 877,557**

NYS Mental Health and Substance Abuse Program
Out-of-Network Claims Paid - Student Enrollee Health Plan (SEHP)
Paid Through December 31, 2013

2013 Incurreds

	Month Incurred												
Month Paid	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Total**
Jan-13	$ 9,341												**$ 9,341**
Feb-13	$ 24,966	$ 11,033											**$ 36,000**
Mar-13	$ 17,235	$ 33,053	$ 8,757										**$ 59,045**
Apr-13	$ 15,339	$ 16,866	$ 33,773	$ 7,094									**$ 73,072**
May-13	$ 4,614	$ 7,803	$ 16,560	$ 36,900	$ 6,476								**$ 72,354**
Jun-13	$ 5,187	$ 8,675	$ 14,197	$ 20,213	$ 76,942	$ 4,534							**$ 129,749**
Jul-13	$ 4,038	$ 4,825	$ 6,295	$ 14,181	$ 30,118	$ 36,588	$ 5,895						**$ 101,940**
Aug-13	$ 3,465	$ 1,715	$ 2,874	$ 7,385	$ 10,213	$ 19,716	$ 33,800	$ 6,984					**$ 86,151**
Sep-13	$ 3,760	$ 4,060	$ 4,413	$ 4,346	$ 2,664	$ 6,939	$ 18,691	$ 28,487	$ 6,906				**$ 80,265**
Oct-13	$ 2,121	$ 4,205	$ 1,190	$ 2,195	$ 4,163	$ 4,518	$ 8,659	$ 15,109	$ 53,573	$ 12,336			**$ 108,070**
Nov-13	$ 503	$ 1,021	$ 1,383	$ 1,512	$ 2,139	$ 2,581	$ 3,950	$ 2,650	$ 15,529	$ 77,904	$ 7,130		**$ 116,301**
Dec-13			$ 560	$ 512	$ 828	$ 1,280	$ 1,886	$ 1,966	$ 9,491	$ 19,968	$ 38,780	$ 7,389	**$ 82,660**

Total	**$ 90,570**	**$ 93,256**	**$ 90,003**	**$ 94,338**	**$ 133,544**	**$ 76,156**	**$ 72,880**	**$ 55,196**	**$ 85,500**	**$ 110,207**	**$ 45,910**	**$ 7,389**	**$ 954,947**

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Mapping Notes
		Interchange Control Header											
ISA		Interchange Header		**ISA**		**Interchange Control Header**			Required			Identifies an interchange of functional groups and interchange control data.	ISA*00* *00* *30*141788609*30*123456789*000309*1356*U*00401*000000001*1*P*:~
					ISA01		Author Info Qualifier	Author Information Qualifier	M	2	2	00 = No Authorization Information Present 03 = Additional Data Identification	Set to 00 (zero zero)
					ISA02		Author Information	Authorization Information	M	10	10		n/a
					ISA03		Security Info Qual	Security Information Qualifier	M	2	2	00 = No Security Information Present 01 = Password	Set to 00 (zero zero)
					ISA04		Security Information	Security Information	M	10	10		n/a
					ISA05		Interchange Id Qual	Interchange Id Qualifier	M	2	2	01 = Duns Number 14 = Duns Plus Prefix 20 = Health Industry Number 27 = Carrier Identification Num 28 = FIIN Number 29 = Medicare Provider Num 30 = Federal Tax Id Num 33 = NAIC Company Code ZZ = Mutually Defined	Set to 30
					ISA06		Interchange Sender Id	Interchange Sender Id	M	15	15		Set to 146013200
					ISA07		Interchange ID Qual	Interchange Id Qualifier	M	2	2	01 = Duns Number 14 = Duns Plus Prefix 20 = Health Industry Number 27 = Carrier Identification Num 28 = FIIN Number 29 = Medicare Provider Num 30 = Federal Tax Id Num 33 = NAIC Company Code ZZ = Mutually Defined	Set to 30
					ISA08		Interchange Receiver Id	Interchange Receiver Id	M	15	15	In absence of a value from the Carrier, defaulted to the Benefit Plan Name.	Set to Trading partner ID
					ISA09		Interchange Date	Interchange Date	M	8	8	CCYYMMDD	System generated. Format: yymmdd
					ISA10		Interchange Time	Interchange Time	M	4	4	HHMM	System generated. Format: hhmm
					ISA11		Inter Ctrl Stand Ident	Interchange Control Standards Identifier	M	1	1	U = US EDI ASC X12, TDCC, and USC	Set to U
					ISA12		Inter Ctrl Version Num	Interchange Control Version Number	M	5	5		Set to 00501
					ISA13		Inter Ctrl Number	Interchange Control Number	M	9	9		System generated
					ISA14		Ack Requested	Acknowledgement Requested	M	1	1	0 = No Acknowledgement Requested 1 = Acknowledgement Requested	Set to 1
					ISA15		Test Indicator	Test Indicator	M	1	1	P = Production Data T = Test Data	set to P
					ISA16		Component Elem Sepera	Component Element Separator	M	1	1		Set to :

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Mapping Notes
		Functional Group Header											
GS		Group Header		**GS**		**Functional Group Header**			Required			Identifies the start of a functional group and provides control data.	GS*BE*146013200*123456789*20031009*1700*1*X*004010X095A1~
					GS01		Functional ID Code	Functional Identifier Code	M	2	2	BE = Benefit Enrollment and Maintenance (834)	Set to BE
					GS02		Application Send's Code	Application Sender's Code	M	2	15		Set to 146013200
					GS03		Application Rec's Code	Application Receiver's Code	M	2	15		By agreement between partners
					GS04		Date	Date	M	8	8	CCYYMMDD	System generated. Format: ccyymmdd
					GS05		Time	Time	M	4	8	Can be HHMM, HHMMSS, HHMMSSD, or HHMMSSDD (D = decimal seconds)	System generated. Format: hhmm
					GS06		Group Ctrl Number	Group Control Number	M	1	9		System generated.
					GS07		Responsible Agency Code	Responsible Agency Code	M	1	2		Set to X
					GS08		Ver/Release ID Code	Version/Release/Industry Identifier Code	M	1	12		Set to 005010X220A1
		Functional Group Trailer											
GE	Trailer			**GE**		**Functional Group Trailer**			Required			Indicates the end of a functional group and provides control information	GE*6542*1~
					GE01		Number of TS Included	Number of Transactions Sets Included	M	1	6	Total number of transaction sets in the functional group or interchange group	System generated.
					GE02		Group Ctrl Number	Group Control Number	M	1	9	Unique control number .	System generated.
		Interchange Control Trailer											
IEA	Trailer			**IEA**		**Interchange Control Trailer**			Required			Indicates the end of an interchange functional groups and related control segments	IEA*1*000000001~
					IEA01		Num of Inc Funct Group	Number of Included Functional Groups	M	1	5	The number of functional groups included in the interchange	System generated.
					IEA02		Inter Ctrl Number	Interchange Control Number	M	9	9	An assigned control number .	System generated.

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
		Header											
ST	Header	Header	010	**ST**		**Transaction Set Header**			Required			Indicates start of transaction set and assigns control number.	ST*834*6 ~
834					ST01		TS ID Code	Transaction Set Identifier Code	M	3	3	Code to identify transaction set type. Set benefit enrollment transaction set to 834.	Set to 834.
					ST02		TS Control Number	Transaction Set Control Number	M	4	9	Unique control number.	The transaction set control numbers in ST02 and SE02 must be identical. Assign starting with 0001 and increment forward. Control numbers are unique within a specific functional group but can repeat in other groups and interchanges.
					ST03		Implementation Convention Reference	Implementation Convention Reference	M	1	35	Reference assigned to identify Implementation Convention	Set to 005010X220A1. This field contains the same value as GS08.
BGN	Header	Header	020	**BGN**		**Beginning Segment**			Required			Indicates the beginning of a transaction set.	BGN*00*000000000000196*20000309*1356 ****2~
					BGN01		TS Purpose Code	Transaction Set Purpose Code	M	2	2	00 = Original. First time transaction sent 15 = Resubmission. Corrected transaction, original not yet processed by receiver. 22 = Information Copy. Same as original transmission.	Default to '00'
					BGN02		Reference Ident	Reference Identification Transaction Set Identifier Code	M	1	30	Unique control number.	Set to a unique identifying reference number.
					BGN03		Date	Date Transaction Set Creation Date	M	8	8	CCYYMMDD	System generated. Set to 8 positions. Format: ccyymmdd
					BGN04		Time	Time Transaction Set Creation Time	M	4	8	Can be HHMM, HHMMSS, HHMMSSD, or HHMMSSDD (D = decimal seconds)	System generated. Format: hhmmss
					BGN05		Time Code	Time Code Time Zone Code	S	2	2	CD Central Daylight Time,CS Central Standard Time,CT Central Time,ED Eastern Daylight Time,ES Eastern Standard Time,ET Eastern Time,MD Mountain Daylight Time,MS Mountain Standard Time,MT Mountain Time,PT Pacific Time. If BGN05 , then BGN04 is required.	Optional. Not used.
					BGN06		Reference Ident	Reference Identification Transaction Set Identifier Code	O	1	30	If BGN01 = 15 or 22, then cross reference Reference Ident of the original transaction.	Optional. If 00 then not used. If 15 or 22 then write original transaction ref id number.
					BGN07		Transaction Type Code - Not Used		n/a	2	2		n/a
					BGN08		Action Code	Reference Identification Transaction Set Identifier Code	M	1	2	2 = Change (Update) - Identifies transactions for additions, terminations and changes to current enrollment 4 = Verify - Identifies system compare or verify partner's systems	Required Default = 2
REF	Header	Header	030	**REF**		**Transaction Set Policy Number**			Situational			Segment is used if a unique ID number applies to the entire transaction set.	REF*38*0000~
38					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	38 = Master policy number code.	Set to 38.
					REF02		Reference Ident	Reference Identification Master Policy Number	X	1	30	Master Policy Number. At least one REF02 is required.	Set to master policy number. Value to be supplied by Carrier Default =00000
DTP	Header	Header	040	**DTP**		**File Effective Date**			Situational				Carrier information requirement can adequately be satisfied without it. Data element is not used.

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	007 = Effective 303 = Maintenance Effective 382 = Enrollment 388 = Payment Commencement	Not used
D8					DTP02		Date Time Format Qual	Date Time Period Format Qualifier	M	2	3	D8 = Date expressed in CCYYMMDD.	Not used
					DTP03		Date Time Period	Date Time Period	M	1	35		Not used
		1000A Sponsor Name											
N1	Header	1000A Sponsor Name	070	**N1**		**Sponsor Name**			Required			Identifies the organization paying for the coverage by type, name, and code. At least one N102 or N103 is required.	N1*P5*NEW YORK STATE*FI*141788609~
P5					N101		Entity ID Code	Entity Identifier Code	M	2	3	P5 = Plan Sponsor.	Set to P5.
					N102		Name		X	1	0	NEW YORK STATE	NEW YORK STATE
					N103		ID Code Qualifier	Entity Identifier Code	X	1	2	FI = Federal Taxpayers Identification Number. ZZ = Mutually Defined (HIPAA Id) If N104 present then required.	Set to FI = Federal Taxpayers Identification Number. Once National Payer ID is mandated, then use ZZ.
					N104		ID Code	Identification Code Sponsor Identifier	X	2	80	Sponsor Identifier. If N103 present then required.	Set to 146013200
		1000B Payer Name											
N1	Header	1000B Payer Name	070	**N1**		**Payer Name**			Required			Identifies the insurance company (receiver) type, name, and code. At least one N102 or N103 is required.	N1*IN**FI*123456789~
IN					N101		Entity ID Code	Entity Identifier Code	M	2	3	IN = Insurer.	Set to IN.
					N102		Name		n/a	1	60	Not used.	Set to placeholder.
					N103		ID Code Qualifier	Entity Identifier Code	X	1	2	FI = Federal Taxpayers Identification Number. XV = Health Care Financing Administration National Payer Identification. If N104 present then required.	FI = Federal Taxpayers Identification Number. XV = Health Care Financing Administration National Payer Identification. Once National Payer ID is mandated, then use only XV
					N104		ID Code	Identification Code Insurer Identification Code	X	2	80	Insurer identification code. If N103 present then required.	Data not captured by a PS field. Value to be supplied by carrier.
		1000C Broker Name											
N1	Header	1000C Broker Name	70	**N1**		**TPA/Broker Name**			Situational			Identifies TPA/broker organization by type, name, and code. At least one N102 or N103 is required.	Segment does not apply.
n/a					N101		Entity ID Code	Entity Identifier Code	M	2	3	BO = Broker TV = Third party admin	n/a
Not used					N102		Name - Not Used		n/a	1	60	Not used.	n/a
n/a					N103		ID Code Qualifier	Entity Identifier Code	X	1	2	94 = Code assigned by receiving organization FI = Federal Taxpayers Identification Number. XV = Health Care Financing Administration National Payer Identification. If N104 present then required.	n/a
n/a					N104		ID Code	Identification Code TPA or Broker Identification	X	2	80	TPA or Broker Identification code. If N103 present then required.	n/a
ACT	Header	1100C Broker Account	120	**ACT**		**TPA/Broker Account Information**			Situational			Specifies account information if different than account number of sponsor.	Segment does not apply.
n/a					ACT01		Account Number	TPA or Broker Account Number	M	1	35	Account number assigned.	n/a
Not used					ACT02		Name - Not Used		n/a	1	60		n/a
Not used					ACT03		ID Code Qual - Not Used		n/a	1	2		n/a
Not used					ACT04		ID Code - Not Used		n/a	2	80		n/a
Not used					ACT05		Acct Num Qual-Not Used		n/a	1	3		n/a
n/a					ACT06		Account Number		X	1	35	Account number - more than one account number applies to this transaction.	n/a

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
		2000 Member Detail											
INS	Detail	2000 Member Detail	010	**INS**		**Member Level Detail**			Optional			Provides insured benefit information for subscriber and dependents. Subscriber information must precede dependent information or have been submitted in a previous transmission.	INS*Y*18*021**A*E**FT**N~
					INS01		Yes/No Cond Resp Code	Yes/No Condition or Response Code Subscriber Indicator	M	1	1	N = No Status of Insured is dependent. Y = Yes Status of insured is subscriber.	N = No Status of Insured is dependent. Y = Yes Status of insured is subscriber.
					INS02		Individual Relat Code	Individual Relationship Code	M	2	2	01 = Spouse 18 = Self 19 = Child 25 = Ex-spouse 53 = Life partner 38 = Collateral dependent	Set SP = 01 Set subscriber = 18 Set S and D = 19 Set X = 25 Set DP = 53 Set O = 38
					INS03		Maintenance Type Code	Maintenance Type Code	O	3	3	001 = Change 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 030 = Audit or compare	001 = Change 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 030 = Audit or compare
					INS04		Maintain Reason Code	Maintenance Reason Code	O	2	3	01 = Divorce 02 = Birth 03 = Death 04 = Retirement 05 = Adoption 06 = Strike 07 = Termination of Benefits 08 = Termination of Employment 09 = COBRA 10 = COBRA Premium Paid 11 = Surviving Spouse 14 = Voluntary Withdrawal 15 = Primary Care Provider Change 16 = Quit 17 = Fired 18 = Suspended 20 = Active 21 = Disability 22 = Plan Change 25 = Change in Identifying Data Elements 26 = Declined Coverage 27 = Pre-Enrollment 28 = Initial Enrollment 29 = Benefit Selection 31 = Legal Separation 32 = Marriage 33 = Personnel Data 37 = Leave of Absence with Benefits 38 = Leave of Absence without Benefits 39 = Lay Off with Benefits 40 = Lay Off without Benefits 41 = Re-enrollment 43 = Change of Location XN = Notification Only XT = Transfer	Use of this segment is limited to identify a change in Benefit Program and Termination Reason for Conversion of Coverage. Set Termination of Benefits = 07 Set Termination of Employment = 08 Set change in Benefit Program = 22 Set Plan Change = 22 Set Alternate Identifier Change = 25 Set Initial Enrollment = 28 Set Re-enrollment = 41
					INS05		Benefit Status Code	Benefit Status Code	O	1	1	Type coverage for which benefits paid A= Active C = Cobra S = Surviving Insured T = Tax equity and fiscal responsibility act	Type of Set default to 'A' unless termination, Cobra or surviving spouse Valid values are 'A', 'C', and 'S' TEFRA is a medical assistance program for families with children with disabilities. Eligibility is determined based on medical and level of care criteria.

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
					INS06		Medicare Plan Code	Medicare Plan Code	O	1	1	A = Medicare Part A B = Medicare Part B C = Medicare Part A and B D = Medicare E = No Medicare	Currently only track Medicare Part B Valid values are 'B' and 'E'
					INS07		Cobra Qual Event Code	Cobra Qualifying Event Code	O	1	2	1 = Termination of Employment 2 = Reduction of work hours 3 = Medicare 4 = Death 5 = Divorce 6 = Separation 7 = Ineligible Child 8 = Bankruptcy of a Retired Employee	1 = Termination of Employment 2 = Reduction of work hours 3 = Medicare 4 = Death 5 = Divorce 6 = Separation 7 = Ineligible Child 8 = Bankruptcy of a Retired Employee
					INS08		Employment Status Code	Employment Status Code	O	2	2	If enrollment is in a non employment based program such as medicare, then use status of subscriber in that program. AO = Active Military - Overseas AU = Active Military - USA FT = Full Time Active L1 = Leave of Absence PT = Part Time Active RT = Retired TE = Terminated	Subscriber only Valid values are: FT PT TE RT L1
					INS09		Student Status Code	Student Status Code	O	1	1	F = Full-time N = Not a student P = Part-time	F = Full-time N = Not a student
					INS10		Yes/No Cond Resp Code	Yes/No Condition or Response Code Handicap Indicator	O	1	1	Handicap indicator: N = no Y = yes	For dependent only
D8					INS11		Date Time Format Qual	Date Time Period Format Qualifier	X	2	3	D8 = Date expressed in CCYYMMDD If INS12 present then required.	Set to D8
					INS12		Date Time Period	Date Time Period Insured Individual Death Date	X	1	35	Date of Death If INS11 present then required.	Dependent date of death not captured on the database
Not used					INS13		Confidentiality - Not Used		n/a			Not used.	Set to placeholder.
Not used					INS14		City Name - Not Used		n/a			Not used.	Set to placeholder.
Not used					INS15		State Code - Not Used		n/a			Not used.	Set to placeholder.
Not used					INS16		Country Code - Not Used		n/a			Not used.	Set to placeholder.
					INS17		Number	Number	O	1	9	Not available	Not a PeopleSoft delivered database element. Data for this element is not available.
REF	Detail	2000 Member Detail	020	**REF**		**Subscriber Number**			Required			Specifies identifying information. Segment contains a unique **SUBSCRIBER** Id Number (SSN or other) This occurrence identified by the OF qualifier. Identifier is used in order to link subscriber with dependents.	REF*0F*123456789~
0F					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	0F = Subscriber Number.	Set to 0F (zero f).
					REF02		Reference Ident	Reference Identification Subscriber Identifier	X	1	30	At least one REF02 is required.	Social security number should be used until the National identifier is available.
REF	Detail	2000 Member Detail	020	**REF**		**Member Policy Number**			Situational			Specifies identifying information. Segment is used if group number applies to all coverage data for the member.	REF*1L*NYSLWOP~
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	1L = Group or Policy Number	Set to 1L.
					REF02		Reference Ident	Reference Identification Insured Group or Policy Number	X	1	30	At least one REF02 is required	Join Company and Ben_Status Valid Company Values: PA ,PE ,NYS, MTH Valid Benefit Statuses: DISP,FAML,IMIL,LPTA,LTDS,LWOP, MILL,PRFL,STDS,WCDF,WCLV, WCMC,WCWR, RTNA. If 'CBL' then = '00306666'

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
REF	Detail	2000 Member Detail	020	**REF**		**Member Identification Number**			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*23*891234567~
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	23 = Client Number	Set to 23
					REF02		Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30	Subscriber Supplemental Identifier. At least one REF02 is required.	Bea_Altid
REF	Detail	2000 Member Detail	020	**REF**		**Member Identification Number**			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*DX*00001~
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	DX = Department/Agency Number	Set to DX
					REF02		Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30	Subscriber Supplemental Identifier. At least one REF02 is required.	Cust_Id If 'HIP' and CUSTID = '00001 then map DEPTID If 'UHG' and txn for dep then add dep # to end of CUSTID field
REF	Detail	2000 Member Detail	020	**REF**		**Member Identification Number**			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*F6*123456789A~
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	F6 = Health Insurance Claim(HIC) Number	Set to F6
					REF02		Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30	Subscriber Supplemental Identifier. At least one REF02 is required.	Health Insurance Claim(HIC) Number
REF	Detail	2000 Member Detail	020	**REF**		**Member Identification Number**			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*Q4*999999999~
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	Q4 = Prior Identification Number	Set to Q4
					REF02		Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30	Subscriber Supplemental Identifier. At least one REF02 is required.	Previous Subscriber SSN covered under.
REF	Detail	2000 Member Detail	020	**REF**		**Member Identification Number**			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*6O*999999999~
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	6O = Cross Reference Number	Set to 6O
					REF02		Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30	Subscriber Supplemental Identifier. At least one REF02 is required.	This number is used to tie the Survivng Insured back to the original Subscriber ID.
REF	Detail	2000 Member Detail	020	**REF**		**Member Identification Number**			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*ZZ*E~
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	ZZ = Mutually Defined	Set to ZZ
					REF02		Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30	Subscriber Supplemental Identifier. At least one REF02 is required.	Valid values are: 'E' = Employee Rate 'T' = Total Rate
DTP	Detail	2000 Member Detail	025	**DTP**		**Member Level Dates**			Situational			Specifies date, time, and time period for member enrollment and benefit changes.	DTP*336*D8*20000207~

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Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	286 = Retirement 296 = Return to Work 297 = Date Last Worked 300 = Enrollment Signature Date 301 = Cobra Qualifying Event 303 = Maintenance Effective 336 = Employment Begin 337 = Employment End 338 = Medicare Begin 339 = Medicare End 340 = Cobra Begin 341 = Cobra End 350 = Education Begin 351 = Education End 356 = Eligibility Begin 357 = Eligibility End 383 = Adjusted Hire 393 = Plan Participation Suspension 394 = Rehire 473 = Medicaid Begin 474 = Medicaid End	Valid values are: 303 = Maintenance Effective 336 = Employment Begin 338 = Medicare Begin 339 = Medicare End
DTP	Detail	2000 Member Detail	025	**DTP**		**Member Level Dates**			Situational			Specifies date, time, and time period for member enrollment and benefit changes.	DTP*336*D8*20000207~
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	286 = Retirement 296 = Return to Work 297 = Date Last Worked 300 = Enrollment Signature Date 301 = Cobra Qualifying Event 303 = Maintenance Effective 336 = Employment Begin 337 = Employment End 338 = Medicare Begin 339 = Medicare End 340 = Cobra Begin 341 = Cobra End 350 = Education Begin 351 = Education End 356 = Eligibility Begin 357 = Eligibility End 383 = Adjusted Hire 393 = Plan Participation Suspension 394 = Rehire 473 = Medicaid Begin 474 = Medicaid End	Valid values are: 303 = Maintenance Effective 336 = Employment Begin 338 = Medicare Begin 339 = Medicare End
					DTP02		Date Time Format Qual	Date Time Period Format Qualifier	M	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8
					DTP03		Date Time Period	Date Time Period Status Information Effective Date	M	1	35		Effective Date

EDI 834 Transaction Set File Layout														
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
		2100A Member Name											
NM1	Detail	2100A Member Name	030	**NM1**		**Member Name**			Required			Segment identifies member being enrolled, changed, or corrected.	NM1*IL*1*SMITH*JOHN*M**SR*34*123456789~
					NM101		Entity ID Code	Entity Identifier Code	M	2	3	74 = Transmission is correcting the identifier information on a member already enrolled. Usage of this code requires the sending of an NM1 with code '70' in loop 2100B.	Set to 74 if changing existing identifying information.
												IL = Enrollment of a new member or update of a member with no change in identifying information. The identifying information for a member is specified under the insurance contract between the sponsor and payer.	Set to IL for new enrollment or change not related to identifying information.
1					NM102		Entity Type Qualifier	Entity Type Qualifier	M	1	1	1 = Person.	Set to 1.
					NM103		Name Last/ Org Name	Name Last or Organization Name Subscriber Last Name	O	1	35		Member Last Name
					NM104		Name First	Name First Subscriber First Name	O	1	25		Member First Name
					NM105		Name Middle	Name Middle Subscriber Middle Name	O	1	25		Member Middle Name
					NM106		Name Prefix - Not Used						Not used
					NM107		Name Suffix	Name Suffix Subscriber Name Suffix	O	1	10		Member Name Suffix
					NM108		ID Code Qualifier		X	1	2	34 = Social security number. ZZ = Mutually defined Use of NM109 is required with NM108.	For BCBS,CBL,ESI, set to ZZ. All other carriers, set to 34 If value is invalid ssn then set to ZZ
					NM109		ID Code	Identification Code Subscriber Identifier	X	2	80	Use of NM108 is required with NM109.	For BCBS, CBL,ESI set to ssn + dependent_benef. All other carriers set to ssn until the National identifier is available
PER	Detail	2100A Member Name	040	**PER**		**Member Communications Numbers**			Situational			Identifies where administrative communication should be sent.	PER*IP**TE*518/229-0457~
IP					PER01		Contact Funct Code	Contact Function Code	M	2	2	IP = Insured Party	Set to IP
					PER02				n/a	1	60	Name - Not Used.	Set to placeholder.
TE					PER03		Comm Number Qual	Communication Number Qualifier	X	2	2	EM = Electronic Mail EX = Telephone Extension FX = Facsimile HP = Home Phone Number TE = Telephone WP = Work Phone Number If PER04 present then required.	Set to TE (if available)
					PER04		Comm Number	Communication Number	X	1	80	If PER03 present then required.	Format: 9999999999
TE					PER05		Comm Number Qual	Communication Number Qualifier	X	2	2	EM = Electronic Mail EX = Telephone Extension FX = Facsimile HP = Home Phone Number TE = Telephone WP = Work Phone Number If PER06 present then required.	Not used
					PER06		Comm Number	Communication Number	X	1	80	If PER05 present then required.	Not used
					PER07		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER08 present then required.	Not used
					PER08		Comm Number	Communication Number	X	1	80	If PER07 present then required.	Not used
N3	Detail	2100A Member Name	050	**N3**		**Member Residence Strt Addr - DCS use field for Mailing address**			Situational			DCS is sending the mailing address for the member. Send for subscriber and dependents.	N3*81 COLUMBIA STREET~
					N301		Address Information	Address Information Subscriber Address Line	M	1	55		Address line 1
					N302		Address Information	Address Information Subscriber Address Line	O	1	55		Address line 2

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
N4	Detail	2100A Member Name	060	**N4**		**Member Residence City, State, ZIP Code - DCS mail address**			Situational			Identifies location of member. Send for subscriber and dependents.	N4*ALBANY*NY*122100000*USA*~
					N401		City Name	City Name Subscriber City Name	O	2	30		City Name
					N402		State or Prov Code	State or Province Code Subscriber State Code	O	2	2		State or Prov Code
					N403		Postal Code	Postal Code Subscriber Postal Code	O	3	15		Postal Code
					N404		Country Code	Country Code	O	2	3		Country
CY					N405		Location Qualifier	Location Qualifier	O	1	2	CY = County	Set to CY
					N406		Location Identifier	Location Identifier Location Identification Code (County)	O	1	30	If N406 is present then N405 is required.	County
DMG	Detail	2100A Member Name	080	**DMG**		**Member Demographics**			Situational			This segment is required for dependents until the national identifier for individuals is available. Once a national identifier is available, the national identifier should be sent in NM109. If DMG01 or DMG02 is present, then other is required.	DMG*D8*19720310*M*I~
D8					DMG01		Date Time format Qual	Date Time Format Qualifier	X	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8.
					DMG02		Date Time Period	Date Time Period Member Birth Date	X	1	35	Date of Birth.	Date of Birth.
					DMG03		Gender Code	Gender Code	O	1	1	F = female M = male U = unknown	F = female M = male U = unknown
					DMG04		Marital Status Code	Marital Status Code	O	1	1	B = Registered Domestic Partner D = Divorced I = Single M = Married R = Unreported S = Separated U = Unmarried(single,divorced,widowed) W = Widowed X = Legally Separated	Set C, Common Law = M Set D, Divorced = D Set E, Separated = S Set H, Head Household = U Set M, Married = M Set S, Single = I Set U, Unknown = R Set W, Widowed = W
					DMG05		Race or Ethic Code	Race or Ethic Code	O	1	1		Not Used
					DMG06		Citizen Status Code	Citizen Status Code	O	1	2		Not Used
LUI	Detail	2100A Member Name	150	**LUI**		**Member Language**			Situational			Used if member's language is other than english. This data should only be transmitted when required by the insurance contract and allowed by federal and state regulations.	Not used
					LUI01		ID Code Qualifier	Identification Code Qualifier	X	1	2	Use of LUI02 is required with LUI01.	Not used
					LUI02		ID Code	Identification Code Language Code	X	2	80	Use of LUI01 is required with LUI02.	Not used
					LUI03		Description	Description Language Description	X	1	80		Not used
					LUI04		Use of Lang Indica	Use of Language Indicator Language Use Indicator	O	1	2		Not used

EDI 834 Transaction Set File Layout														
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
		2100B Incorrect Member Name											
NM1	Detail	2100B Incorrect Member Name	030	**NM1**		**Incorrect Member Name**			Situational			Segment is used only with a corrected name in loop 2100A.	NM1*70*1*SMITH*JON***34*987654321~
70					NM101		Entity ID Code	Entity Identifier Code	M	2	3	70 = Prior Incorrect Insured Use if correcting identifier information on a member already enrolled. Send NM1 with code 74 in loop 2100A.	Set to 70.
1					NM102		Entity Type Qualifier	Entity Type Qualifier	M	1	1	1 = Person	Set to 1
					NM103		Name Last/ Org Name	Name Last or Organization Name Prior Incorrect Insured Last Name	O	1	35		Prior Incorrect Insured Last Name
					NM104		Name First	Name First Prior Incorrect Insured First Name	O	1	25		Prior Incorrect Insured First Name
					NM105		Name Middle	Name Middle Prior Incorrect Insured Middle Name	O	1	25		Prior Incorrect Insured Middle Name
					NM106		Name Prefix	Name Prefix Prior Incorrect Insured Name Prefix	O	1	10		Set to placeholder.
					NM107		Name Suffix	Name Suffix Prior Incorrect Insured Name Suffix	O	1	10		Prior Incorrect Insured Name Suffix
34					NM108		ID Code Qualifier	Identification Code Qualifier	X	1	2	34 = Social security number. ZZ = Mutually Defined Use of NM109 is required with NM108.	For BCBS,CBL,ESI, set to ZZ All other carriers, set to 34
					NM109		ID Code	Identification Code Prior Incorrect Insured Identifier	X	2	80	Use of NM108 is required with NM109.	For BCBS, CBL,ESI set to ssn + dependent_benef. All other carriers set to ssn
DMG	Detail	2100B Incorrect Member Name	080	**DMG**		**Incorrect Member Demographics**			Situational			Segment used only if demographic information, such as date of birth is used to identify a member and it is being changed.	DMG*D8*19740311~
D8					DMG01		Date Time Format Qual	Date Time Period Format Qualifier	M	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8.
					DMG02		Date Time Period	Date Time Period Prior Incorrect Insured Birth Date	X	1	35	Prior incorrect insured birth date. Use of DMG01 is required with DMG02.	Prior Incorrect Insured Birth Date
					DMG03		Gender Code	Gender Code	O	1	1	F = female M = male U = unknown	F = female M = male U = unknown
		2100C Member Address - DCS using for residence address											
NM1	Detail	2100C Member Address	030	**NM1**		**Member Mailing Address - DCS use field for residence address**			Situational			DCS is sending the residence address when the mailing address is a PO Box address in loop 2100A.	NM1*31*1~
31					NM101		Entity ID Code	Entity Identifier Code	M	2	3	31 = Postal Mailing Address	Set to 31
1					NM102		Entity Type Qualifier	Entity Type Qualifier	M	1	1	1 = Person	Set to 1
N3	Detail	2100C Member Address	050	**N3**		**Member Mail Street Addr - DCS use field for residence address**			Situational			DCS is sending the residence address when the mailing address is a PO Box address in loop 2100A.	N3*Street 1~
					N301		Address Information	Address Information Subscriber Address Line	M	1	55		Address Information
					N302		Address Information	Address Information Subscriber Address Line	O	1	55		Address Information
N4	Detail	2100C Member Address	060	**N4**		**Member Mail City, State, Zip**			Situational			This loop is sent if the member has a different mailing address from the residence address in loop 2100A.	N4*ALBANY*NY*122100000*USA*~
					N401		City Name	City Name Subscriber City Name	O	2	30		City Name
					N402		State or Prov Code	State or Province Code Subscriber State Code	O	2	2		State or Prov Code
					N403		Postal Code	Postal Code Subscriber Postal Code	O	3	15		Postal Code
					N404		Country Code	Country Code	O	2	3		Country Code
Not Used					N405		Location Qualifier-not used		n/a				Not Used
Not Used					N406		Location Identifier-not used		n/a				Not Used

EDI 834 Transaction Set File Layout														
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
		2100D Member Employer											
NM1	Detail	2100D Member Employer	030	**NM1**		**Member Employer**			Situational			This loop is to be sent when the member is employed by someone other that the sponsor and the insurance contract requires the payer be notified of such employment.	Segment does not apply.
					NM101		Entity ID Code	Entity Identifier Code	M	2	3		n/a
					NM102		Entity Type Qualifier	Entity Type Qualifier	M	1	1		n/a
					NM103		Name Last/ Org Name	Name Last or Organization Name Insured Employer Name	O	1	35		n/a
					NM104		Name First	Name First Insured Employer First Name	O	1	25		n/a
					NM105		Name Middle	Name Middle Insured Employer Middle Name	O	1	25		n/a
					NM106		Name Prefix	Name Prefix Insured Employer Name Prefix	O	1	10		n/a
					NM107		Name Suffix	Name Suffix Insured Employer Name Suffix	O	1	10		n/a
					NM108		ID Code Qualifier	Identification Code Qualifier	X	1	2	Use of NM109 is required with NM108.	n/a
					NM109		ID Code	Identification Code Insured Employer Identifier	X	2	80	Use of NM108 is required with NM109.	n/a
PER	Detail	2100D Member Employer	040	**PER**		**Member Employer Communications Numbers**			Situational			When employer is applicable, segment identifies to whom administrative communications should be sent.	Segment does not apply.
					PER01		Contact Funct Code	Contact Function Code	M	2	2		n/a
					PER02		Name - Not Used		n/a	1	60	Name - Not Used.	n/a
					PER03		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER04 present then required.	n/a
					PER04		Comm Number	Communication Number	X	1	80	If PER03 present then required.	n/a
					PER05		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER06 present then required.	n/a
					PER06		Comm Number	Communication Number	X	1	80	If PER05 present then required.	n/a
					PER07		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER08 present then required.	n/a
					PER08		Comm Number	Communication Number	X	1	80	If PER07 present then required.	n/a
N3	Detail	2100D□Member	050	**N3**		**Member Employer Street Address**			Situational			When employer is applicable, segment identifies employer address.	Segment does not apply.
					N301		Address Information	Address Information	M	1	55		n/a
					N302		Address Information	Address Information	O	1	55		n/a
N4	Detail	2100D Member Employer	060	**N4**		**Member Employer City, State, Zip**			Situational			When employer is applicable, segment identifies employer address.	Segment does not apply.
					N401		City Name	City Name	O	2	30		n/a
					N402		State or Prov Code	State or Province Code	O	2	2		n/a
					N403		Postal Code	Postal Code	O	3	15		n/a
					N404		Country Code	Country Code	O	2	3		n/a
					N405		Location Qualifier	Location Qualifier	O	1	2		n/a
					N406		Location Identifier	Location Identifier	O	1	30	If N406 is present then N405 is required.	n/a
		2100E Member School											
NM1	Detail	2100E Member School	030	**NM1**		**Member School**			Situational			Loop is sent when member is enrolled in school and sponsor is required to notify payer.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					NM101		Entity ID Code	Entity Identifier Code	M	2	3		Not used
					NM102		Entity Type Qualifier	Entity Type Qualifier	M	1	1		Not used
					NM103		Name Last/ Org Name	Name Last or Organization Name	O	1	35		Not used

EDI 834 Transaction Set File Layout														
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
PER	Detail	2100E Member School	040	**PER**		**Member School Communications Numbers**			Situational			When school is applicable, segment identifies to whom administrative communications should be sent.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					PER01		Contact Funct Code	Contact Function Code	M	2	2	SK = School clerk	Not used
					PER02		Name - Not Used		n/a	1	60	Name - Not Used.	Set to placeholder.
					PER03		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER04 present then required.	Not used
					PER04		Comm Number	Communication Number	X	1	80	If PER03 present then required.	Not used
					PER05		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER06 present then required.	Not used
					PER06		Comm Number	Communication Number	X	1	80	If PER05 present then required.	Not used
					PER07		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER08 present then required.	Not used
					PER08		Comm Number	Communication Number	X	1	80	If PER07 present then required.	Not used
N3	Detail	2100E Member School	050	**N3**		**Member School Street Address**			Situational			When school is applicable, segment identifies school address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N301		Address Information	Address Information	M	1	55		Not used
					N302		Address Information	Address Information	O	1	55		Not used
N4	Detail	2100E Member School	060	**N4**		**Member School City, State, Zip**			Situational			When school is applicable, segment identifies school address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N401		City Name	City Name	O	2	30		Not used
					N402		State or Prov Code	State or Province Code	O	2	2		Not used
					N403		Postal Code	Postal Code	O	3	15		Not used
					N404		Country Code	Country Code	O	2	3		Not used
		2100F Custodial Parent											
NM1	Detail	2100F Custodial Parent	030	**NM1**		**Custodial Parent**			Situational			Loop is sent when custodial parent of a minor is someone other than the subscriber.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Could customize dependent/beneficiary or dependent/beneficiary comment panels. Customization not recommended.
					NM101		Entity ID Code	Entity Identifier Code	M	2	3		Not used
					NM102		Entity Type Qualifier	Entity Type Qualifier	M	1	1		Not used
					NM103		Name Last/ Org Name	Name Last or Organization Name	O	1	35		Not used
					NM104		Name First	Name First	O	1	25		Not used
					NM105		Name Middle	Name Middle	O	1	25		Not used
					NM106		Name Prefix	Name Prefix	O	1	10		Not used
					NM107		Name Suffix	Name Suffix	O	1	10		Not used
					NM108		ID Code Qualifier	Identification Code Qualifier	X	1	2	Use of NM109 is required with NM108.	Not used
					NM109		ID Code	Identification Code	X	2	80	Use of NM108 is required with NM109.	Not used
PER	Detail	2100F Custodial Parent	040	**PER**		**Custodial Parent Communications Numbers**			Situational			When custodial parent is applicable, segment identifies to whom administrative communications should be sent.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					PER01		Contact Funct Code	Contact Function Code	M	2	2		Not used
					PER02		Name - Not Used		n/a	1	60	Name - Not Used.	Not used
					PER03		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER04 present then required.	Not used
					PER04		Comm Number	Communication Number	X	1	80	If PER03 present then required.	Not used
					PER05		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER06 present then required.	Not used
					PER06		Comm Number	Communication Number	X	1	80	If PER05 present then required.	Not used
					PER07		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER08 present then required.	Not used
					PER08		Comm Number	Communication Number	X	1	80	If PER07 present then required.	Not used

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
N3	Detail	2100F Custodial Parent	050	**N3**		**Custodial Parent Street Address**			Situational			When custodial parent is applicable, segment identifies custodial address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N301		Address Information	Address Information	M	1	55		Not used
					N302		Address Information	Address Information	O	1	55		Not used
N4	Detail	2100F Custodial Parent	060	**N4**		**Custodial Parent City, State, Zip**			Situational			When custodial parent is applicable, segment identifies custodial address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N401		City Name	City Name	O	2	30		Not used
					N402		State or Prov Code	State or Province Code	O	2	2		Not used
					N403		Postal Code	Postal Code	O	3	15		Not used
					N404		Country Code	Country Code	O	2	3		Not used
		2100G Responsible Person											
NM1	Detail	2100G Responsible Person	030	**NM1**		**Responsible Person**			Situational			Loop identifies person responsible for the member. Responsible person is someone other than the subscriber. Data is intended for coverage programs that are not to be employment related, such as Medicare and Medicaid.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					NM101		Entity ID Code	Entity Identifier Code	M	2	3		Not used
					NM102		Entity Type Qualifier	Entity Type Qualifier	M	1	1		Not used
					NM103		Name Last/ Org Name	Name Last or Organization Name	O	1	35		Not used
					NM104		Name First	Name First	O	1	25		Not used
					NM105		Name Middle	Name Middle	O	1	25		Not used
					NM106		Name Prefix	Name Prefix	O	1	10		Not used
					NM107		Name Suffix	Name Suffix	O	1	10		Not used
					NM108		ID Code Qualifier	Identification Code Qualifier	X	1	2	Use of NM109 is required with NM108.	Not used
					NM109		ID Code	Identification Code	X	2	80	Use of NM108 is required with NM109.	Not used
PER	Detail	2100G Responsible Person	040	**PER**		**Responsible Person Communications Numbers**			Situational			When responsible person is applicable, segment identifies to whom administrative communications should be sent.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					PER01		Contact Funct Code	Contact Function Code	M	2	2		Not used
					PER02		Name - Not Used		n/a	1	60	Name - Not Used.	Not used
					PER03		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER04 present then required.	Not used
					PER04		Comm Number	Communication Number	X	1	80	If PER03 present then required.	Not used
					PER05		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER06 present then required.	Not used
					PER06		Comm Number	Communication Number	X	1	80	If PER05 present then required.	Not used
					PER07		Comm Number Qual	Communication Number Qualifier	X	2	2	If PER08 present then required.	Not used
					PER08		Comm Number	Communication Number	X	1	80	If PER07 present then required.	Not used
N3	Detail	2100G Responsible Person	050	**N3**		**Responsible Person Street Address**			Situational			When responsible person is applicable, segment identifies responsible address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N301		Address Information	Address Information	M	1	55		Not used
					N302		Address Information	Address Information	O	1	55		Not used
N4	Detail	2100G Responsible Person	060	**N4**		**Responsible Person City, State, Zip**			Situational			When responsible person is applicable, segment identifies responsible address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N401		City Name	City Name	O	2	30		Not used
					N402		State or Prov Code	State or Province Code	O	2	2		Not used
					N403		Postal Code	Postal Code	O	3	15		Not used
					N404		Country Code	Country Code	O	2	3		Not used

EDI 834 Transaction Set File Layout														
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
		2200 Disability Information											
DSB	Detail	2200 Disability Information	200	**DSB**		**Disability Information**			Situational			Segment used when enrolling or changing a disabled member. The DSB loop may only appear for the Subscriber.	DSB*3~
					DSB01		Disability Type Code	Disability Type Code	M	1	1	1 = Short Term Disability 2 = Long Term Disability 3 = Permanent or Total Disability 4 = No Disability	Valid Values: Set T = 2 Set P = 3 Set N = 4
Not used					DSB02		Quantity - Not Used					Not used	Not used
Not used					DSB03		Occupation Cd - Not Used					Not used	Not used
Not used					DSB04		Work Inty Code - Not Used					Not used	Not used
Not used					DSB05		Product Opt Cd - Not Used					Not used	Not used
Not used					DSB06		Monetary Amt - Not Used					Not used	Not used
DX					DSB07		Prod/Serv ID Qual	Product Service ID Qualifier	X	2	2	DX = International Classification of Diseases Clinical Modification(Icd-9-cm) Diagnosis If DSB09 present then required.	Not used
585					DSB08		Medical Code Value	Medical Code Value Diagnosis Code	X	1	15	Medical Code Value the only allowed value is 585 - End Stage Renal Disease If DSB08 present then required.	Not used
DTP	Detail	2200 Disability Information	210	**DTP**		**Disability Eligibility Dates**			Situational			Segment is used to send first and last date of disability.	DTP*360*D8*1996*1001~
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	360 = Disability Begin 361 = Disability End	360 = Disability Begin 361 = Disability End
D8					DTP02		Date Time Format Qual	Date Time Period Format Qualifier	M	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8.
					DTP03		Date Time Period	Date Time Period Disability Eligibility Date	M	1	35	Disability Eligibility Date	Disability Eligibility Date

EDI 834 Transaction Set File Layout														
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
		2300 Health Coverage											
HD	Detail	2300 Health Coverage	260	**HD**		**Health Coverage**			Situational			Segment is used to enroll a new member or add, update, or terminate coverage for an existing member.	HD*021**HLT**IND~
					HD01		Maintenance Type Code	Maintenance Type Code	M	3	3	001 = Change 002 = Delete 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 026 = Correction 030 = Audit or compare 032 = Employee Info Not Applicable	001 = Change 002 = Delete 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 030 = Audit or Compare
Not used					HD02		Maint Reason - Not Used					Not used	Not Used
					HD03		Insurance Line Code	Insurance Line Code	O	2	3	AG = Preventitive Care/Wellness AH = 24 Hour Care AJ = Medicare Risk AK = Mental Health DCP = Dental Capitation DEN = Dental EPO = Exclusive Provider Organization FAC = Facility HE = Hearing HLT = Health HMO = Health Maintenance Organization LTC = Long-Term Care LTD = Long-Term Disability MM = Major Medical MOD = Mail Order Drug PDG = Prescription Drug POS = Point of Service PPO = Preferred Provider Organization PRA = Practitioners STD = Short-Term Disability UR = Utilization Review VIS = Vision	Evaluate retro stack Valid Values : HLT PDG DEN VIS
					HD04		Plan Cvrg Description	Plan Cvrg Description	O	1	50	Use this element when additional information is needed by the insurer to describe the exact type of coverage being provided. If required by an insurer, this information must be included. The insurer establishes the content of this element.	Not applicable
					HD05		Coverage Level Code	Coverage Level Code	O	3	3	CHD = Children Only DEP = Dependents Only E1D = Employee and 1 Dependent E2D = Employee and 2 Dependents E3D = Employee and 3 Dependents E5D = Employee and 1 or More Dependents E6D = Employee and 2 or More Dependents E7D = Employee and 3 or More Dependents E8D = Employee and 4 or More Dependents E9D = Employee and 5 or More Dependents ECH = Employee and Children EMP = Employee Only ESP = Employee and Spouse FAM = Family IND = Individual SPC = Spouse and Children SPO = Spouse Only TWO = Two Party	Valid Values: IND FAM

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
DTP	Detail	2300 Health Coverage	270	**DTP**		**Health Coverage Eligibility Dates**			Required			Segment contains the date that maintenance was performed or effective, and the benefit begin and end dates for the coverage.	DTP*348*D8*20000320~
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	303 = Maintenance Effective 348 = Benefit Begin 349 = Benefit End	Valid Values: 348 = Benefit Begin 349 = Benefit End 303 = Maintenance Effective
D8					DTP02		Date Time Format Qual	Date Time Period Format Qualifier	M	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8.
					DTP03		Date Time Period	Date Time Period Coverage Period	M	1	35	Coverage Period	Coverage Period
REF	Detail	2300 Health Coverage	290	**REF**		**Health Coverage Policy Number**			Situational			Segment is used to identify a policy or group number for a particular insurance product if it has not already been identified in either REF02, position 1-030 or REF02, position 2-020. This is necessary when not all coverage types have the same group or policy.	REF*1L*001A01~
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	17 = Client Reporting Category	Set to 1L
					REF02		Reference Ident	Reference Identification Insured Group or Policy Number	X	1	30	Insured Group or Policy Number At least one REF02 is required.	Join Benefit Plan and Benefit Program
HD	Detail	2300 Health Coverage	260	**HD**		**Health Coverage**			Situational			Segment is used to indicate Med D enrollment	HD*021**PDG~ (Medicare D Enrollment)
					HD01		Maintenance Type Code	Maintenance Type Code	M	3	3	001 = Change 002 = Delete 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 026 = Correction 030 = Audit or compare 032 = Employee Info Not Applicable	001 = Change 002 = Delete 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 030 = Audit or Compare
Not used					HD02		Maint Reason - Not Used					Not used	Not Used
					HD03		Insurance Line Code	Insurance Line Code	O	2	3	AG = Preventitive Care/Wellness AH = 24 Hour Care AJ = Medicare Risk AK = Mental Health DCP = Dental Capitation DEN = Dental EPO = Exclusive Provider Organization FAC = Facility HE = Hearing HLT = Health HMO = Health Maintenance Organization LTC = Long-Term Care LTD = Long-Term Disability MM = Major Medical MOD = Mail Order Drug PDG = Prescription Drug POS = Point of Service PPO = Preferred Provider Organization PRA = Practitioners STD = Short-Term Disability UR = Utilization Review VIS = Vision	Evaluate retro stack Valid Values : PDG
					HD04		Plan Cvrg Description	Plan Cvrg Description	O	1	50	Use this element when additional information is needed by the insurer to describe the exact type of coverage being provided. If required by an insurer, this information must be included. The insurer establishes the content of this element.	Not applicable

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
					HD05		Coverage Level Code	Coverage Level Code	O	3	3	CHD = Children Only DEP = Dependents Only E1D = Employee and 1 Dependent E2D = Employee and 2 Dependents E3D = Employee and 3 Dependents E5D = Employee and 1 or More Dependents E6D = Employee and 2 or More Dependents E7D = Employee and 3 or More Dependents E8D = Employee and 4 or More Dependents E9D = Employee and 5 or More Dependents ECH = Employee and Children EMP = Employee Only ESP = Employee and Spouse FAM = Family IND = Individual SPC = Spouse and Children SPO = Spouse Only TWO = Two Party	Not applicable
DTP	Detail	2300 Health Coverage	270	**DTP**		**Health Coverage Eligibility Dates**			Required			Segment contains the date that maintenance was performed or effective, and the benefit begin and end dates for the coverage.	DTP*348*D8*20000320~
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	303 = Maintenance Effective 348 = Benefit Begin 349 = Benefit End	Valid Values: 348 = Benefit Begin 349 = Benefit End 303 = Maintenance Effective
D8					DTP02		Date Time Format Qual	Date Time Period Format Qualifier	M	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8.
					DTP03		Date Time Period	Date Time Period Coverage Period	M	1	35	Coverage Period	Coverage Period
REF	Detail	2300 Health Coverage	290	**REF**		**Health Coverage Policy Number**			Situational			Segment is used to identify a policy or group number for a particular insurance product if it has not already been identified in either REF02, position 1-030 or REF02, position 2-020. This is necessary when not all coverage types have the same group or policy.	Not applicable
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	17 = Client Reporting Category	Not applicable
					REF02		Reference Ident	Reference Identification Insured Group or Policy Number	X	1	30	Insured Group or Policy Number At least one REF02 is required.	Not applicable
IDC	Detail	2300 Health Coverage	300	**IDC**		**Identification Card**			Situational			Segment is used to request the production of an identification card due to an enrollment add, change, or statement. An enrollment statement refers to no change being made except to request a replacement ID card.	IDC*12345678901016*H~ Not used anymore
					IDC01		Plan Cvrg Description	Plan Coverage Description	M	1	50	A description or number that identifies the plan or coverage. Element used when additional information is needed by the insurer to identify the type of ID card that will be produced. If requested, this information must be established by the insurer. Set IDC01 to a single zero if this does not apply.	Set to the member's card number.
					IDC02		ID Card Type Code	ID Card Type Code	M	1	1	D = Dental Insurance H = Health Insurance P = Prescription Drug Insurance	D = Dental Insurance H = Health Insurance P = Prescription Drug Insurance
					IDC03		Quantity	Quantity Identification Card Count	O	1	15	Send only if quantity is greater than 1	Set to zero

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
					IDC04		Action Code	Action Code	O	1	2	1 = Add 2 = Change RX = Replace (no data change)	Set new enrollee to '1' Set changes to '2'
LX	Detail	2300 Health Coverage	310	**LX**		**Provider Information**			Situational			Loop provides information about primary care or capitated physicians and pharmacies chosen by the enrollee in a managed care plan when that selection is made through the sponsor. Use one iteration of the loop to identify each applicable health care service.	The scope of Nybeas does not include the maintenance of a PC P dictionary by DCS and does not provide for maintaining database records to support employee PCP selections and changes. The delivered interface will not include PCP data fields
					LX01		Assigned Number	Assigned Number	M	1	6	Number assigned for differentiation within a transaction set.	Not used

EDI 834 Transaction Set File Layout														
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
		2310 Provider Information											
NM1	Detail	2310 Provider Information	320	**NM1**		**Provider Name**			Required			The National Provider ID should be passed in NM109. Until the NP ID is available the Federal Tax ID should be used. Fields NM103 through NM107 are used when the sponsor has the provider's name but does not pass the standard ID in NM109 because the ID is unknown or local regulations prevent using Social Security Numbers or Federal Tax IDs. If the entity code, NM102, is 1 for person and the name is being passed, NM103 and NM104 must be used and NM105, NM106 andNM107 may be used. When the name is being passed for a non-person entity, then use only NM103. NM104 through NM107 are not populated.	The scope of Nybeas does not include the maintenance of a PC P dictionary by DCS and does not provide for maintaining database records to support employee PCP selections and changes. The delivered interface will not include PCP data fields
					NM101		Entity ID Code	Entity Identifier Code	M	2	3		Not used
					NM102		Entity Type Qualifier	Entity Type Qualifier	M	1	1		Not used
					NM103		Name Last/ Org Name	Name Last or Organization Name	O	1	35		Not used
					NM104		Name First	Name First	O	1	25		Not used
					NM105		Name Middle	Name Middle	O	1	25		Not used
					NM106		Name Prefix	Name Prefix	O	1	10		Not used
					NM107		Name Suffix	Name Suffix	O	1	10		Not used
					NM108		ID Code Qualifier	Identification Code Qualifier	X	1	2	Use of NM109 is required with NM108.	Not used
					NM109		ID Code	Identification Code	X	2	80	Use of NM108 is required with NM109.	Not used
					NM110		Entity Relat Code	Entity Relationship Code	X	2	2		Not used
PLA	Detail	2310 Provider Information	395	**PLA**		**PCP Change Reason**			Situational			Segment is used to report the reason and the effective date that a member changes primary care provider.	The scope of Nybeas does not include the maintenance of a PC P dictionary by DCS and does not provide for maintaining database records to support employee PCP selections and changes. The delivered interface will not include PCP data fields
					PLA01		Action Code	Action Code	M	1	2		Not used
					PLA02		Entity ID Code	Entity Identifier Code	M	2	3		Not used
					PLA03		Date	Date	M	8	8		Not used
													Not used
					PLA05		Maintain Reason Code	Maintain Reason Code	O	2	3		Not used
		2320 Coordination of Benefits											
COB	Detail	2320 Coordination of Benefits	400	**COB**		**Coordination of Benefits**			Situational			Loop is used when an individual has another insurance plan with benefits similar to those covered by the insurance product specified in the HD segment for this occurrence of Loop ID-2300. COB information is provided by individual, not by subscriber.	COB*S*NYSHIP*1~ Used to indicate NYSHIP is Secondary due to Medicare D enrollment
					COB01		Payer Resp Seq No Code	Payer Responsibility Sequence Number Code	O	1	1	P = Primary S = Secondary T = Tertiary U = Unknown	Valid Values: S = Secondary
					COB02		Reference Ident	Reference Identification Insured Group or Policy Number	O	1	30	Insured Group or Policy Number	NYSHIP
					COB03		Benefits Coord Code	Coordination of Benefits Code	O	1	1	1 = Coordination of Benefits 5 = Unknown 6 = No Coordination of Benefits	1 = Coordination of Benefits

EDI 834 Transaction Set File Layout

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute Min	Attribute Max	Comments	Notes / Examples
REF	Detail	2320 Coordination of Benefits	405	**REF**		**Additional Coordination of Benefits Identifiers**			Situational			Specifies COB identifying information.	The scope of Nybeas does not include the maintenance of a COB data by DCS. The delivered interface will not include PCP data fields
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	1W = Member Identification Number 6O = Account Suffix Code 6P = Group Number A6 = Employee Identification Number SY = Social Security Number	Not used
					REF02		Reference Ident	Reference Identification	X	1	30	Insured Group or Policy Number At least one REF02 is required.	Not used
N1	Detail	2320 Coordination of Benefits	410	**N1**		**Other Insurance Company Name**			Situational			Identifies other insurance company (COB) by type, name, and code.	The scope of Nybeas does not include the maintenance of a COB data by DCS. The delivered interface will not include PCP data fields
IN					N101		Entity ID Code	Entity Identifier Code	M	2	3	IN = Insurer.	Not Used
					N102		Name	Entity Identifier Code	X	1	60	Insurer name.	Not Used
					N103		ID Code Qualifier	Entity Identifier Code	X	1	2	FI = Federal Taxpayers Identification Number. NI = National Association of Insurance Commissioners Identification. XV = Health Care Financing Administration National Payer Identification.	Not used
					N104		ID Code	Plan Sponsor	X	2	80	Insured Group or Policy Number	Not used
DTP	Detail	2320 Coordination of Benefits	450	**DTP**		**Coordination of Benefits Eligibility Dates**			Situational			Segment contains the dates for which coordination of benefits is in effect.	The scope of Nybeas does not include the maintenance of a COB data by DCS. The delivered interface will not include PCP data fields
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	344 = Coordination of benefits begin. 345 = Coordination of benefits end.	Not Used
D8					DTP02		Date Time Format Qual	Date Time Period Format Qualifier	M	2	3	D8 = Date expressed in CCYYMMDD.	Not Used
					DTP03		Date Time Period	Date Time Period	M	1	35	Date COB is in effect.	Not Used
		Transaction Set Trailer											
SE	Trailer			**SE**		**Transaction Set Trailer**			Required			Indicates end of transaction set and provides a count of the segments.	SE*39*1 ~
					SE01		Number of Inc Segs	Number of Included Segments	M	1	10	Total number of segments in the transaction set including ST and SE.	System generated.
					SE02		TS Control Number	Transaction Set Control Number	M	4	9	Unique control number .	The transaction set control numbers in SE02 and ST02 must be identical. Assign starting with 0001 and increment forward. Control numbers are unique within a specific functional group but can repeat in other groups and interchanges.

Exhibit II.I

Mental Health & Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan"

Number of Users Who Accessed Live and Work Well Website by Month

2011	
Nov	Dec
3256	3138

2012											
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
4401	*4306*	*3781*	*4044*	*4521*	*4132*	*4323*	*4626*	*4177*	*4256*	*3127*	*3659*

2013											
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
5705	*5039*	*5103*	*4997*	*4615*	*4757*	*4923*	*4873*	*3801*	*4387*	*3580*	*3642*

Note: As of 12/1/02, there were 2573 registered LAWW users.

Empire Plan Mental Health and Substance Abuse Program

Union Events and Retiree Meetings

Month	Title	Type	# of attendees
February	UUP Winter Delegates Assembly	Union Event	300
April	PEF Health & Safety Conference	Union Event	350
April	CSEA Women's Conference	Union Event	300
May	UUP Spring Delegates Assembly	Union Event	300
May	CSEA Spring Conference	Union Event	500
August	CSEA Annual Retiree Delegates Meeting	Retiree Meeting	100
Sept thru Nov		Retiree Meetings	100 to 300
September	Council 82 Convention	Union Event	200
September	Council 82 Convention	Retiree Meeting	200
October	PEF Convention	Union Event	1,000
October	UUP Fall Delegates	Union Event	300
October	CSEA Annual Delegates Meeting	Union Event	1,000

Note – representative sample of fairs/events that Offeror would likely be invited to attend on an annual basis. Location varies for events.

2012 NYSHIP Health Fairs with 80+ Attendees

Date	Location	Date	Location
March 22, 2012	Tax & Finance (Albany)	October 26, 2012	City of White Plains
April 4, 2012	Office of State Comptroller (Albany)	November 7, 2012	Office of Mental Health (Albany)
April 11, 2012	SUNY Fredonia	November 14, 2012	Department of Transportation (Albany)
April 19, 2012	Morrisville State College	November 27, 2012	Rensselaer County (Jail – open to all County Employees)
May 16, 2012	Clinton Correctional Facility	November 28, 2012	City of Poughkeepsie
June 20, 2012	Bare Hill Correctional Facility	November 28, 2012	Dept of Transportation (Hauppauge)
September 18, 2012	Department of Labor (Albany)	December 5, 2012	Cornell University – Veterinary School Gala
October 5, 2012	NYS Thruway & Canal Corp(Albany)	December 6, 2012	Buffalo State University
October 25, 2012	Helen Hayes Hospital	December 7, 2012	Cornell University – Geneva Campus
November 15, 2012	Binghamton University	December 12, 2012	Roswell Park Cancer Institute
November 14, 2012	Office of General Services (Albany)		

Note - representative sample of health fairs that Offeror would be invited to attend in first year of contract as well as future years for largest venues

State of New York
Department of Civil Service
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

Statement of Disability

Dependent 19 Years of Age or Older PS-451 (4/10)

PART A ***(To Be Completed By Enrollee. Keep a copy of the completed form for your records.)***

Enrollee's Name *(Print)*	Health Insurance ID Number	Enrollee's Phone Number

Home Address *(No. and Street)*	City	State	Zip Code

I request continuation of NYSHIP coverage for the below named Dependent, who is disabled and incapable of self-support. * If the child is not my own, legally adopted (including a child in a waiting period prior to finalization of adoption) or dependent stepchild, I have completed and submitted a PS-*457 Statement of Dependence* with the requested documentation to my Agency Health Benefits Administrator.

Dependent Information	Relationship (check one): ☐ Son ☐ Daughter ☐ Other Child*	
Dependent's Name	Dependent's Social Security Number	Dependent's Date of Birth

Is Dependent presently employed? ☐ Yes ☐ No Is yes, explain:	Is Dependent married? ☐ Yes ☐ No	Percent of support provided by enrollee: _____ %

Is disabled dependent enrolled in Medicare A & B? ☐ Yes ☐ No If yes, provide copy of dependent's Medicare Card.

☐ Check if Dependent is permanently residing in your household and residence began prior to the age coverage would terminate. If otherwise, explain:

Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of enabling the NYS Department of Civil Service to process your request to continue enrollment for a disabled dependent 19 years of age or older in the New York State Health Insurance Program, Dental Program, Vision Program, and/ or other employee benefit fund program. The information will be used in accordance with Section 96 (1) of the Public Officers Law, also known as the Personal Privacy Protection Law. Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Director, Division of Employee Benefits, NYS Department of Civil Service, Albany, NY 12239. For information about the Personal Privacy Protection Law, call (518) 457-9375. For information about NYSHIP Eligibility for Disabled Dependents, contact your Agency Health Benefits Administrator. If after calling your Health Benefits Administrator you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

HIPAA Privacy Authorization to Release Protected Health Information

By my signature below, I authorize the attending physician to provide my insurance carrier or health maintenance organization (HMO) with health information (to be indicated in Part D of this form) regarding the mental or physical disability of my dependent for whom I am requesting NYSHIP coverage. I also authorize the insurance carrier or HMO to disclose its determination (to be indicated in Part C of this form) to the Department of Civil Service. The purpose of these disclosures is to determine my dependent's eligibility for NYSHIP coverage and to implement that determination. I understand that I may revoke this authorization in writing at any time, as described in the NYSHIP Notice of Privacy Practices. Unless I revoke this authorization, this authorization will expire after my dependent's eligibility for coverage has been determined and implemented by the Department of Civil Service in its administration of the NYSHIP health plans. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected by HIPAA.

Enrollee's Signature	**Date**

PART B ***(To Be Completed By Employing Agency)*** **PLEASE PRINT OR TYPE**

Effective Date Of Insurance For Dependent Above.	Previous Statement Submitted? ☐ Yes ☐ No	Was Dependent A Late Enrollment? ☐ Yes ☐ No

Enrollee's Health Insurance Coverage: ☐ Individual ☐ Family	Health Insurance Option ☐ Empire Plan ☐ HMO (write option and name) _____

Employing Agency	Agency Code	HBA Phone Number

I have reviewed the dependent information and have verified that the Dependent meets the eligibility requirements of the Program.

Authorized Signature	**Date**

PART C ***(To Be Completed By UnitedHealthcare or the Health Maintenance Organization)***

☐ Permanently Disabled	☐ Temporarily Disabled Through (Supply Date)	☐ Not Disabled	☐ Date Disability Started (Supply Date)
Signature			**Date**

PART D ***(To Be Completed By Attending Physician and mailed by the enrollee or attending physician to the appropriate carrier)***

Empire Plan Enrollees Mail To:
UnitedHealthcare
PO Box 1600
Kingston, New York 12402-1600

HMO Enrollees Mail To:

Mail this form directly to your HMO.

Physician's Name *(Print)* M.D.	**Physician's Address**
Enrollee's Name *(Print)*	Health Insurance ID Number
Dependent's Name *(Print)*	
Is this Dependent incapable of self-support by reason of physical or mental health disability? ☐ Yes ☐ No	

Date dependent became incapable of self-support.	Estimated duration of disability.	Date of your most recent examination of this patient.

Complete description of medical condition, including diagnosis, prognosis, current status and service being received:

If more space is necessary, attach additional pages.

PLEASE NOTE: Unless all questions are answered completely, a determination cannot be made.

Physician's Signature	**Date**

State of New York
Department of Civil Service
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

Statement of Disability

Dependent 19 Years of Age or Older PS-451I (4/10)

Health insurance benefits in the New York State Health Insurance Program (NYSHIP) are available for an enrollee's unmarried dependent children age 19 or older who are incapable of supporting themselves because of a mental or physical disability acquired before termination of their eligibility for health insurance, as described below.

Health insurance benefits in the New York State Heath Insurance Program (NYSHIP) are available for an enrollee's dependent children as described under the following circumstances:

1. The enrollee's own, legally adopted (including children in a waiting period prior to finalization of adoption) and dependent stepchildren under age 19;

2. The enrollee's "other" dependent children who reside permanently with the enrollee *and* receive more than 50 percent of their support from the enrollee, including medical expenses under age 19, **You must also complete a PS-457 Statement of Dependence to establish "other" dependent children's eligibility for NYSHIP;**

3. The enrollee's dependent child who is covered as a full-time student between the ages of 19 and 25. Up to four years may be deducted from the dependent student's age for documented service in a branch of the US Military.

Any expenses incurred for the attending physician's statement on the PS-451 Statement of Disability are the responsibility of the enrollee or dependent and are not considered a covered medical expense. See your General Information Booklet for additional information and for whom to contact, if you have questions.

Approval for enrollment in NYSHIP is contingent upon continuance of the enrollee's Family Coverage under the New York State Health Insurance Program. The employing agency or the Employee Benefits Division will notify the enrollee of the coverage determination.

Note: The employing agency for retirees, vestees, dependent survivors, enrollees covered under Preferred List provisions and COBRA enrollees of New York State Government and Participating Employers is the Employee Benefits Division of the Department of Civil Service. For enrollees either currently or formerly employed by a Participating Agency, that agency is the employing agency, regardless of the enrollee's status.

INSTRUCTIONS FOR COMPLETING THE PS-451 STATEMENT OF DISABILITY

1. **Enrollee** completes **Part A.**
2. **Employing Agency** completes **Part B,** (Parts A and B must be completed before any other parts of the form are completed to ensure confidentiality of the Dependent's medical information).
3. Leave **Part C blank** (see step 6)
4. **Attending Physician** completes **Part D** (attending physician cannot complete this section until Parts A and B are complete).
5. **Enrollee** or **Attending Physician** mails the completed form to the appropriate carrier:

Empire Plan Enrollees Mail To:	**HMO Enrollees Mail To:**
UnitedHealthcare PO Box 1600 Kingston, New York 12402-1600	Mail this form directly to your HMO.

6. If mental health specialist input is required for an Empire Plan enrollee, UnitedHealthCare may forward the PS-451 to OptumHealth. United HealthCare, the HMO or OptumHealth completes **Part C** and mails only Page 1 of the PS-451 to the Employee Benefits Division at the above address.

Exhibit II.L

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE'S
"MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM FOR THE EMPIRE PLAN, EXCELSIOR PLAN, STUDENT EMPLOYEE HEALTH PLAN RFP"

Non-Quantitative Treatment Limitations

Non-Quantitative Treatment Limitation	Examples of limitations included in UHC's medical contract
Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether treatment is experimental or investigative	Preauthorization required for durable medical equipment, skilled nursing services, and home care services. Preauthorization required for certain infertility benefits - Empire Plan maintains list of "Qualified Procedures." Prenotification required for MRI, CT, PET scan or nuclear medicine test (penalty applies if call not made). UHC may deny services or pharmaceutical products deemed experimental, investigational or unproven, unless certain criteria are met.
Formulary design for prescription medications	N/A for the Rx Program. The same formulary design is in place for MHSA conditions as is for all other conditions.
For plans with multiple network tiers (such as preferred providers and participating providers), network tier design	MPN maintains three tiers for providers (chiropractors and physical therapists). Providers receive the same level of reimbursement, however, the amount of pre-treatment paperwork required varies.

Standards for provider admission to participate in a network, including reimbursement rates	UHC applies credentialing standards based on review of provider applications, which include applicable licensing, education and training. Providers must accept or come to agreement with UHC on rates for network inclusion.
Methods for determining usual, customary, and reasonable charges	FAIRHealth determines reasonable and customary amounts for Empire Plan out-of-network claims.
Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (fail-first policies or step therapy protocols)	N/A to the Medical Program
Exclusions based on failure to complete a course of treatment	N/A to the Medical Program
Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage	Air ambulance is provided to the closest facility where care can be provided.

EMPIRE PLAN MIXED SERVICES PROTOCOL
Medical v. Behavioral Health Clarifications

Services, treatment, supplies and equipment that qualify as covered services under the applicable Member Contract and designated as Medical on this Exhibit shall be the financial responsibility of MEDICAL CARRIER or HOSPITAL CARRIER and services, treatment, supplies and equipment that qualify as Covered Services under this Agreement and designated as mental health/substance abuse care on this Exhibit shall be the financial responsibility of ValueOptions®. Where the term psychiatric diagnosis is used in this document it means the mental health and substance abuse diagnosis listed in the Benefit Rules Document.

Key to Optum MSP	Medical vs. Behavioral Health	Explanation	Financial Responsibility
II – B, II- F, II – G, II – H, II – I,	1. When a Member is admitted for treatment of a medical diagnosis and there is a concomitant psychiatric diagnosis, the medical care rendered is the responsibility of EBCBS	Patient is admitted to a medical unit. This is a medical benefit.	EBCBS
II – B, II- F, II – G, II – H, II – I,	2. When a Member is admitted for treatment of a psychiatric diagnosis and there is a concomitant medical problem, the psychiatric care rendered is the financial responsibility of ValueOptions. ➢ If a member receives psychiatric treatment while on a medical unit, this is the responsibility of ValueOptions. ➢ If the Member is medically cleared and transferred to a psychiatric unit, ValueOptions shall assume financial responsibility upon transfer to the psychiatric unit. This benefit needs to be pre-certified. ➢ If the Member is transferred to a medical unit at the recommendation of a non-psychiatrist, EBCBS is responsible ➢ If medical care and or medical tests continues when the Member is on a psychiatric unit, the medical portion of the claim, including tests ordered by a non-psychiatrist shall be the responsibility of EBCBS	Patient is admitted to a psychiatric unit. This is a ValueOptions benefit, covered after pre-certification by ValueOptions. Pt receives psychiatric consults on a medical unit. This is a ValueOptions benefit. Routine medical procedures covered under the per diem rate are ValueOptions' responsibilities. Medical tests on a psychiatric unit outside of routine procedures covered under the ValueOptions facility contract are the responsibility of EBCBS Example: MRI ordered to rule out organic cause of psychosis. Claims must be itemized to reflect psychiatric and medical charges.	ValueOptions ValueOptions Split: ValueOptions/ EBCBS

EMPIRE PLAN MIXED SERVICES PROTOCOL
Medical v. Behavioral Health Clarifications

Key to Optum MSP	Medical vs. Behavioral Health	Explanation	Financial Responsibility
II- J	3. Lab and routine medical tests ordered by a ValueOptions participating provider with a psychiatric diagnosis are the responsibility of UHC ➢ Labs and routine medical tests ordered by a medical provider even those with a psychiatric diagnosis are the responsibility of UHC	A psychiatrist orders labs for a pt on Lithium A PCP orders a urine drug screen to rule out Substance use	UHC or EBCBS if lab services at OP Hospital and EE is physically present UHC or EBCBS if lab services at OP Hospital and EE is physically present
II - C	4. When a Member receives uncomplicated inpatient detoxification in a free standing substance abuse facility VO is financially responsible. When the seriousness of the enrollee's medical condition, as determined by a non-psychiatrist, requires treatment on a medical unit other than the designated detoxification unit, the expense shall be considered a medical expense and shall not be the financial responsibility of ValueOptions.	Patient admitted to a free standing substance abuse facility. VO is financially responsible Patient admitted to a medical detoxification unit in an acute care facility, either on a detox unit or medical unit, VO performed the utilization review, but EBCBS is financially responsible. Patient is admitted to a medical unit other than a designated detoxification unit (i.e. Hospital that does not have a detox unit). This is a medical benefit. VO will complete the Utilization review of these service and work with the medical carrier to ensure appropriate claims payment	VO EBCBS EBCBS
II - B	5. When a Member is admitted to a medical unit for a medical complaint, but the medical evaluation does not lead to a medical diagnosis and a psychiatric diagnosis is then assigned to the case, at the point when the patient is medically cleared and transferred to a psychiatric unit and the primary care giver is a psychiatrist the care	The patient is admitted to a medical unit by a non-psychiatrist. Evaluation notes a psychiatric diagnosis is the cause of admission. This is the responsibility of	EBCBS

EMPIRE PLAN MIXED SERVICES PROTOCOL
Medical v. Behavioral Health Clarifications

Key to Optum MSP	Medical vs. Behavioral Health	Explanation	Financial Responsibility
	rendered shall be the financial responsibility of ValueOptions. *Subject to ValueOptions review of medical necessity, and preauthorization.*	EBCBS The patient is transferred from a medical primary care giver to a psychiatric primary care giver and transferred to a psychiatric unit under the care of a psychiatrist. ValueOptions is responsible for payment.	 ValueOptions
II-A	6. A member is referred or presents at an emergency room and obtains services which are not followed by a hospitalization.	ValueOptions will be responsible for all claims with a behavioral health diagnosis	ValueOptions
II-K	8. All ambulance transfers between psychiatric units and from medical units to psychiatric units shall be the responsibility of ValueOptions. ValueOptions is not financially responsible for ambulance transfers from psychiatric to medical units. *ValueOptions is responsible for emergency ambulance transportation to emergency rooms for members with psychiatric diagnosis. If the member requires transportation to a psychiatric unit this is the cost of ValueOptions.*	ValueOptions is responsible for ambulance transfers between psychiatric units if authorized by ValueOptions. Ambulance transfers from the community which result in psychiatric admission will be paid by ValueOptions. ValueOptions is responsible for ambulance transfers from a medical unit to a psychiatric unit if authorized by ValueOptions. ValueOptions is responsible for ER to psychiatric transfers to the nearest ValueOptions authorized facility ValueOptions is not responsible for ambulance transfers from a psychiatric unit to a medical unit.	ValueOptions ValueOptions ValueOptions ValueOptions UHC/or EBCBS if ambulance is hospital owned and operated

EMPIRE PLAN MIXED SERVICES PROTOCOL
Medical v. Behavioral Health Clarifications

Key to Optum MSP	Medical vs. Behavioral Health	Explanation	Financial Responsibility
		ValueOptions is responsible for the cost of transportation to the ER when a psychiatric diagnosis is submitted.	ValueOptions
II-D	9. When a Member undergoes psychological or neurological testing (e.g., one of several diagnostic procedures used to determine organic brain disease or deficit), such testing shall be the financial responsibility of UHC. Psychological testing is a covered benefit and paid by ValueOptions when evaluated by ValueOptions to be a Medically Necessary part of the patient's psychiatric evaluation process and when pre-certified.	Neurological testing for a medical diagnosis is the responsibility of UHC. This includes testing ordered by a non-psychiatrist to establish severity or prognosis for conditions commonly believed to be medical: including but not limited to brain injury, dementia and stroke. Psychological testing if pre-certified by ValueOptions and as part of the patient's psychiatric evaluation will be paid for by ValueOptions. Neurological testing ordered for a mental health diagnosis shall be paid for by ValueOptions. Precertification is recommended	UHC ValueOptions UHC
II - L	10. When a Member undergoes treatment that includes biofeedback and such treatment: has been demonstrated to be effective in the treatment of conditions that are primarily medical in nature, ValueOptions shall not be clinically or financially responsible. If treatment is for a DSM-IV diagnosis and is provided by a provider who meets ValueOptions' minimum licensure requirements, it will be covered. Peer Advisor preauthorization is recommended.	Treatment of conditions that are medical in nature are not reviewed or paid for by ValueOptions. If treatment is for a DSM-IV diagnosis and authorized by ValueOptions it will be covered.	UHC ValueOptions
II - E			

EMPIRE PLAN MIXED SERVICES PROTOCOL
Medical v. Behavioral Health Clarifications

Key to Optum MSP	Medical vs. Behavioral Health	Explanation	Financial Responsibility
	11. Members receiving inpatient or outpatient ECT by an authorized provider at an authorized facility shall have their psychiatric treatment paid for by ValueOptions	If the member receives inpatient or outpatient ECT ValueOptions is responsible for the psychiatric charges. The charges for the facility, treatment, anesthesia and drugs will be paid for by ValueOptions Independent anesthesiology bill related to ECT	ValueOptions UHC
	12. When the above guidelines are insufficient, the following additional general principles shall be used to determine claim responsibility: (a) What is the primary cause for hospitalization? Which condition could only be treated in a hospital setting? (b) What does the medical record list as a primary diagnosis for this admission? (c) Is the attending physician of record a psychiatrist or a Primary Care Physician/medical consultant? (d) Has a member been admitted to a psychiatric unit or a medical/surgical unit?	(a) Is the patient's primary diagnosis a psychiatric one and could it only be treated in an inpatient psychiatric setting? (b) Does the medical record list the primary diagnosis as a DSM-V diagnosis defined in Attachment I? (c) Is the attending physician a psychiatrist? This is a ValueOptions benefit. Is the attending physician a medical doctor? This is not a ValueOptions benefit. (d) Patient is receiving care in a psychiatric unit. This is a ValueOptions benefit. Patient is receiving care in a medical/surgical unit. This is not a	

EMPIRE PLAN MIXED SERVICES PROTOCOL
Medical v. Behavioral Health Clarifications

Key to Optum MSP	Medical vs. Behavioral Health	Explanation	Financial Responsibility
		ValueOptions benefit.	
	(e) What condition is causing a member to remain in the hospital and who is treating this problem?	(e) Is the diagnosis, which required continued hospitalization, a DSM-V diagnosis as defined in Attachment I, and is the patient treated by a psychiatrist?	
	13. In the event that application of these general principles is insufficient in establishing differentiation between what is a medical versus a psychiatric claim, the ValueOptions Medical Director and the MEDICAL CARRIER or HOSPITAL CARRIER Medical Director shall collaborate to arrive at a final determination.		

By signing below, I, as an authorized signatory of the plan, represent that the aforementioned mixed services protocol are approved and will be incorporated into the plan documents and the summary plan description made available to beneficiaries on or before the effective date of services performed by ValueOptions, Inc.®

_____
Client Signature: Approval

_____
Print Name & Title

_____
Date

Exhibit III.A

Empire Plan Mental Health and Substance Abuse Program
CD of Claim Utilization by Provider and GeoAccess Information

Empire Plan MHSA claims and census data can be obtained by completing and submitting **Exhibit I.Z**, Confidentiality Agreement and Certificate of Non-Disclosure, as required by Section II.A.7 of the RFP.

Upon receipt of the completed, notarized **Exhibit I.Z** and the Offeror's letter containing the required attestation, Prospective Offerors will be sent the following data/information:

	Item	File Name	Comment
1.	Market Basket of 2013 Claims Data	2013 MHSA Claim Detail (comma delimited text file)	To be used to prepare Exhibit V.A.2, V.A.3 and V.B of the RFP
2.	Data Dictionary	2013 MHSA Claim Detail layout.xlsx (Excel file)	Descriptions of fields in the detail claim file.
3.	Geo-coded Census Database	Exhibit III.B – Demographic Data 2015.xlsx (Excel File)	Geocoded census data for Offerors to use in preparing Exhibit I.Y.3
4.	MHSA Provider file	MHSA Program Providers Exhibit I.Y.4.xlsx (Excel file)	MHSA Provider file to be used to prepare Exhibit I.Y.4 of the RFP.

Mental Health and Substance Abuse Program RFP for the Empire Plan, Excelsior Plan and Student Employee Health Plan
Instructions for Completing Exhibits V.A.2 and V.A.3

1. Using Exhibit V.A.2, the Offeror shall quote its Guaranteed Average Unit Cost (GAUC) for Network Outpatient Services. This Exhibit includes a listing of outpatient CPT and HCPCS codes based on 2013 paid MHSA claims submitted on behalf of Empire Plan enrollees. The Offeror is directed to support its 2015 Plan Year GAUC quote with its projected utilization of Plan primary services and Network Provider contracted amounts for each CPT and HCPCS code by provider licensure (where applicable) as presented on Exhibit V.A.2.

2. Using Exhibit V.A.3, the Offeror shall quote its Guaranteed Average Unit Cost (GAUC) for Network Inpatient/ALOC Services. This Exhibit includes a listing of inpatient Revenue Codes based on 2013 paid MHSA claims submitted on behalf of Empire Plan enrollees. The Offeror is directed to support its 2015 Plan Year 2015 GAUC quote with its projected utilization of Plan primary services and Network Provider contracted amounts for each Revenue Code as presented on Exhibit V.A.3.

3. The quoted Network Provider average contracted amounts for the CPT, HCPCS and Revenue codes listed in Exhibits V.A.2 and V.A.3 (column b) should be on a unit basis. For example, if the code is an inpatient service, the quote should represent the average contracted amount per day. If the code is an outpatient or office service, the quote should represent the average contracted amount per service. Further, the quoted amounts shall be based on MHSA Plan primary claims only and be prior to the application of Copayment or Bad Debt and Charity assessments.

4. The amounts quoted shall represent the Offeror's weighted average contracted amount for the 2015 Plan Year for each code, provider licensure (CPT and HCPCS services only) and projected utilization for the 2015 Plan Year.

IMPORTANT: The Network Provider average contracted amounts presented in Exhibits V.A.2 and V.A.3 (column b) are not binding to the Offeror. These amounts are required to support the Offeror's GAUC for the Network Services, which is binding.

The 2013 MHSA Claim Detail file is available for informational purposes. Offerors may utilize the detail claim file to gain insight of the current distribution of claims by provider and service to develop its GAUC quotes. See Exhibit III.A for instructions on how to obtain this file.

The development of the Offeror's Network Provider average contracted amounts and completion of Exhibits V.A.2 and V.A.3 are solely the Offeror's responsibility. The Department makes no guarantees that either the services mix or utilization contained in the 2013 MHSA Claim Detail File is representative of future MHSA utilization.

Exhibit V.A.2

Mental Health and Substance Abuse Program RFP #2014-MH-1
for the Empire Plan, Excelsior Plan and Student Employee Health Plan
Guaranteed Average Unit Cost Quote - Network Outpatient Services

CPT/HCPCS Code	Provider Licensure(4)	a Offeror's Projected Utilization (Plan Primary Only) (1)	b Average Contracted Fee Per Licensed Provider Type(2)(3)	c = Σ d / sum Σ a Average Weighted Contracted Fee Per CPT Code	d = a x b Projected Total Cost
90791	MD Level				
90791	Doctoral Level				
90791	Masters Level				
90792	MD Level				
90792	Doctoral Level				
90792	Masters Level				
90832	MD Level				
90832	Doctoral Level				
90832	Masters Level				
90833	MD Level				
90833	Doctoral Level				
90833	Masters Level				
90834	MD Level				
90834	Doctoral Level				
90834	Masters Level				
90836	MD Level				
90836	Doctoral Level				
90836	Masters Level				
90837	MD Level				
90837	Doctoral Level				
90837	Masters Level				
90838	MD Level				
90838	Doctoral Level				
90838	Masters Level				
90839	MD Level				
90839	Doctoral Level				
90839	Masters Level				
90845	MD Level				
90845	Doctoral Level				
90845	Masters Level				
90846	MD Level				
90846	Doctoral Level				
90846	Masters Level				
90847	MD Level				
90847	Doctoral Level				
90847	Masters Level				
90849	MD Level				
90849	Doctoral Level				
90849	Masters Level				
90853	MD Level				
90853	Doctoral Level				
90853	Masters Level				
90863	MD Level				
90863	Doctoral Level				
90863	Masters Level				
90867	MD Level				
90867	Doctoral Level				
90867	Masters Level				
90868	MD Level				
90868	Doctoral Level				

Mental Health and Substance Abuse Program RFP #2014-MH-1

for the Empire Plan, Excelsior Plan and Student Employee Health Plan

Guaranteed Average Unit Cost Quote - Network Outpatient Services

90868	Masters Level				
90870	MD Level				
90870	Doctoral Level				
90870	Masters Level				
90899	MD Level				
90899	Doctoral Level				
90899	Masters Level				
96101	MD Level				
96101	Doctoral Level				
96101	Masters Level				
96102	MD Level				
96102	Doctoral Level				
96102	Masters Level				
96103	MD Level				
96103	Doctoral Level				
96103	Masters Level				
96116	MD Level				
96116	Doctoral Level				
96116	Masters Level				
96118	MD Level				
96118	Doctoral Level				
96118	Masters Level				
96119	MD Level				
96119	Doctoral Level				
96119	Masters Level				
96120	MD Level				
96120	Doctoral Level				
96120	Masters Level				
96150	MD Level				
96150	Doctoral Level				
96150	Masters Level				
96151	MD Level				
96151	Doctoral Level				
96151	Masters Level				
96152	MD Level				
96152	Doctoral Level				
96152	Masters Level				
99201	MD Level				
99201	Doctoral Level				
99201	Masters Level				
99202	MD Level				
99202	Doctoral Level				
99202	Masters Level				
99203	MD Level				
99203	Doctoral Level				
99203	Masters Level				
99204	MD Level				
99204	Doctoral Level				
99204	Masters Level				
99205	MD Level				
99205	Doctoral Level				
99205	Masters Level				
99211	MD Level				
99211	Doctoral Level				
99211	Masters Level				
99212	MD Level				
99212	Doctoral Level				
99212	Masters Level				
99213	MD Level				
99213	Doctoral Level				
99213	Masters Level				

Mental Health and Substance Abuse Program RFP #2014-MH-1

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Guaranteed Average Unit Cost Quote - Network Outpatient Services

99214	MD Level				
99214	Doctoral Level				
99214	Masters Level				
99215	MD Level				
99215	Doctoral Level				
99215	Masters Level				
99217	MD Level				
99217	Doctoral Level				
99217	Masters Level				
99221	MD Level				
99221	Doctoral Level				
99221	Masters Level				
99222	MD Level				
99222	Doctoral Level				
99222	Masters Level				
99223	MD Level				
99223	Doctoral Level				
99223	Masters Level				
99231	MD Level				
99231	Doctoral Level				
99231	Masters Level				
99232	MD Level				
99232	Doctoral Level				
99232	Masters Level				
99233	MD Level				
99233	Doctoral Level				
99233	Masters Level				
99235	MD Level				
99235	Doctoral Level				
99235	Masters Level				
99236	MD Level				
99236	Doctoral Level				
99236	Masters Level				
99238	MD Level				
99238	Doctoral Level				
99238	Masters Level				
99239	MD Level				
99239	Doctoral Level				
99239	Masters Level				
99241	MD Level				
99241	Doctoral Level				
99241	Masters Level				
99242	MD Level				
99242	Doctoral Level				
99242	Masters Level				
99243	MD Level				
99243	Doctoral Level				
99243	Masters Level				
99244	MD Level				
99244	Doctoral Level				
99244	Masters Level				
99245	MD Level				
99245	Doctoral Level				
99245	Masters Level				
99251	MD Level				
99251	Doctoral Level				
99251	Masters Level				
99252	MD Level				
99252	Doctoral Level				
99252	Masters Level				
99253	MD Level				

Mental Health and Substance Abuse Program RFP #2014-MH-1

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Guaranteed Average Unit Cost Quote - Network Outpatient Services

99253	Doctoral Level				
99253	Masters Level				
99254	MD Level				
99254	Doctoral Level				
99254	Masters Level				
99255	MD Level				
99255	Doctoral Level				
99255	Masters Level				
99281	MD Level				
99281	Doctoral Level				
99281	Masters Level				
99282	MD Level				
99282	Doctoral Level				
99282	Masters Level				
99283	MD Level				
99283	Doctoral Level				
99283	Masters Level				
99284	MD Level				
99284	Doctoral Level				
99284	Masters Level				
99285	MD Level				
99285	Doctoral Level				
99285	Masters Level				
99291	MD Level				
99291	Doctoral Level				
99291	Masters Level				
99304	MD Level				
99304	Doctoral Level				
99304	Masters Level				
99305	MD Level				
99305	Doctoral Level				
99305	Masters Level				
99306	MD Level				
99306	Doctoral Level				
99306	Masters Level				
99307	MD Level				
99307	Doctoral Level				
99307	Masters Level				
99308	MD Level				
99308	Doctoral Level				
99308	Masters Level				
99309	MD Level				
99309	Doctoral Level				
99309	Masters Level				
99310	MD Level				
99310	Doctoral Level				
99310	Masters Level				
99334	MD Level				
99334	Doctoral Level				
99334	Masters Level				
99342	MD Level				
99342	Doctoral Level				
99342	Masters Level				
99347	MD Level				
99347	Doctoral Level				
99347	Masters Level				
99348	MD Level				
99348	Doctoral Level				
99348	Masters Level				
99349	MD Level				
99349	Doctoral Level				

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Guaranteed Average Unit Cost Quote - Network Outpatient Services

99349	Masters Level				
99408	MD Level				
99408	Doctoral Level				
99408	Masters Level				
99409	MD Level				
99409	Doctoral Level				
99409	Masters Level				
99442	MD Level				
99442	Doctoral Level				
99442	Masters Level				
99443	MD Level				
99443	Doctoral Level				
99443	Masters Level				
A0425	Ambulance - per mile				
A0427	MD Level				
A0427	Doctoral Level				
A0427	Masters Level				
A0428	Ambulance - per service				
A0429	Ambulance - per service				
H0014	MD Level				
H0014	Doctoral Level				
H0014	Masters Level				
H0015	MD Level				
H0015	Doctoral Level				
H0015	Masters Level				
H0019	MD Level				
H0019	Doctoral Level				
H0019	Masters Level				
H0020	MD Level				
H0020	Doctoral Level				
H0020	Masters Level				
H0035	MD Level				
H0035	Doctoral Level				
H0035	Masters Level				
H2011	MD Level				
H2011	Doctoral Level				
H2011	Masters Level				
H2012	MD Level				
H2012	Doctoral Level				
H2012	Masters Level				
S9484	MD Level				
S9484	Doctoral Level				
S9484	Masters Level				
H0031	Board Cert Behavioral Analyst				
H0031	Applied Behavioral Analyst Aide				
H0032	Board Cert Behavioral Analyst				
H0032	Applied Behavioral Analyst Aide				
H2019	Board Cert Behavioral Analyst				
H2019	Applied Behavioral Analyst Aide				
Totals		0			$0.00

Guaranteed Average Unit Cost (GAUC) Quote - Network Outpatient Services (Σ d / Σ a) **#DIV/0!**

(1) Offeror's projected utilization for the 2015 Plan Year pertaining to incurred claims paid as primary.

(2) The Offeror should use its 2015 average contracted fee for each CPT/HCPCS code in support of its proposed GAUC. The supporting average contracted fees are not binding to the Offeror.

Mental Health and Substance Abuse Program RFP #2014-MH-1

for the Empire Plan, Excelsior Plan and Student Employee Health Plan
Guaranteed Average Unit Cost Quote - Network Outpatient Services

(3) The contracted amount per CPT/HCPCS Code should represent the unit amount per service/mile and the amount is prior to the application of any Copayment or Bad Debt and Charity assessments.

(4) If payment of contracted fees do not vary according to provider licensure, insert the projected utilization and fee quote on the first code line.

Exhibit V.A.3

Mental Health and Substance Abuse Program RFP 2014-MH-1
for the Empire Plan, Excelsior Plan and Student Employee Health Plan
Guaranteed Average Unit Cost Quote - Network Inpatient and Alternative Level of Care (ALOC) Services

Revenue Code	a Offeror's Projected Utilization (Plan Primary Only)(1)	b Average Contracted Fee Per Revenue Code(2)(3)	c = a x b Total Cost
0114			
0116			
0118			
0124			
0126			
0128			
0134			
0136			
0138			
0144			
0154			
0156			
0158			
0450			
0451			
0459			
0510			
0513			
0710			
0761			
0888			
0900			
0901			
0905			
0906			
0912			
0913			
0914			
0915			
0916			
0919			
0940			
0941			
0944			
0961			
1001			
1002			
	0		$ -

Guaranteed Average Unit Cost (GAUC) Quote - Network Inpatient and ALOC Services (Σ c / Σ a)	#DIV/0!

(1) Offeror's projected utilization for the 2015 Plan Year pertaining to incurred claims paid as primary.

(2) The Offeror should use its 2015 average contracted fee for each Revenue code in support of its proposed GAUC. The supporting average contracted fees are not binding to the Offeror.

(3) The contracted amount per Revenue Code should represent the unit amount per day/service and the amount is prior to the application of the Copayment or Bad Debt and Charity assessments.

Exhibit V.B

Mental Health and Substance Abuse Program RFP #2014-MH-1
for the Empire Plan, Excelsior Plan and Student Employee Health Plan
Administrative Fee Quote

	Fee Quote	**Basis**
Monthly Administrative Fee Quote	_____	**Per Enrollee Per Month**