

**NEW JERSEY STATE DEPARTMENT OF BANKING AND INSURANCE
LIFE AND HEALTH DIVISION
VALUATION BUREAU
POST OFFICE 325
TRENTON, NEW JERSEY 08625**

SELECTIVE CONTRACTING ARRANGEMENT APPLICATION

The information requested in these applications are based upon P.L. 1993, C.162, Section 22 and the Selective Contracting Arrangements of Insurers regulation (N.J.A.C. 11:4-37) published in the New Jersey Register on January 18, 1994 with Adopted Amendments published on June 15, 1998 and May 15, 2006. Copies of the SCA regulation and application may be obtained from the Department of Banking and Insurance's website.

Instructions for Completing New SCA Applications:

If you are a carrier and want to establish an SCA (11:4-37.1) by contracting with an HMO, ODS or PPO (ie., prescription drugs), or if you are direct contracting with providers you are required to obtain an SCA approval.

No fees are required in filing this application.

Please send two copies of this application to the address below. Place each copy of the application in a separate three ring binder with identification on the front and spine. Number all pages consecutively. Tabs should be inserted indicating each of the major sections of the application. Incomplete applications will be returned.

New Jersey State Department of Banking and Insurance
Life and Health Division
Valuation Bureau
P.O. Box 325
20 West State Street
Trenton, New Jersey 08625-0325

**SELECTIVE CONTRACTING ARRANGEMENT (SCA)
APPLICATION FOR APPROVAL
COVER SHEET**

1. Name of Insurer NAIC number

2. Affiliated Companies (associated with this SCA arrangement)

3. Address

4. City 5. County 6. State 7. Zip Code

8. Telephone Number 9. Chief Executive Officer

10. Name of Network Provider Organization NAIC number if applicable
(PPO, ODS, HMO) (if one used)

11. Address of Network Provider Organization

12. City 13. County 14. State 15. Zip Code

13. Telephone Number 17. President or CEO

I certify that all information and statements made in this application are true, complete and current to the best of my knowledge and belief.

Name and Title Signature date
(Office of Insurer)

SCA APPLICATION SUBMISSION REQUIREMENTS

SECTION I.

General:

#1. A narrative description of the health benefit plan(s) to be offered. (Please specify Hospital/Medical, Dental, Vision, and/ or Prescription Drugs. For a managed care pharmacy plan, please also see (N.J.A.C. 11:22-5.7.) For managed care dental plans, please see (N.J.A.C. 11:22-5.8).

Please include in the description whether the Network Based Health Benefit Plan is utilizing an (1) HMO; (2) ODS Licensed; (3) ODS Certified; (4) PPO or direct contracting. Please specify large group (50 plus employees), small group (2-49 employees) and/ or individuals. Please identify the geographic service area.

#2. Please provide the name, address, telephone number and key contact person for each HMO, ODS, and/ or PPO.

#3. A description of the relationship between the carrier and the PPO, ODS, or HMO. Please describe any transfer of risk involved in this arrangement. If none, please include a certification by the PPO senior officer that the PPO does not assume risk or engage in the business of insurance.

#4. A copy of the contract between the carrier and the PPO, ODS, or HMO. For all management contracts, please see (N.J.A.C 11:22-1.5). For contracts between a carrier and an ODS, please see (N.J.A.C. 11:24B - 4).

SECTION II. (If you are an ODS or HMO, skip Section II) Organizational / Legal

#1. Articles of incorporation for the PPO-Department of State authorization to do business in New Jersey.

#2. By-Laws for PPO

#3. List of owners and investors of the PPO

#4. Address of the insurer's and PPO's place of business for managed care in NJ.

#5. List of Board Members (including names, addresses and occupations) of the PPO.

#6. Biographical Affidavits of officers and directors of the PPO. (See website for biographical affidavit form.

#7. Organizational Charts for the PPO. Charts should be labeled with the company's name. Charts should include names and titles.

SECTION III.

Health Care Services:

#1. A description and map of the geographic service area to be covered, by county. If sub-areas are to be proposed as boundaries of the service area, the map should also include zip codes.

#2. Direct Contracting or PPO not covered by ODS: (If you are not direct contracting; if your Network Provider Organization is covered by ODS or HMO regulations, skip to #3)

- a. Describe how you formed your network. The method used to select network providers. The credentialing criteria. The time frame for recredentialing providers.
- b. A list of the names, addresses of providers by county, specialty, municipality and zip code.
- c. Maps of the geographic service areas identifying the location of these providers.
- d. Completed applicable tables. See attachments on website.
- e. A copy of the provider directory that is made available to covered persons.

#3. Utilization Review

- a. The name, title and organization of the person responsible for Utilization Review.
- b. (If the ODS or HMO is responsible for utilization review, skip to #5)
- c. A description of the criteria and methods to be used in utilization control, particularly the criteria for determining over-and under-utilization.
- d. A description of the mechanisms for evaluating the success or failure of the utilization review program.

#4. Quality Assurance

- a. The name, title and organization of the person responsible for Quality Assurance.
- b. (If the ODS or HMO, is responsible for quality assurance, skip to #5)
- c. A clear description of how quality of care will be monitored and controlled
- d. The criteria used to define and measure quality
- e. The criteria used to determine the success or failure of the quality assurance program
- f. A description of the staff who will be responsible for the quality assurance program and their qualifications.

#5. Provider agreements

- a. A copy of the provider agreements currently in use.
- b. The completed provider agreement certification and checklist (See website)
- c. Or a copy of the approval letter(s) for all your provider agreements.
- d. And a signed certification that there have been no changes to the provider agreements since approval.