EXHIBIT 1

MISCELLANEOUS/CONSULTANT SERVICES
(Award Without Formal Request For Proposal)

STATE AGENCY (Name and Address):
Department of Health
Corning Tower
Albany, NY 12237

NYS COMPTROLLER'S NUMBER:C030706

ORIGINATING AGENCY GLBU: DOH01
DEPARTMENT ID: 3450000

CONTRACTOR (Name and Address):

Health Insurance Plan of Greater New York
d/b/a EmblemHealth
55 Water Street
New York, NY 10041-8190

TYPE OF PROGRAM(S):

Essential Plan [Basic Health Program, NY SSL § 369-gg]

CHARITIES REGISTRATION NUMBER:

063827

CONTRACT TERM

FROM: 11/01/2015
TO: 12/31/2020

CONTRACTOR HAS (X) HAS NOT ( ) TIMELY FILED WITH THE ATTORNEY GENERAL'S CHARITIES BUREAU ALL REQUIRED PERIODIC OR ANNUAL WRITTEN REPORTS

FUNDING AMOUNT FOR CONTRACT TERM: Based on approved capitation rates

FEDERAL TAX IDENTIFICATION NUMBER:
131828429

NYS VENDOR IDENTIFICATION NUMBER:
1000026036

MUNICIPALITY NO. (if applicable)

STATUS:
CONTRACTOR IS ( ) IS NOT (X) A SECTARIAN ENTITY

CONTRACTOR IS (X) IS NOT () A NOT-FOR-PROFIT ORGANIZATION

CONTRACTOR IS (X) IS NOT ( ) A N Y STATE BUSINESS ENTERPRISE

( ) IF MARKED HERE, THIS CONTRACT IS RENEWABLE FOR ___ ADDITIONAL ONE-YEAR PERIOD(S) AT THE SOLE OPTION OF THE STATE AND SUBJECT TO APPROVAL OF THE OFFICE OF THE STATE COMPTROLLER.

APPENDICES ATTACHED AND PART OF THIS AGREEMENT
Precedence shall be given to these documents in the order listed below.

-X-	APPENDIX A	Standard Clauses as required by the Attorney General for all State contracts.
-X-	APPENDIX X	Modification Agreement Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)
-X-	APPENDIX Q	Modification of Standard Department of Health Contract Language
-X-	STATE OF NEW YORK AGREEMENT	
-X-	APPENDIX C	Program Specific Requirements
-X-	APPENDIX C-1	Marketplace Facilitated Enroller Program
-X-	APPENDIX D	NY State of Health Invitation and Requirements for Issuer Certification and Recertification for Participation in 2016, as amended by the Q and A posted on the NY State of Health website
-X-	APPENDIX D-1	Contractor's proposal for certification to participate in Basic Health Program
-X-	APPENDIX E-1	Proof of NYS Workers' Compensation Coverage
-X-	APPENDIX E-2	Proof of NYS Disability Insurance Coverage

-X-	APPENDIX G	Notices
___	APPENDIX H	Federal Health Insurance Portability and Accountability Act ("HIPAA") Business Associate Agreement ("Agreement")
-X-	APPENDIX I	Trading Partner Agreement
-X-	APPENDIX J	Capitation Rates
___	APPENDIX M	Participation by Minority Group Members and Women with respect to State Contracts: Requirements and Procedures

CONTRACT NO.: C030706

IN WITNESS THEREOF, the parties hereto have executed or approved this AGREEMENT on the dates below their signatures.

CONTRACTOR

Health Insurance Plan of Greater New York
d/b/a EmblemHealth

By: Shawn Fahey, Jr.

Shawn Fahey, Jr.
Printed Name

Title: SVP

Date: Oct. 29, 2015

STATE AGENCY

New York State Department of Health,
NY State of Health

By: Donna Frescatore

Donna Frescatore
Printed Name

Title: Executive Director, NY State of Health

Date: 11/30/15

State Agency Certification:
"In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract."

STATE OF NEW YORK)
)SS.:
County of NY)

On the 29 day of October in the year 2015 before me, the undersigned, personally appeared Shawn Fahey, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Jill Trachtenberg
Notary Public - State of New York
No. 02TR6133113
Qualified in New York County
My Comm. Expires Sept. 12, 2017

Jill Trachtenberg Asst General Counsel
(Signature and office of the individual taking acknowledgement)

ATTORNEY GENERAL'S SIGNATURE

APPROVED AS TO FORM
NYS ATTORNEY GENERAL
DEC 08 2015
Lorraine I. Remo
LORRAINE I. REMO
PRINCIPAL ATTORNEY

Title:

Date:

STATE COMPTROLLER'S SIGNATURE

Title:

Date:

APPROVED
DEPT. OF AUDIT & CONTROL
DEC 16 2015
Charlotte E. Breyer
THE STATE COMPTROLLER

NEW YORK STATE OF OPPORTUNITY. | **Department of Health**

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

November 23, 2015

Karen Ignagni
Health Insurance Plan of Greater New York
d/b/a EmblemHealth
55 Water Street
New York, NY 10041-8190

Re: Essential Plan [Basic Health Program, NY SSL 369-gg]
Contract no.: C030706
Contract Period: 11/1/2015 – 12/31/2020

Dear Ms. Ignagni;

By this letter, Appendix Q, Modification of Standard Department of Health Contract Language, is amended to add the following provision to Section II, Payment and Reporting:

Funds provided pursuant to this Agreement shall not be used for any partisan political activity, or for activities that may influence legislation or the election or defeat of any candidate for public office.

Please have the signatory to the above referenced Contract sign below to accept this change. Please return five (5) original copies of this signed letter within three (3) business days, via overnight express, to James Essman, whose contact information is provided below.

Your prompt response is appreciated. Thank you.

APPROVED
DEPT. OF AUDIT & CONTROL
DEC 16 2015
Charlotte E. Breyer
FOR THE STATE COMPTROLLER

Very truly yours,

Donna Frescatore
Donna Frescatore
Executive Director
NY State of Health

APPROVED AS TO FORM
NYS ATTORNEY GENERAL
DEC 08 2015
Lorraine I. Remo
LORRAINE I. REMO
PRINCIPAL ATTORNEY

Health Insurance Plan of Greater New York
d/b/a EmblemHealth

By: Shawn Fitzgibbon

Printed Name: Shawn Fitzgibbon

Title: Chief Product Officer

Date: November 24, 2015

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.

GLBU: DOH01
APPENDIX X

Contract Number:_____ Contractor:_____

Amendment Number X-_____ BSC Unit ID: 345<XXXX>

This is an AGREEMENT between THE STATE OF NEW YORK, acting by and through NYS Department of Health, having its principal office at Albany, New York, (hereinafter referred to as the STATE), and _____ (hereinafter referred to as the CONTRACTOR), for amendment of this contract.

This amendment makes the following changes to the contract (check all that apply):

_____ Modifies the contract period at no additional cost

_____ Modifies the contract period at additional cost

_____ Modifies the budget or payment terms

_____ Modifies the work plan or deliverables

_____ Replaces appendix(es) _____ with the attached appendix(es)_____

_____ Adds the attached appendix(es) _____

_____ Other: (describe) _____

This amendment *is*__ *is not*__ a contract renewal as allowed for in the existing contract.

All other provisions of said AGREEMENT shall remain in full force and effect.

Additionally, Contractor certifies that it is not included on the prohibited entities list published at http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf as a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York. Under the Act, the Commissioner of the Office of General Services (OGS) has developed a list (prohibited entities list) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). Contractor (or any assignee) also certifies that it will not utilize on such Contract any subcontractor that is identified on the prohibited entities list.

Prior to this amendment, the contract value and period were:

$_____ From ___/___/___ to ___/___/___.
(Value before amendment) (Initial start date)

This amendment provides the following modification (complete only items being modified):

$_____ From ___/___/___ to ___/___/___.

This will result in new contract terms of:

$_____ From ___/___/___ to ___/___/___.
(All years thus far combined) (Initial start date) (Amendment end date)

Revised 6/3/2013

Signature Page for:

Contract Number:_____ Contractor:_____

Amendment Number: X-_____ BSC Unit ID: 345<XXXX>_____

IN WITNESS WHEREOF, the parties hereto have executed this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE:

By:_____ Date: _____
(signature)

Printed Name:_____

Title:_____

STATE OF NEW YORK)
) SS:
County of _____)

On the ___ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
(Signature and office of the individual taking acknowledgement)

STATE AGENCY SIGNATURE

"In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract."

By:_____ Date:_____
(signature)

Printed Name:_____

Title:_____

ATTORNEY GENERAL'S SIGNATURE

By:_____ Date:_____

STATE COMPTROLLER'S SIGNATURE

By:_____ Date:_____

APPENDIX Q

MODIFICATION OF STANDARD DEPARTMENT OF HEALTH CONTRACT LANGUAGE

State of New York Agreement, Section II, Payment and Reporting, is replaced in its entirety with the following:

II. Payment and Reporting

Payment by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be **in Accordance with Appendix C.**

Payment 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 email at helpdesk@sfs.ny.gov or by telephone at 1-855-233-8363. CONTRACTOR acknowledges that it will not receive payment under this Contract 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.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us/vendors/vendorguide/guide.htm.

Revised 6/3/2013

STATE OF NEW YORK
AGREEMENT

This AGREEMENT is hereby made by and between the State of New York Department of Health (STATE) and the public or private agency (CONTRACTOR) identified on the face page hereof.

WITNESSETH:

WHEREAS, the STATE has determined that it is in need of the services described in Appendix C; and

WHEREAS the CONTRACTOR covenants that it is willing and able to undertake the services and provide the necessary materials, labor and equipment in connection therewith;

NOW THEREFORE, in consideration of the promises, responsibilities and covenants herein, the STATE and the CONTRACTOR hereby agree as follows:

I. Conditions of Agreement

A. This AGREEMENT incorporates the face pages attached and all of the marked appendices identified on the face page hereof.

B. The maximum compensation for the contract term of this AGREEMENT shall not exceed the amount specified on the face page hereof.

C. This AGREEMENT may be renewed for additional periods (PERIODS), as specified on the face page hereof.

D. To exercise any renewal option of this AGREEMENT, the parties shall prepare new appendices, to the extent that any require modification, and a Modification Agreement (the attached Appendix X is the blank form to be used). Any terms of this AGREEMENT not modified, shall remain in effect for each PERIOD of the AGREEMENT.

The modification agreement is subject to the approval of the Office of the State Comptroller.

E. Appendix A (Standard Clauses as required by the Attorney General for all State Contracts) takes precedence over all other parts of the AGREEMENT.

F. For the purposes of this AGREEMENT, the term "Proposal" includes all Appendix C documents as marked on the face page hereof.

II. Payment and Reporting

A. The CONTRACTOR shall submit complete and accurate invoices and/or vouchers, together with supporting documentation required by the contract, the State Agency, and the State Comptroller, to the STATE's designated payment office in order to receive payment at one of the following addresses:

1. Preferred Method: Email a .pdf copy of your signed voucher to the BSC at: DOHaccountspayable@ogs.ny.gov with a subject field as follows:
Subject: **Unit ID: 3450000 , Contract #: C030706**

2. Alternate Method: Mail vouchers to BSC at the following U.S. postal address:

NYS Department of Health
Unit ID 3450000
PO Box 2117
Albany, NY 12220-0017

B. Payment of such invoices and/or vouchers by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be in Accordance with Appendix C.

Payment for invoices and/or vouchers 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 email at helpdesk@sfs.ny.gov or by telephone at 1-855-233-8363. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract 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.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us/vendors/vendorguide/guide.htm.

III. Term of Contract

A. Upon approval of the NYS Office of the State Comptroller, this AGREEMENT shall be effective for the term as specified on the cover page.

B. This agreement may be cancelled at any time by the STATE giving to the CONTRACTOR not less than thirty (30) days written notice that on or after a date therein specified this agreement shall be deemed terminated and cancelled.

IV. Proof of Coverage

Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for:

☐ Workers' Compensation, for which one of the following is incorporated into this contract as Appendix E-1:

- **CE-200,** Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
- **C-105.2** – Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; OR
- **SI-12** – Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** – Certificate of Participation in Workers' Compensation Group Self-Insurance.

☐ Disability Benefits coverage, for which one of the following is incorporated into this contract as Appendix E-2:

- o **CE-200,** Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
- o **DB-120.1** – Certificate of Disability Benefits Insurance; OR
- o **DB-155** – Certificate of Disability Benefits Self-Insurance

V. General Specifications

A. The work shall be commenced and shall be actually undertaken within such time as the Department of Health may direct by notice, whether by mail, e-mail, or other writing, whereupon the CONTRACTOR will give continuous attention to the work as directed, to the end and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the Department may prescribe.

B. The Department reserves the right to stop the work covered by this contract at any time that the Department of Health deems the CONTRACTOR to be unable or incapable of performing the work to the satisfaction of the Department, and in the event of such cessation of work, the Department shall have the right to arrange for the completion of the work in such manner as it may deem advisable, and if the cost thereof exceeds the amount of this contract, the CONTRACTOR shall be liable to the State of New York for any such cost on account thereof.

C. Contractor will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

D. Work for Hire Contract
This contract shall be considered a "Work for Hire Contract." The Department will be the sole owner of all source code and any software which is developed for use in the application software provided to the Department as a part of this contract.

E. Technology Purchases Notification -- The following provisions apply if this contract procures only "Technology"

1. For the purposes of this policy, "technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.

2. If this contract is for procurement of software over $20,000, or other technology over $50,000, or where the department determines that the potential exists for coordinating purchases among State agencies and/or the purchase may be of interest to one or more other State agencies, PRIOR TO APPROVAL by OSC, this contract is subject to review by the New York State Office of Information Technology Services.

3. The terms and conditions of this contract may be extended to any other State agency in New York

F. Date/Time Warranty

1. Definitions: For the purposes of this warranty, the following definitions apply:

"Product" shall include, without limitation: when solicited from a vendor in a State government entity's contracts, RFPs, IFBs, or mini-bids, any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition function, calculation, comparing or sequencing. Where services are being furnished, e.g., consulting, systems integration, code or data conversion or data entry, the term "Product" shall include resulting deliverables.

"Third Party Product" shall include product manufactured or developed by a corporate entity independent from the vendor and provided by the vendor on a non-exclusive licensing or other distribution Agreement with the third party manufacturer. "Third Party Product" does not include product where vendor is : (a) a corporate subsidiary or affiliate of the third party manufacturer/developer; and/or (b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

2. Date/Time Warranty Statement

Contractor warrants that Product(s) furnished pursuant to this Contract shall, when used in accordance with the Product documentation, 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 must perform as a package or system, this warranty shall apply to the Products as a system.

Where 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), Contractor warrants that services shall be provided in an accurate and timely manner without interruption, failure or error due to the inaccuracy of 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. Contractor shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom, including but not limited to the failure or untimely performance of such services.

This Date/Time Warranty shall survive beyond termination or expiration of this contract 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 this Contract for breach of warranty.

G. No Subcontracting

Subcontracting by the contractor shall not be permitted except by prior written approval and knowledge of the Department of Health. All subcontracts shall contain provision specifying that the work performed by the subcontractor must be in accordance with the terms of this AGREEMENT, and that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the AGREEMENT between the STATE and the CONTRACTOR.

H. Superintendence by Contractor

The Contractor shall have a representative to provide supervision of the work which Contractor employees are performing to ensure complete and satisfactory performance with the terms of the Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the Department of Health. A confirmation in writing of such orders or directions will be given by the Health Department when so requested from the Contractor.

I. Sufficiency of Personnel and Equipment

If the Department of Health is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, Department shall have the authority to require the Contractor to use such additional personnel, to take such steps necessary to perform the services satisfactorily at no additional cost to the State.

J. Experience Requirements

The Contractor shall submit evidence to the satisfaction of the Department that it possesses the necessary experience and qualifications to perform the type of services required under this contract and must show that it is currently performing similar services. The Contractor shall submit at least two references to substantiate these qualifications.

K. Contract Amendments

This agreement may be amended by written agreement signed by the parties and subject to the laws and regulations of the State pertaining to contract amendments. This agreement may not be amended orally.

The contractor shall not make any changes in the scope of work as outlined herein at any time without prior authorization in writing from the Department of Health and without prior approval in writing of the amount of compensation for such changes.

L. Provisions Upon Default

1. In the event that the Contractor, through any cause, fails to perform any of the terms, covenants or promises of this agreement, the Department acting for and on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor

2. If, in the judgement of the Department of Health, the Contractor acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgement of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

M. Termination Provision

Upon termination of this agreement, the following shall occur:

1. Contractor shall make available to the State for examination all data, records and reports relating to this Contract; and

2. Except as otherwise provided in the Contract, the liability of the State for payments to the Contractor and the liability of the Contractor for services hereunder shall cease.

N. Contract Insurance Requirements

1. The CONTRACTOR must without expense to the State procure and maintain, until final acceptance by the Department of Health of the work covered by this contract, insurance of the kinds and in the amounts hereinafter provided, in insurance companies authorized to do such business in the State of New York covering all operations under this contract, whether performed by it or by subcontractors. Before commencing the work, the CONTRACTOR shall furnish to the Department of Health a certificate or certificates, in a form satisfactory to said Department, showing that it has complied with the requirements of this section, which certificate or certificates shall state that the policies shall not be changed or cancelled until thirty days written notice has been given to said Department. The kinds and amounts of required insurance are:

   a. A policy covering the obligations of the successful bidder in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the contract shall be void and of no effect unless the successful bidder procures such policy and maintains it until acceptance of the work (reference Appendix E).

   b. Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than $500,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than $1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two or more persons in any one occurrence, and not less than $500,000 for damages arising out of damage to or destruction of property during any single occurrence and not less than $1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.

      i. Contractor's Liability Insurance issued to and covering the liability of the successful bidder with respect to all work performed by it under this proposal and the contract.

      ii Protective Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.

      iii Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.

O. Certification Regarding Debarment and Suspension

Regulations of the Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in Federal program and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the Federal Government. A person who is debarred or suspended by a Federal agency is excluded from Federal financial and non-financial assistance and benefits under Federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one Federal agency has government wide effect.

Pursuant to the above cited regulations, the New York State Department of Health (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government wide exclusion (including and exclusion from Medicare and State health care program participation on or after August 25, 1995), and the Department of Health must require its prospective contractors, as prospective lower tier participants, to provide the certification in Appendix B to Part 76 of Title 45 CFR, as set forth below:

APPENDIX B TO 45 CFR PART 76-CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

Instructions for Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered and erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered Transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of parties Excluded from Federal Procurement and Non-procurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions

1. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily exclude from participation in this transaction by any Federal department agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

P. Confidentiality Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this AGREEMENT shall contain the following, or similar acknowledgment: "Funded by the New York State Department of Health". Any such materials must be reviewed and approved by the STATE for conformity with the policies and guidelines for the New York State Department of Health prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the CONTRACTOR shall be free to publish in scholarly journals along with a disclaimer that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health. The Department reserves the right to disallow funding for any educational materials not approved through its review process.

2. Any publishable or otherwise reproducible material developed under or in the course of performing this AGREEMENT, dealing with any aspect of performance under this AGREEMENT, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the STATE, and shall not be published or otherwise disseminated by the CONTRACTOR to any other party unless prior written approval is secured from the STATE or under circumstances as indicated in paragraph 1 above. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the STATE. The STATE shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

3. No report, document or other data produced in whole or in part with the funds provided under this AGREEMENT may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report, document or other data developed pursuant to this AGREEMENT.

4. All reports, data sheets, documents, etc. generated under this contract shall be the sole and exclusive property of the Department of Health. Upon completion or termination of this AGREEMENT the CONTRACTOR shall deliver to the Department of Health upon its demand all copies of materials relating to or pertaining to this AGREEMENT. The CONTRACTOR shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the Department of Health or its authorized agents.

5. The CONTRACTOR , its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this AGREEMENT, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.

Q. Provision Related to Consultant Disclosure Legislation

1. If this contract is for the provision of consulting services as defined in Subdivision 17 of Section 8 of the State Finance Law, the CONTRACTOR shall submit a "State Consultant Services Form B, Contractor's Annual Employment Report" no later than May 15th following the end of each state fiscal year included in this contract term. This report must be submitted to:
   a. The NYS Department of Health, at the STATE's designated payment office address included in this AGREEMENT; and
   b. The NYS Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th Floor, Albany NY 12236 ATTN: Consultant Reporting - or via fax at (518) 474-8030 or (518) 473-8808; and
   c. The NYS Department of Civil Service, Alfred E. Smith Office Building, Albany NY 12239, ATTN: Consultant Reporting.

R. Provision Related to New York State Procurement Lobbying Law

1. The STATE reserves the right to terminate this AGREEMENT in the event it is found that the certification filed by the CONTRACTOR in accordance with New York State Finance Law §139-k was intentionally false or intentionally incomplete. Upon such finding, the STATE may exercise its termination right by providing written notification to the CONTRACTOR in accordance with the written notification terms of this AGREEMENT.

S. Provision Related to New York State Information Security Breach and Notification Act

1. 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). CONTRACTOR shall be liable for the costs associated with such breach if caused by CONTRACTOR'S negligent or willful acts or omissions, or the negligent or willful acts or omissions of CONTRACTOR'S agents, officers, employees or subcontractors.

T. Accessibility of State Agency Web-based Intranet and Internet Information and Applications

1. Any web-based intranet and Internet information and applications development, or programming delivered pursuant to the contract or procurement, will comply with New York State Enterprise IT Policy NYS-P08-005, *Accessibility of Web-Based Information and Applications as* such policy may be amended, modified or superseded, which requires that state agency web-based intranet and Internet information and applications are accessible to persons with disabilities. Web content must conform to New York State Enterprise IT Policy NYS-P08-005 Appendix A, as determined by quality assurance testing. Such quality assurance testing will be conducted by NYSDOH and awarded contractor and the results of such testing must be satisfactory to NYSDOH before web content will be considered a qualified deliverable under the contract or procurement.

U. New York State Tax Law Section 5-a

1. Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded state contracts for commodities, services and technology valued at more than $100,000 to certify to the New York State Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

   This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offerer meeting the registration requirements but who is not so registered in accordance with the law.

   Contractor must complete and submit directly to the New York State Taxation and Finance, Contractor Certification Form ST-220-TD. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If the information changes for the contractor, its affiliate(s), or its subcontractor(s), a new form (ST-220-TD) must be filed with DTF.

   Contractor must complete and submit to the Department of Health the form ST-220-CA certifying that the contractor filed the ST-220-TD with DTF. Failure to make either of these filings may render an offerer non-responsive and non-responsible. Offerers shall take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

V. Piggybacking

New York State Finance Law section 163(10)(e) (see also http://www.ogs.state.ny.us/procurecounc/pgbguidelines.asp) allows the Commissioner of the NYS Office of General Services to consent to the use of this contract by other New York State Agencies, and other authorized purchasers, subject to conditions and the Contractor's consent.

W. Lead Guidelines

All products supplied pursuant to this agreement shall meet local, state and federal regulations, guidelines and action levels for lead as they exist at the time of the State's acceptance of this contract.

X. Indemnification

1. The CONTRACTOR shall be solely responsible and answerable in damages for any and all accidents and/or injuries to persons (including death) or property arising out of or related to the services to be rendered by the CONTRACTOR or its subcontractors pursuant to this AGREEMENT. The CONTRACTOR shall indemnify and hold harmless the STATE and its officers and employees from claims, suits, actions, damages and costs of every nature arising out of the provision of services pursuant to this AGREEMENT.

2. The CONTRACTOR is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the STATE nor make any claims, demand or application to or for any right based upon any different status.

Y. On-Going Responsibility

1. General Responsibility Language: The CONTRACTOR shall at all times during the Contract term remain responsible. The Contractor agrees, if requested by the Commissioner of Health or his or her designee, to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity.

2. Suspension of Work (for Non-Responsibility) :The Commissioner of Health or his or her designee, in his or her sole discretion, reserves the right to suspend any or all activities under this Contract, at any time, when he or she discovers information that calls into question the responsibility of the Contractor. In the event of such suspension, the Contractor will be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the Contractor must comply with the terms of the suspension order. Contract activity may resume at such time as the Commissioner of Health or his or her designee issues a written notice authorizing a resumption of performance under the Contract

3. Termination (for Non-Responsibility) : Upon written notice to the Contractor, and a reasonable opportunity to be heard with appropriate Department of Health officials or staff, the Contract may be terminated by Commissioner of Health or his or her designee at the Contractor's expense where the Contractor is determined by the Commissioner of Health or his or her designee to be non-responsible. In such event, the Commissioner of Health or his or her designee may complete the contractual requirements in any manner he or she may deem advisable and pursue available legal or equitable remedies for breach.

Z. Provisions Related to Iran Divestment Act

As a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York, a provision has been added to the State Finance Law (SFL), § 165-a, effective April 12, 2012. Under the Act, the Commissioner of the Office of General Services (OGS) has developed a list (prohibited entities list) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). Pursuant to SFL § 165-a(3)(b), the initial list has been posted on the OGS website at http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf.

By entering into this Contract, CONTRACTOR (or any assignee) certifies that it will not utilize on such Contract any subcontractor that is identified on the prohibited entities list. Additionally, CONTRACTOR agrees that should it seek to renew or extend the Contract, it will be required to certify at the time the Contract is renewed or extended that it is not included on the prohibited entities list. CONTRACTOR also agrees that any proposed Assignee of the Contract will be required to certify that it is not on the prohibited entities list before the New York State Department of Health may approve a request for Assignment of Contract.

During the term of the Contract, should New York State Department of Health receive information that a person is in violation of the above referenced certification, New York State Department of Health will offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment which is in violation of the Act within 90 days after the determination of such violation, then New York State Department of Health shall take such action as may be appropriate including, but not limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the CONTRACTOR in default.

New York State Department of Health reserves the right to reject any request for assignment for an entity that appears on the prohibited entities list prior to the award 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 C
PROGRAM SPECIFIC REQUIREMENTS
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I. DEFINITIONS

"Affordable Care Act (ACA)" shall mean the federal Patient Protection and Affordable Care Act, (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111 -152).

"Agreement" shall mean this Agreement by and between CONTRACTOR and the New York State Department of Health acting by and on behalf of the State of New York ("STATE") with respect to the purchase and sale of Essential Plans through the NY State of Health, The Official Health Plan Marketplace.

"Basic Health Program Blueprint" or **"BHP Blueprint"** shall mean the comprehensive written document submitted by the New York State Department of Health to the U.S. Department of Health and Human Services in accordance with 42 CFR 600.110, which outlines the elements necessary for certification of a Basic Health Program or BHP in accordance with applicable law.

"Capitation Payment" is the monthly payment by the STATE to CONTRACTOR of the Capitation Rate.

"Capitation Rate" shall mean the fixed monthly amount that CONTRACTOR receives for providing an Enrollee coverage in an Essential Plan.

"Certification" or **"Essential Plan Certification"** shall mean the Marketplace's authorization of a health plan to be offered on the Marketplace as an Essential Plan or an Essential Plan Plus Adult Vision / Dental, based on verification that a health plan complies with the Essential Plan requirements of the Invitation, as modified by the Marketplace, including: (i) the Applicant-Specific Requirements set forth in Section 3.1(D), including the provision of Essential Health Benefits; (ii) the Quality and Enrollee Satisfaction requirements in Section 4.2(D); (iii) the Network Adequacy Requirements in Section 4.1, including sufficient geographic distribution of Essential Community Providers; (iv) the Policy Form Filings and Plan Information Submission requirements in Section 3.1(E), as well as provisions of applicable law with respect to Essential Plans.

"Cost Sharing" means any expenditure required by or on behalf of an Enrollee with respect to covered health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes Premiums, balance billing amounts for non-network providers, and spending for non-covered services.[1]

"Coverage Effective Date" is the date when medical coverage, or medical and dental coverage, becomes effective for a particular Enrollee.

"Department of Financial Services (DFS)" is the New York State Department of Financial Services.

"Eligible Individual" is an individual eligible to enroll in an Essential Plan in accordance with the BHP Blueprint and applicable law.[2]

"Essential Health Benefits (EHB)" shall mean the minimum health benefits specified by the STATE. The Essential Health Benefits are delineated in Attachment A of the Invitation.

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[1] 42 CFR 600.5
[2] 42 CFR 600.305(a)

"Essential Plan" shall mean a health benefit plan that has been certified by the STATE as an Essential Plan pursuant to NY Social Services Law section 369-gg(1)(e), to be offered through the Marketplace in accordance with NY Social Services Law section 369-gg.[3]

"Essential Plan Plus Adult Vision/Dental" shall mean a health benefit plan that offers the same benefits and Cost Sharing as the Essential Plan and coverage for adult dental and vision benefits, which has been certified by the STATE pursuant to NYS Social Services Law section 369-gg(1)(e), to be offered through the Marketplace in accordance with NY Social Services Law section 369-gg.

"Enrollee" shall mean an Eligible Individual enrolled in an Essential Plan offered through the Marketplace.

"Federal Poverty Level (FPL)" means the most recently published Federal Poverty Level, updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2).

"Marketplace" shall mean the NY State of Health, The Official Health Plan Marketplace (formerly known as the New York Health Benefit Exchange or Exchange) established within the New York State Department of Health pursuant to Executive Order Number 42 on April 12, 2012.

"Health Care Services" shall mean the provision of medical services, supplies and benefits that are medically necessary and covered services, in accordance with CONTRACTOR's subscriber contract, including medical, behavioral health, chemical dependency, inpatient and outpatient services.

"Health Information Technology for Economic and Clinical Health Act (HITECH Act)" shall mean the Health Information Technology for Economic and Clinical Health Act enacted as part of the American Recovery and Reinvestment Act of 2009, and the regulations issued pursuant thereto or as thereafter amended.

"Health Insurance Portability and Accountability Act of 1996 (HIPAA)" shall mean the Health Insurance Portability and Accountability Act of 1996 and the regulations issued pursuant thereto or as thereafter amended.

"Indian" means a person who is a member of an Indian tribe.

"Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 USCS §§ 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"Insurance Affordability Program" means a program that is one of the following:

(1) A State Medicaid program under title XIX of the Social Security Act.

(2) A State children's health insurance program (CHIP) under title XXI of the Social Security Act.

[3] NY Social Services Law §369-gg(2), 42 U.S.C. 18051

(3) A State basic health program established under section 1331 of the Affordable Care Act.

(4) A program that makes coverage in a qualified health plan through the Marketplace with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals.

(5) A program that makes available coverage in a qualified health plan through the Marketplace with cost-sharing reductions established under section 1402 of the Affordable Care Act.[4]

"Invitation" shall mean the Invitation and Requirements for Insurer Certification and Recertification for Participation in 2016 and the attachments thereto, issued by the Marketplace on April 17, 2015 and revised May 15, 2015 to health insurers to participate in the Marketplace, as modified by the Questions and Answers regarding the Invitation posted on the Marketplace website.

"Medical Record" shall mean a complete record of care rendered by a provider documenting the care rendered to the Enrollee, including inpatient, outpatient, and emergency care, in accordance with all applicable federal, State and local laws, rules and regulations. Such record shall be signed by the medical professional rendering the services.

"Member Handbook" shall mean the publication that may be prepared by the CONTRACTOR, subject to STATE approval, which is issued to new Enrollees to inform them of how to access covered Health Care Services and explains their rights and responsibilities as an Enrollee of the CONTRACTOR.

"Non-Participating Provider" shall mean a provider of health care services or dental services with which the CONTRACTOR has no Provider Agreement.

"Participating Provider" shall mean a provider of Health Care Services or Dental Services that has a Provider Agreement with the CONTRACTOR.

"Personally Identifiable Information (PII)" shall mean information that can be used to distinguish or trace a person's identity, such as their name, social security number, etc., alone or when combined with other personal or identifying information that is linked or linkable to a particular individual.

"Protected Health Information (PHI)" refers to individually identifiable health information as defined in 45 CFR 164.402.

"Premium" shall mean the dollar amount payable by the Enrollee to the CONTRACTOR to effectuate and maintain coverage.

"Provider Agreement" shall mean any written contract between the CONTRACTOR and Participating Providers to provide Health Care Services or Dental Services to CONTRACTOR's Enrollees.

"Recertification" shall refer to the Marketplace's annual review and verification of an Essential Plan's compliance with the requirements for Certification and the provisions of applicable law regarding Essential Plans.

[4] 42 CFR 435.4

"Service Area" shall mean the geographic area(s) designated by the STATE or DFS in which a Contractor's Essential Plan(s) shall be offered.
"Subscriber" shall mean the Enrollee to whom the CONTRACTOR issues a Subscriber Contract to obtain health care coverage on behalf of him or herself.

"Subscriber Contract" shall mean the contract between CONTRACTOR and a Subscriber which is based on the model policy form created by the STATE and issued to each Enrollee by the CONTRACTOR at the time of Enrollment which details the provision of health care coverage under this Agreement.

"Summary of Benefits and Coverage (SBC)" refers to a document provided by CONTRACTOR to Enrollees describing simple and consistent information about plan benefits and coverage. The SBC helps Enrollees to better understand their coverage and compare coverage options.

II. AGREEMENT / RELATIONSHIP OF PARTIES

A. Essential Plans

The terms and conditions and obligations of the Parties set forth in this Agreement pertain to Essential Plans offered through the Marketplace.

B. Independent Contractors

1. The parties acknowledge and agree that, as required by 42 CFR 600.415 in carrying out its responsibilities, the STATE is not acting on behalf of CONTRACTOR. In the performance of this Agreement the STATE and the CONTRACTOR shall at all times be acting as independent contractors, and nothing in this Agreement shall be deemed to create a relationship of employer or employee or principal or agent between the STATE and CONTRACTOR.

2. Neither CONTRACTOR nor its Participating Providers, authorized subcontractors, agents, officers or employees, are agents, officers, employees or representatives of the STATE. Neither the STATE nor its authorized subcontractors, agents, officers, or employees are representatives of the CONTRACTOR.

C. Application of Law

The Parties acknowledge and agree that federal and State laws and regulation with respect to Essential Plans, the BHP Blueprint, and related issues addressed in this Agreement continue to develop on an ongoing basis. In the event that laws and regulations pertaining to Essential Plans and/or the BHP Blueprint change the requirements or processes set forth in this Agreement, the requirements of federal and state laws and regulations shall govern. The STATE shall issue procedural guidance and administrative instructions for CONTRACTOR with respect to certain requirements and processes set forth in this Agreement, to provide clarification in accordance with applicable law and regulations.

D. Coordination

CONTRACTOR and the STATE acknowledge and agree that the delivery of services to Enrollees pursuant to this Agreement will require the joint effort, coordination and cooperation of the Parties.

As set forth in detail herein, the Parties shall support each other in their marketing, enrollment, and Enrollee transition efforts in accordance with applicable law. The Parties shall communicate and cooperate with each other on an ongoing basis in accordance with the terms of this Agreement.

III. ESSENTIAL PLANS

A. Terms and Conditions for Essential Plan Certification

1. At all times during the Contract Term, pursuant to 42 C.F.R. 600.415(a) and NY State Social Services Law 369-gg(1)(a), CONTRACTOR shall be duly licensed pursuant to NY State Insurance Law Article 42 or 43, or certified pursuant to NY State Public Health Law Article 44 to provide health insurance in New York, in good standing and in compliance with state solvency requirements as determined by DFS and/or the STATE; or, have applied for such licensure or certification and reasonably anticipate being (a) licensed or certified prior to November 1, 2015 and (b) demonstrate to the satisfaction of the STATE that they have the capacity to be fully operational by November 1, 2015.

2. Essential Plans and Essential Plans Plus Adult Vision / Dental must be certified by the STATE to be offered to potential enrollees through the Marketplace.

3. Certification of CONTRACTOR's health insurance plan(s) as Essential Plan(s) by the STATE confirms that the plan(s) also comply with the following provisions of the Invitation:

   a. the Applicant-Specific Requirements set forth in Section 3.1(D), including Essential Plan benefits, Cost Sharing and Individual Premium Contributions;

   b. the Quality and Enrollee Satisfaction requirements in Section 4.2(D);

   c. the Network Adequacy Requirements in Section 4.1, including sufficient geographic distribution of Essential Community Providers; and

   d. the Premium Rate and Policy Form and Filing requirements in Section 3.1(E).

4. STATE will notify the CONTRACTOR of Essential Plan certification by e-mail and/or regular mail.

B. Contractor's Essential Plans

1. CONTRACTOR shall make available in the Marketplace, the Essential Plans that have been certified by the STATE.

2. CONTRACTOR shall offer four (4) variations of Essential Plan products based on Enrollee income as a percentage of FPL and other criteria delineated by the STATE.

3. CONTRACTOR shall make Essential Plans and, to the extent offered by the CONTRACTOR, Essential Plan Plus Adult Vision / Dental available in its entire Service Area as approved by DFS or the STATE at the time of application, unless granted an exception by the STATE in accordance with the provisions of this Agreement.

4. Any exception to the requirement that an Essential Plan be offered in CONTRACTOR'S entire Service Area requires the prior approval of the STATE during the certification process, following review of a written statement of facts justifying the exception. Any such exception must be determined to be necessary, non-discriminatory and in the best interest of the public.

5. CONTRACTOR's Essential Plans shall cover geographic areas that are established without regard to racial, ethnic, language or health status related factors, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

6. CONTRACTOR's Essential Plans shall comply with the following documentation submitted by CONTRACTOR and approved by the STATE or DFS, which is incorporated by reference and made a part of this Agreement:

   a. Participation Proposal, attached to this Agreement as Appendix D-1; and

   b. Network information submitted and approved by the STATE.

7. CONTRACTOR'S Essential Plans shall include the following features in the Essential Plan and the Essential Plan Plus Adult Vision / Dental:

   a. Care coordination and care management for Enrollees, with a particular focus on Enrollees with chronic health conditions;

   b. Initiatives to foster patient involvement in their health care decision-making, including the use of incentives for appropriate health care utilization and patient choice of provider;

   c. Incentives for use of preventive services.[5]

8. CONTRACTOR shall submit to the STATE a URL link that provides access to the CONTRACTOR's formulary.[6] The formulary must be an up-to-date list of all covered drugs and must clearly identify that the list is applicable to its Essential Plan(s). The formulary must clearly identify the applicable cost-sharing of individual drugs.

9. CONTRACTOR shall comply with NY State Public Health Law section 4406-c and Insurance Law section 3216(i)(27), 3221(a)(16) and 4303(jj), 42 C.F.R. 600.405(d) and 45 CFR 156.125, which prohibits discriminatory benefit design. STATE shall review CONTRACTOR's formulary to assure compliance with State law.

10. CONTRACTOR shall comply with the Essential Plan Naming Conventions required by the STATE, to assist consumers in easily identifying Essential Plans.

11. CONTRACTOR shall comply with STATE processes, procedures, and requirements established for the certification of individual health plans as Essential Plans or Essential Plans Plus Adult Vision / Dental.

12. CONTRACTOR shall have Information Technology systems and processes in place to accomplish data transfers in compliance with this Agreement and applicable law, including Enrollment, Reconciliation, claims and encounter data, and Reports, as set forth herein.

[5] 42 CFR 600.410(d)(3)(i)-(iii)
[6] 42 CFR 600.405(a)

C. Essential Plan Maintenance

1. CONTRACTOR acknowledges and agrees that the certification of Essential Plan(s) is conditioned upon ongoing compliance with applicable federal and State law and regulation governing Essential Plan certification; federal and State law regarding the provision of health and/or dental insurance in New York State; as well as the terms and conditions of this Agreement. CONTRACTOR's Essential Plans may be decertified if CONTRACTOR: (i) fails to adhere to material certification standards set forth in this Agreement, its Participation Proposal and applicable law; (ii) fails to resolve State agency sanctions, (iii) fails to comply with any applicable corrective action plan following reasonable notice and opportunity to cure, or (ii) fails to recertify.

2. In the event that the STATE determines decertification of an Essential Plan(s) is required pursuant to this Agreement and applicable law, the STATE will provide CONTRACTOR with written notice of this determination and the opportunity for a hearing prior to decertification. The hearing will be before the Commissioner of Health or his designee. Decertification shall occur in accordance with all applicable laws and regulations governing the removal of an Essential Plan from the Marketplace, including notification to Enrollees.

3. During the Contract Term (excepting the Recertification process) CONTRACTOR shall not change Essential Plan standardized benefits or cost-sharing features, including Essential Health Benefits, unless required pursuant to federal or State law.

4. CONTRACTOR may change or discontinue an Essential Plan only in accordance with this Agreement.

5. STATE may suspend enrollment in an Essential Plan in the event that a state agency requires suspension, or in the event that the STATE determines that it is in the best interest of the public. Notification of such suspension shall occur in accordance with applicable laws and regulations.

IV. PROVIDER NETWORKS

A. Network Adequacy Requirements

1. For Essential Plans offered through the Marketplace, CONTRACTOR will establish and maintain a network of Participating Providers that is sufficient to meet the access standards in 45 C.F.R. 156.230[7] and 156.235, the Invitation, existing STATE managed care network adequacy standards, and the requirements of this Agreement, together with instructions and guidance issued by the STATE. The network adequacy requirements and standards for Essential Plans shall be consistent with the network adequacy requirements and standards that exist outside of the Marketplace pursuant to the NY State Public Health Law and regulation.

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[7] Section 45 C.F.R. 156.230 requires a provider network to meet the following standards:

a. Includes essential community providers in accordance with 45 C.F.R. 156.235;

b. Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and

c. Is consistent with the network adequacy standards of section 2702 of the PHS Act.

2. In establishing the network, CONTRACTOR must consider the following: anticipated enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services covered in each product, the number of providers who are not accepting new patients, and the geographic location of the providers and Enrollees.

3. To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population and to assure that all services will be accessible without undue delay. This includes being geographically accessible (i.e. meeting time / distance standards) and being accessible for people with disabilities.

4. STATE may, on a case-by-case basis, defer certain network adequacy requirements set forth in this Agreement if it determines there is sufficient access to services in a county. The STATE reserves the right to rescind the deferment at any time, upon thirty (30) days' notice to the CONTRACTOR, should circumstances in a county change.

5. CONTRACTOR must identify any existing network that it intends to use to satisfy network adequacy requirements for Essential Plan(s), which network must be approved by the STATE.

B. Network Composition

1. CONTRACTOR's network must contain all of the provider types necessary to furnish the Essential Plan(s), including but not limited to hospitals, physicians (primary care and specialists), mental health and substance abuse providers, allied health professionals, ancillary providers, Durable Medical Equipment (DME) providers, home health providers, and pharmacies. Specifically, the CONTRACTOR's network must meet the following:

   a. Each county network must include at least one hospital, however, for the following counties and boroughs, the network must include at least three (3) hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, Manhattan, Queens;

   b. Hospitals that have 50 or more beds must meet the patient safety standards set forth in 45 CFR 156.1110, including a quality assessment and performance improvement program and discharge planning.[8]

   c. Each county network must include the core provider types and ratios established through the Provider Network Data System ("PNDS");

   d. Provide a choice of three (3) primary care physicians ("PCPs") in each county, but more may be required based on enrollment and geographic accessibility;

   e. Include at least two (2) of each required specialist provider types in each county, but more may be required based on enrollment and geographic accessibility;

   f. Time and distance standards:

[8] 45 CFR 156.1110, see also 42 CFR 482.21 and 42 CFR 482.43.

(i) Primary Care Providers: For Metropolitan areas, 30 minutes by public transportation. For non-Metropolitan areas, 30 minutes or 30 miles by public transportation or by car. In rural areas, transportation standards may exceed these thresholds if justified.

(ii) Other Providers: CONTRACTOR shall undertake its best efforts to meet the 30 minute / 30 mile standard.

2. In its behavioral health network, CONTRACTOR shall include individual providers, outpatient facilities, residential treatment facilities, and inpatient facilities. The network must include facilities that provide inpatient and outpatient alcohol and substance use services. Facilities providing inpatient alcohol and substance use services must be capable of providing detoxification and rehabilitation services.

3. In its dental network, CONTRACTOR shall include geographically accessible general dentists sufficient to offer each Enrollee a choice of two (2) primary care dentists in their service area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 Enrollees. In addition, dental networks shall include at least one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders (TMD) and oral / maxiofacial prosthodontic must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral. The network must include dentists with expertise serving special needs populations (e.g. HIV positive and developmentally disabled patients).

C. Essential Community Providers

1. CONTRACTOR shall have a sufficient number and geographic distribution of Essential Community Providers, where available to provide reasonable and timely access to such a broad range of such providers.

2. CONTRACTOR shall include a federally qualified health center and a tribal operated health clinic in each county network, to the extent such providers are available.

D. Sanctioned Providers

1. CONTRACTOR shall not include in its network any provider who:

a. Has, over the previous five (5) year period, been sanctioned or prohibited from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act and/or 18 NYCRR 515.3, and/or 18 NYCRR 515.7.

b. Has had his or her license suspended by the New York State Education Department or the State Office of Professional Medical Conduct.

2. CONTRACTOR shall review its provider network on a monthly basis to identify providers that require exclusion.

E. Network Adequacy Review / Process

1. STATE:

a. Shall review network adequacy on a county by county basis. For certain network adequacy purposes, the county may be extended by approximately ten (10) miles beyond the county line if CONTRACTOR demonstrates a lack of health care resources or demonstrates that utilization patterns of consumers typically reside outside of the county. In such cases, and in rural areas in particular, CONTRACTOR may contract with providers in adjacent counties to fulfill network adequacy requirements.

b. Shall review the adequacy of CONTRACTOR's network upon submission and on a quarterly basis thereafter. The frequency of submission and review shall be gradually increased to monthly.

c. Shall, in the event an insufficiency in CONTRACTOR's network is identified, provide CONTRACTOR with written notice of such insufficiency and an opportunity to cure within the specific time period required by the STATE, which time period shall be not less than thirty (30) days. Failure to cure the insufficiency within the time period dictated by the STATE could result in a statement of deficiency, as applicable, or the suspension of the Essential Plan's authority to enroll new applicants in the county in which the CONTRACTOR's network is found deficient. In the event that the STATE determines in its sole discretion that CONTRACTOR'S network fails to provide appropriate access to services covered by an Essential Plan, after the Essential Plan has had an opportunity to cure such deficiency and has failed to do so, the STATE may terminate this Agreement.

d. Reserves the right to update or modify the process for CONTRACTOR'S submission of its network for review and approval by the STATE, with at least sixty (60) days advance notice to CONTRACTOR.

2. CONTRACTOR shall:

a. Until monthly submission has commenced, shall make available to the STATE a URL link that provides an up-to-date online directory of providers. The STATE shall make such link publicly available on the Marketplace website.

b. Submit changes to its networks to STATE as soon as they occur (e.g. addition or termination of large hospital or physician's practice), but no later than fifteen (15) days from the date of the occurrence.

c. Submit its network through the Health Commerce System ("HCS") in accordance with the PNDS Instructions included in the Invitation, or as otherwise directed by the STATE. The network submission must include, as applicable, out-of-state providers within the CONTRACTOR's network and must include agreements with specialty centers and centers of excellence. The STATE reserves the right to request further explanation and/or details in the event that the system is not able to capture or accurately identify particular providers;

d. Ensure that for each provider included in the network that is submitted for review and approval, it has secured a Provider Agreement;

e. Ensure that the network data submitted to the STATE is accurate and complies with applicable law and the requirements of this Agreement, and any guidance issued by the STATE.

f. Ensure that the consumer network protections set forth in Chapter 60 of the Laws of 2014 are available to Enrollees, including the provisions related to Emergency Medical Services and Surprise Bills.[9]

V. POLICY FORM AND PREMIUM RATE FILING

A. Review of Rates and Forms

1. CONTRACTOR must use the model policy forms provided by STATE, with revisions to the model language limited to the bracketed sections of the model policy forms.

2. CONTRACTOR must accept the Capitation Rate approved by STATE, as further described in this Agreement, and apply the applicable cost-sharing.

3. Form changes to Essential Plans shall occur on an annual basis in accordance with instructions from STATE. Annual approval of forms will be incorporated into the STATE's Recertification process for Essential Plans.

B. Plan Management Templates

1. CONTRACTOR shall submit to STATE the required Essential Plan templates that provide prescription drug information, service area and contact information, on or before the date provided by STATE.

2. CONTRACTOR acknowledges that data contained within the Essential Plan plan management templates supply information necessary to populate the Marketplace web portal, and populate the Essential Plan information for other data transactions. As a result, CONTRACTOR shall adhere to instructions and guidance provided by the STATE when populating such templates and correcting information contained in the templates.

VI. QUALITY AND ENROLLEE SATISFACTION

Monitoring by State

1. CONTRACTOR shall develop and maintain a quality strategy that encompasses all the requirements set forth in section 1311(g) of the ACA. This strategy must be implemented and updated annually with progress reported as designated by STATE. The Quality Strategy must address the following:

a. The implementation of quality improvement activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and

[9] NY Financial Services Law, Article 6

care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan;

b. The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

c. The implementation of activities to improve health outcomes, and patient safety, as well as to reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information technology under the plan or coverage;

d. The implementation of wellness and health promotion activities;

e. The implementation of activities to reduce health care disparities, including through the use of language services, community outreach, and cultural competency trainings;

f. A description of any current or proposed innovative programs to expand access to mental health services including but not limited to telepsychiatry or consultative services for co-management of common behavioral health conditions in adults.

2. CONTRACTOR will be required to participate in the DOH Quality Assurance Reporting Requirements (QARR). The quality indicators in QARR are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance's ("NCQA") health Care Effectiveness Data and Information Set ("HEDIS") with New York State specific measures added to address health issues of importance to the State. QARR data will be used as a major component of Insurer quality rankings that will appear on the Marketplace website and will also be used in identifying clinical best practices, as well as areas of concern with respect to quality of care and administering the health plan benefit package. The QARR data collected by CONTRACTOR will also be posted on the DOH website in eQARR and related publications.

3. QARR technical specifications are released annually, with reporting of data due on or about June 15th.

4. CONTRACTOR will be required to report quality measures as well as all other required member-level files, including:

   a. HEDIS Volume 2;

   b. Programming for all required measures;

   c. A HEDIS audit conducted by a licensed audit organization of their QARR data prior to submission to DOH.

   d. A certified and federally approved CAPHS vendor to administer CAHPS.

5. CONTRACTOR shall annually survey a sample of their Essential Plan Enrollees using the standardized CAHPS Health Plan Survey tool. The CAHPS Health Plan Survey allows STATE

to assess many aspects of the Enrollees' experience of care, including their access to care and services and their interactions with their providers and health plan.

6. CONTRACTOR shall have the infrastructure in place that allows them to implement their Quality Strategy and related improvement activities as well as to participate in quality improvement initiatives sponsored by STATE. Such infrastructure incudes the ability to administer Enrollee surveys, to offer member education / outreach or incentive programs, physician training and/or incentive programs, and practice level assessments among other things.

VII. ELIGIBILITY AND ENROLLMENT

A. Obligations of STATE

1. STATE shall be responsible for determining an individual applicant's eligibility for an Essential Plan as well as other Insurance Affordability Programs.[10] The STATE shall not permit an applicant to request an eligibility determination for less than all Insurance Affordability Programs.[11]

2. STATE shall use a single streamlined application to collect necessary information and determine eligibility for enrollment in an Essential Plan.[12]

3. STATE will make eligibility determinations in accordance with the requirements of the BHP Blueprint, state and federal law, and state policies and procedures.[13]

4. When individual Enrollees report a change in circumstances, the STATE shall re-determine eligibility and allow for transition to another Insurance Affordability Program in accordance with the BHP Blueprint, the requirements of state and federal law and state policies and procedures.[14]

5. STATE shall review Essential Plan eligibility for individual Enrollees every twelve (12) months, unless eligibility is re-determined sooner based on new information received and verified from Enrollee reports or data sources.[15]

6. STATE shall provide Enrollees with an annual notice of redetermination of eligibility.[16] If an Enrollee remains eligible for coverage in an Essential Plan, the STATE shall provide Enrollee with notice of a reasonable opportunity at least annually to change plans. Enrollee shall remain in the plan selected for the previous year unless the Enrollee terminates coverage in the plan by selecting a new plan, withdrawing from a plan, or the plan is no longer available.[17]

7. STATE shall provide Enrollees in plans that are no longer available with a reasonable opportunity to select a new plan.

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[10] 42 C.F.R. 600.330(a)
[11] 45 C.F.R. 155.310(b)
[12] 42 C.F.R. 600.310(a)
[13] 42 C.F.R. 600.345(a)(2)
[14] 45 C.F.R. 600.340(a)
[15] 42 C.F.R. 600.340(a)
[16] 42 C.F.R. 600.340(e)
[17] 42 C.F.R. 600.340(b)

8. To ensure coverage is effective in a timely manner, the STATE will provide to the CONTRACTOR and to potential enrollees a transaction identification number. The CONTRACTOR may require potential enrollees to provide the transaction identification number when making an initial payment of premium to CONTRACTOR, if any.

9. Eligibility determination notices issued by the STATE in accordance with the BHP Blueprint shall include a notice of the right to appeal the determination, and instructions regarding how to file an appeal.[18]

10. STATE shall provide applicants with the opportunity to appeal Essential Plan eligibility determinations through the Marketplace.[19]

11. STATE shall communicate and coordinate with the CONTRACTOR with respect to the processes, file formats and technology required for the transmission of enrollment data by and between the STATE and the CONTRACTOR.

12. STATE shall initiate termination of the enrollment of individual Enrollees in accordance with applicable law, including the following circumstances: Enrollee is no longer eligible for coverage; rescission of coverage; termination or decertification of an Essential Plan; Enrollee change from one plan to another.[20]

B. Obligations of CONTRACTOR

1. CONTRACTOR shall accept new Essential Plan enrollments all year, meaning that Eligible Individuals may enroll in an Essential Plan in accordance with applicable law at any time of the year.[21]

2. To the extent that CONTRACTOR authorizes employees or representatives to provide application assistance to individuals enrolling in Insurance Affordability Programs through the Marketplace, including Essential Plans, CONTRACTOR shall comply with the provisions of Appendix C-1 of this Agreement regarding the Marketplace Facilitated Enrollment (FE) Program.

3. Commencing November 1, 2015, CONTRACTOR shall make available for purchase in the Marketplace the Essential Plans that have been certified by the Marketplace. Eligible individuals will be able to enroll directly through the Marketplace website, or may use an authorized agent or broker, Navigator, Certified Application Counselor, or Marketplace Facilitated Enroller; and, to the extent permitted by federal and State law and regulation, other third-party assistors or CONTRACTOR customer service representatives.

4. Individuals who enroll in an Essential Plan offered through the Marketplace from November 1, 2015 through December 15, 2015 and qualify for an Essential Plan as:

   a. individuals with income greater than 150 percent and less than or equal to 200 percent of FPL ("Essential Plan 1"), or

[18] 45 C.F.R. 600.335(a)
[19] 42 C.F.R. 600.335(b)
[20] 42 C.F.R. 600.525(a), 45 C.F.R. 155.430(b)
[21] NY State Social Services Law § 369-gg(4)(b)

b. individuals with income greater than 138 percent and less than or equal to 150 percent of FPL ("Essential Plan 2"),

will have an initial effective date of January 1, 2016.

5. Individuals who enroll in an Essential Plan offered through the Marketplace from November 1, 2015 through December 31, 2015 and qualify for an Essential Plan as:

   a. individuals with income greater than 100 percent and less than or equal to 138 percent of FPL Not Eligible for Medicaid Due to Immigration Status ("Essential Plan 3"), or

   b. individuals with income at or below 100 percent of FPL Not Eligible for Medicaid Due to Immigration Status ("Essential Plan 4"),

will have an initial effective date of January 1, 2016.

6. For individuals who enroll in an Essential Plan offered through the Marketplace on or after January 1, 2016, effective dates for enrollment shall be as follows:

   a. Individuals who have income at or below 138 percent of FPL, and do not qualify for Medicaid Due to Immigration Status, the effective date of Essential Plan coverage will be the first of the month in which they selected a Essential Plan. For example, an individual who selects an Essential Plan on February 15, 2016 will have coverage in the Essential Plan starting February 1, 2016.

   b. Individuals who have incomes above 138 percent of the FPL who select a plan between the first and fifteenth day of the month, will have coverage that begins on the first day of the next month. Such individuals who select a plan between the 16th and last day of the month will have coverage that begins on the first day of the second month following the month in which they select an Essential Plan.

7. Enrollment is not effectuated until CONTRACTOR receives initial payment of Premium, if applicable, from the prospective enrollee and sends a confirmation 834 transaction to the STATE (the "Coverage Effective Date"). Unless otherwise required under federal law, CONTRACTOR shall provide a ten (10) day grace period to Enrollees for their initial premium payment to effectuate coverage. Initial payments received by the 10th of the month in which the initial coverage is in effect shall be considered timely.

8. CONTRACTOR will not be financially responsible for any claims incurred by a prospective enrollee until the initial Premium payment is made prior to or during the ten (10) day grace period. CONTRACTOR will be financially responsible for any claims incurred during the ten (10) day grace period if the prospective enrollee pays the initial Premium prior to or during such ten (10) day grace period.

9. After enrollment is effectuated, CONTRACTOR shall provide Enrollee with a thirty (30) day grace period to pay Premiums prior to disenrollment.[22]

[22] 42 C.F.R. 600.525(3)

10. CONTRACTOR shall provide Enrollees with reasonable notice of past due Premiums and an opportunity to pay prior to disenrollment.[23]

11. If CONTRACTOR receives an application directly from a potential enrollee for enrollment in a Essential Plan, the CONTRACTOR must either (i) direct the applicant to the Marketplace for a determination of eligibility and enrollment in an Essential Plan if eligible, or (ii) ensure the applicant received an eligibility determination from the Marketplace through the Marketplace website, whether through an assistor (i.e. broker, Navigator) or by enrolling the individual directly if and when permitted by federal regulation.[24]

12. CONTRACTOR shall not, with respect to its Essential Plan(s), discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.[25]

13. CONTRACTOR shall, for a period not to exceed one (1) year as determined by the STATE and HHS, accept retroactive enrollments from the STATE in special circumstances as determined by the STATE. Such circumstances shall include retroactive enrollments required to comply with eligibility appeals processes, or retroactive enrollments required to correct an error of the STATE or the CONTRACTOR, and other such cases agreed to by STATE and CONTRACTOR. In such cases, the Enrollee shall be required to pay in full his or her share of Premiums for all months of coverage received.

C. Enrollment / Disenrollment Transactions

1. CONTRACTOR must accept enrollment information in an electronic format, in a manner consistent with applicable privacy and security provisions of state and federal law and administrative guidance.[26] CONTRACTOR shall enter into a Trading Partner Agreement with STATE to address the secure exchange of HIPAA compliant health care transactions.

2. The STATE shall transmit enrollment data to CONTRACTOR via HIPAA compliant 834 transactions. CONTRACTOR must be prepared and able to accept daily enrollment information in a HIPAA compliant 834 transaction, and acknowledge receipt of enrollment information by returning HIPAA compliant 999 transactions to STATE, as well as such other HIPAA compliant transactions as may be necessary pursuant to this Agreement. The transfer of enrollment data and other HIPAA compliant transactions shall be conducted pursuant to the Trading Partner Agreement attached as an Appendix to this Agreement and Trading Partner Guides referenced in such Trading Partner Agreement, as amended from time to time.

3. STATE shall transmit 834 transactions to CONTRACTOR on a daily basis and CONTRACTOR shall process these transactions regularly, in accordance with the following timeframes:

   a. Transaction files, including maintenance and termination transactions, shall be picked up daily;

   b. Acknowledgement transactions (999 transactions) must be sent within 24-hours of picking up the files;

[23] 42 C.F.R. 457.570(a)
[24] 45 C.F.R. 156.265(b)
[25] 42 C.F.R. 600.165
[26] 45 C.F.R. 156.265(c)

c. Effectuation transactions must be sent within five (5) business days of the grace period end date for those enrollees with premium, or within five (5) business days of receipt of the enrollment transaction, for those enrollees with no premium;

d. Terminations and cancellations must be sent within five (5) business days of the termination or cancellation;

e. Error files must be reviewed and errors corrected on a regular basis, but no less often than once per week.

4. In conducting HIPAA transactions, STATE and CONTRACTOR shall adhere to the Trading Partner Agreement attached hereto as an Appendix and the individual Trading Partner Guides referenced therein.

5. CONTRACTOR shall reconcile enrollment files with the STATE no less than once per month, and in accordance with procedures established by the STATE and as set forth in the Trading Partner Agreement attached hereto as an Appendix.

D. Coverage Effective Date

1. CONTRACTOR must notify an Enrollee of his or her effective date of medical coverage, or medical and dental coverage (the "Coverage Effective Date").

2. Notification of the Coverage Effective Date may be accomplished through a "Welcome Letter" or similar notification. To the extent practicable, such notification must precede the Coverage Effective Date.

3. As of the Coverage Effective Date, and until the Effective Date of Disenrollment, the CONTRACTOR shall, pursuant to the terms and conditions of the Essential Plan, be responsible for the coverage of all covered care and services provided under the Essential Plan's benefit package and delivered to Essential Plan Enrollees, with the exception of benefits provided through state fee for service programs.

4. CONTRACTOR shall not be liable for the cost of any services rendered to an Enrollee prior to his or her Coverage Effective Date.

E. Process

1. CONTRACTOR shall accept enrollments of Eligible Individuals in the order in which the enrollment information is received without regard to the Eligible Individual's sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, or type of illness or condition.

2. CONTRACTOR shall be responsible for collecting applicable Premium payments, if any, from Enrollees.

3. In accordance with federal regulation, CONTRACTOR shall offer method of payment options to Enrollees that do not discriminate against individuals without bank accounts or credit cards.

VIII. ENROLLEE RIGHTS AND NOTIFICATION

A. Information Requirements

1. CONTRACTOR shall provide all Enrollees an information package as required by 45 C.F.R. 156.265(e), including a Subscriber Contract and a Summary of Benefits and Coverage ("SBC").

2. The CONTRACTOR shall issue such information to the Enrollee as soon as possible but no later than fourteen (14) days after the Coverage Effective Date.

3. The CONTRACTOR must provide Enrollees with an annual notice that the Subscriber Contract and SBC are available upon request.

4. The CONTRACTOR must make information available to prospective Enrollees and Enrollees (including information regarding internal and external appeals rights) in plain language and in a manner that is accessible and timely to individuals with disabilities, including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. CONTRACTOR must:

   a. Provide written materials in a prose that is understood by an eighth-grade reading level except as otherwise required by STATE and must be printed in at least 10-point type.

   b. Make available written materials and other informational materials in a language other than English whenever at least five percent (5%) of the prospective Enrollees or Enrollees of the CONTRACTOR in any county of the service area speak that particular language and do not speak English as a first language; or, alternatively, provide taglines in common non-English languages indicating the availability of written translation materials in any language the prospective or current Enrollees speak.

   c. Make available verbal interpretation services in any language to current or potential enrollees who speak a language other than English as a primary language to the extent reasonably practicable. Interpreter services must be offered in person where practical, but otherwise may be offered by telephone.

   d. Have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include readers to assist the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies.

   e. To the extent that HHS establishes standards on written materials and/or verbal information for the Marketplace that provides greater protections than the standards set forth above, adhere to such standards.

5. CONTRACTOR must inform individuals of the services provided in paragraph "4" above and how to access such services and alternative mechanisms.[27]

[27] 45 C.F.R. 155.205(b)(3)

B. Provider Directories

1. The CONTRACTOR shall maintain and update, and make publicly available, a listing by specialty of all Participating Providers, including facilities (the "Provider Directory").[28] Such Provider Directory shall include names, office addresses, telephone numbers, specialty, board certification for physicians, any affiliations with participating hospitals, information on language capabilities and wheelchair accessibility of Participating Providers. The Provider Directory should also identify providers that are considered Primary Care Physicians and providers that are not accepting new patients. Consistent with the 2014 Out-of-Network Law, electronic versions of such directories shall be updated within fifteen (15) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

2. CONTRACTOR shall make available to the STATE a URL link that provides access to the CONTRACTOR's Provider Directory. The directory must clearly identify the network of providers participating in Essential Plans. If multiple network configurations are offered by the CONTRACTOR, the directories must clearly identify the network for the particular Essential Plan(s). The directory must clearly distinguish this network(s) from other networks offered by CONTRACTOR so that a consumer using the directory can clearly and easily access the correct directory via the URL link provided to the Marketplace.

3. CONTRACTOR shall implement a system to periodically verify the accuracy of its reported Essential Plan provider network(s), to validate participation by individual providers and assure that individual providers are aware of their participation in the Essential Plan network(s). Such system may include, but not be limited to, direct outreach to providers listed by the CONTRACTOR as participating in the Essential Plan network(s). CONTRACTOR shall provide to STATE the method and frequency with which it shall carry out such verifications and report to the STATE the results of such verification efforts within a timeframe specified by STATE.

4. CONTRACTOR shall develop and implement protocols to address inquiries and complaints concerning provider directories. CONTRACTOR shall provide to STATE the protocols developed within a timeframe specified by STATE.

5. CONTRACTOR shall notify Enrollees in writing at least annually that updates to its provider directory are available online, and that updates and/or a copy of the directory may be provided in hardcopy upon request.

C. Treatment Cost Calculator for Services Rendered by a Participating Provider

CONTRACTOR shall, in accordance with and to the extent required by federal regulations, have a treatment cost calculator available through an Internet Web site and by toll free telephone number for individuals without access to the Internet. Such treatment cost calculators must be able to demonstrate Enrollee cost sharing under the individual's plan, or coverage with respect to the furnishing of a specific item or service by a Participating Provider in a timely manner upon the request of the individual.

[28] 45 C.F.R. 600.150(a)(5)

D. Member Identification Cards

1. CONTRACTOR shall issue an identification card to Enrollees as soon as is possible but no later than seven (7) days following receipt of enrollment transaction from STATE. The identification card shall contain pertinent information including the CONTRACTOR's member services toll free telephone number.

2. If unforeseen circumstances prevent the CONTRACTOR from issuing the official identification card to new Enrollees within the above timeframe, the CONTRACTOR shall implement an alternative method by which individuals may identify themselves as Enrollees prior to receiving the card or otherwise make the enrollment and cost-sharing information readily available to the Enrollees and Participating Providers.

E. Member Handbooks / Subscriber Contracts

The CONTRACTOR shall issue to a new Enrollee as soon as possible but no later than fourteen (14) days after the Coverage Effective Date a Subscriber Contract or Member Handbook; and, at the option of CONTRACTOR, a Member Handbook.

IX. TERMINATION OF COVERAGE

A. Obligations of STATE

1. STATE shall permit an Enrollee to terminate his or her coverage in an Essential Plan in the event of a qualifying event (including as a result of the Enrollee obtaining other minimum essential coverage), upon fourteen (14) days' notice to the STATE before the requested effective date of termination.[29] In such case the last day of coverage is:

   a. The termination date specified by the Enrollee, if the Enrollee provides fourteen (14) days' notice before the requested date of termination;[30]

   b. Fourteen (14) days after the termination is requested by the Enrollee, if the Enrollee does not provide notice at least fourteen (14) days before the requested effective date of termination;[31] or

   c. On a date determined by CONTRACTOR on or after the date on which termination has been requested by the Enrollee, if the CONTRACTOR agrees to effectuate termination in fewer than fourteen (14) days and the Enrollee requests an earlier termination effective date.[32]

[29] 45 C.F.R. 155.430(b)(i)
[30] 45 C.F.R. 155.430(d)(2)(i)
[31] 45 C.F.R. 155.430(d)(2)(ii)
[32] 45 C.F.R. 155.430(d)(2)(iii)

d. If the Enrollee is newly eligible for Medicaid or CHP, the last day of enrollment in an Essential Plan is the day before the individual is determined eligible for Medicaid or CHP.[33]

2. STATE shall initiate termination of an Enrollee's coverage in an Essential Plan, and shall permit CONTRACTOR to terminate such coverage in the following circumstances:[34]

a. Enrollee is no longer eligible for coverage in an Essential Plan, in which case the last day of enrollment is the last day of eligibility, unless the Enrollee requests an earlier termination date in accordance with applicable regulation;[35]

b. Non-payment of Premiums for coverage of the Enrollee following the expiration of the thirty (30) day grace period, in which case the last day of coverage is the last day of the month of the grace period.

c. The Essential Plan is discontinued or is decertified in accordance with applicable law.

3. In accordance with 45 C.F.R. 155.430(c), the STATE shall promptly and without undue delay inform CONTRACTOR of Enrollee termination.

B. Obligations of CONTRACTOR

1. CONTRACTOR shall not terminate coverage because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services.

2. CONTRACTOR may cancel an Eligible Individual's enrollment in the event that the initial Premium payment is not received during the ten (10) day grace period referred to in this Agreement.

3. CONTRACTOR shall make reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before termination of coverage for such individuals.[36]

4. CONTRACTOR may only initiate termination for failure to pay initial Premium (i.e., Cancellations), rescission, and non-payment of Premium after the thirty (30) day grace period has ended. In all other circumstances, CONTRACTOR may only terminate coverage for an Enrollee after such termination is initiated by the STATE in a standard HIPAA compliant 834 transaction or pursuant to such other procedures designated by the STATE.

5. If the CONTRACTOR determines that termination of Enrollee coverage is warranted in accordance with 45 C.F.R. 155.430, CONTRACTOR may request that termination be initiated by the STATE by providing notice to the STATE in writing or in such other format as the STATE may determine, and shall provide such request promptly and without undue

[33] 45 C.F.R. 155.430(d)(2)(iv)
[34] 45 C.F.R. 155.430(b)(2)
[35] 45 C.F.R. 155.430(d)(3)
[36] 45 C.F.R. 155.430(c)(3)

delay. Upon examination and successful validation of such request, the STATE will promptly initiate such termination and provide notice of termination to the CONTRACTOR.

6. CONTRACTOR is not responsible for providing benefits after the effective date of disenrollment.

7. CONTRACTOR must maintain reasonably sufficient records of termination of coverage and retain these records for a period of ten (10) years to facilitate audit functions.[37]

X. RECERTIFICATION / TERMINATION OF ESSENTIAL PLAN AGREEMENT

A. Recertification

1. The STATE shall notify CONTRACTOR of the opportunity for Recertification no later than May 1st each year. CONTRACTOR may add, remove or modify Essential Plans during the Recertification process in accordance with STATE instruction.

2. The STATE will complete Recertification on an annual basis but no later than September 15 of each year.

B. Non-renewal

In lieu of annual Recertification, CONTRACTOR may opt not to renew Essential Plan(s). CONTRACTOR shall notify the STATE of its decision to not renew in a manner and timeframe that is consistent with existing State law and in accordance with this Agreement. The CONTRACTOR must follow applicable laws and regulations in terminating Essential Plans, including notification to Enrollees. The STATE will monitor the transition process, coordinating processes with Marketplace Customer Service to facilitate transition.

C. Contractor Discontinuance of Counties in Service Area

CONTRACTOR discontinuance of a county or counties in its Service Area requires the prior approval of the STATE.

In the event that CONTRACTOR proposes to voluntarily discontinue providing Essential Plan(s) in a particular county or counties in its Service Area, the CONTRACTOR shall provide the STATE with a written statement of facts justifying the discontinuance. Any such discontinuance must be determined to be necessary and non-discriminatory.

D. Contractor Failure, Delay or Inability to Comply with the Agreement

Any delay by, or failure or inability of the CONTRACTOR to comply with the terms and conditions of this Agreement, either in whole or in part, in accordance with provisions, specifications, and/or schedules contained herein shall be excused and a reasonable time for performance pursuant to this Agreement, shall be extended to include the period of such delay or nonperformance, if caused by or resulting from fire, explosion, accident, labor dispute, flood, war, riot, acts of God, legal action including injunction, present or future law, governmental order, rule or regulation, or any other reasonable cause beyond the CONTRACTOR'S immediate and direct control, including STATE or

[37] 45 C.F.R. 155.430(c)(4)

another government agency postponing or deferring certain pertinent functions related to the operation of the Marketplace. It is agreed, however, that a cause itemized or referred to above shall not excuse a delay, failure or inability to the CONTRACTOR to perform if such cause arose as a result of the negligence or willful act or omission of the CONTRACTOR which in the exercise of reasonable judgment, could have been avoided by the CONTRACTOR. Pending the restoration, settlement or resolution of the cause for delay, failure or inability of the CONTRACTOR to perform, the CONTRACTOR shall continue to perform those obligations of this Agreement which are not related or subject to such cause.

E. Contractor Initiated Termination of Agreement

CONTRACTOR shall notify STATE of circumstances causing the CONTRACTOR to be unable to perform activities and services required under this Agreement.

If circumstances result in the CONTRACTOR'S inability to perform services, sixty (60) days' notice of termination should be provided by the CONTRACTOR to the STATE with notice to Enrollees of the conclusion of coverage under this Agreement and the availability of conversion rights pursuant to the Subscriber Contract.

F. State Initiated Termination of Agreement

The STATE may cancel this AGREEMENT in the event that the STATE determines:

1. the CONTRACTOR substantially fails to meet, perform or observe a material requirement or promise set forth in this Agreement, and/or substantially violates applicable law;

2. there is or has been a breach of HIPAA Compliance / Security requirements set forth in this Agreement or the Trading Partner Agreement attached hereto as an Appendix;

3. that CONTRACTOR does not meet financial requirements, except to the extent that a corrective action plan has been approved by DFS.

G. Process for Termination and Transition of Enrollees

If this Agreement between STATE and CONTRACTOR is terminated for any reason, the CONTRACTOR must work in conjunction with STATE to develop a plan to transition Enrollees to another Contractor in the Enrollee's service area. This plan must include notifying Enrollees of other available health plan options, at least one hundred and eighty (180) days prior to termination, and providing follow up letters to remind individuals to enroll with another health plan, in addition to any other requirement under New York State law.

XI. MEMBER SERVICES

1. CONTRACTOR shall operate a "Member Services" or "Customer Services" department during regular business hours, which must be accessible to Enrollees via toll free telephone number. Customer service representatives must be available during regular business hours to address complaints and utilization inquiries.

2. CONTRACTOR must maintain a telephone system capable of accepting incoming calls regarding complaints and utilization review outside of regular business hours, providing

instructions for leaving a message, and have measures in place to ensure a response to those calls the next business day after the call was received.

3. CONTRACTOR must be prepared to adjust customer service staff to meet expected performance levels on peak Marketplace volume days.

4. Consumer complaints received through the Marketplace and sent to the CONTRACTOR require a response from CONTRACTOR no later than three (3) business days from the day the Marketplace sends the complaint. If the matter involves an urgent coverage issue, the CONTRACTOR must respond and act upon the complaint within 24 hours of receipt. The timeframes in this subparagraph apply regardless of whether the complaint is generated as a result of technical problems with the CONTRACTOR's system or technical problems with the Marketplace system. In the event that the complaint involves a technical error by the Marketplace or the applicant or Enrollee needs a technical transaction to resolve the complaint, the CONTRACTOR will work cooperatively and diligently with the Marketplace to ensure that coverage is not delayed pending resolution of technical issues.

XII. MARKETING

A. Obligations of STATE

1. The STATE shall implement a multi-faceted marketing and outreach campaign that is focused on connecting New Yorkers with quality, affordable health insurance through its user friendly Marketplace website.

2. The STATE shall engage in targeted outreach to consumers through navigators, consumer advocates, brokers, Marketplace Regional Advisory Committee members and other stakeholders to promote use of the Marketplace.

3. The STATE shall initiate an advertising campaign designed to publicize the access to quality, affordable health insurance.

B. Obligations of CONTRACTOR

1. CONTRACTOR shall cooperate in good faith with the STATE's marketing and outreach activities, including the development of advertising and outreach materials for Essential Plans and communication with the Marketplace's External Affairs, Outreach and Marketing team.

2. CONTRACTOR may maintain a direct link to the Marketplace website on CONTRACTOR's website. The STATE will provide approved links for this purpose (also known as "widgets").

3. CONTRACTOR shall cooperate with STATE to educate its agents and brokers about the Essential Plans available through the Marketplace and the process for agent and broker training and certification by the Marketplace.

4. CONTRACTOR's marketing of Essential Plans may include: (i) advertisements in print, radio, television, outdoor advertising and/or social media, (ii) written and electronic communications sent to CONTRACTOR's members, Participating Providers and brokers, such as newsletters; and (iii) distribution of materials at local community centers, health fairs and other areas where potential enrollees are likely to gather.

5. CONTRACTOR shall use the name, logo and branding designated by the STATE in referring to the Marketplace in marketing and outreach activities including any printed materials. Such materials must prominently display the Marketplace website and toll free telephone number.

6. CONTRACTOR shall provide the STATE with brand symbols in the format necessary for the use on the Marketplace website.

7. CONTRACTOR shall not employ marketing practices that are designed to have the effect of discouraging the enrollment of individuals with significant health needs in their Essential Plans.

8. CONTRACTOR shall comply with provisions of federal and state law regulating advertising materials and marketing practices. CONTRACTOR's advertising materials must accurately reflect general information that would be applicable to potential enrollees. Materials must not contain false or misleading information. CONTRACTOR shall not offer incentives of any kind to potential enrollees to enroll in an Essential Plan or renew their coverage.

9. CONTRACTOR is prohibited from the door-to-door solicitation of potential enrollees or distribution of material, and may not engage in "cold calling" inquiries or solicitation. For purposes of this section, "cold calling" shall not include outreach to individuals enrolled in other products or plans offered by CONTRACTOR or individuals formerly enrolled in products or plans offered by CONTRACTOR.

10. CONTRACTOR may not require Participating Providers to distribute CONTRACTOR prepared communications to their patients. Marketing may not take place in patient rooms or treatment areas.

11. CONTRACTOR shall provide copies of advertising materials and/or descriptions of its advertising campaigns to the STATE upon request.

C. Corrective and Remedial Actions

1. If the CONTRACTOR's marketing activities fail to comply with the requirements of this Agreement, the STATE may take any of the following actions as it, in its sole discretion, deems necessary to protect the interests of potential enrollees. CONTRACTOR shall take the corrective and remedial actions directed by the STATE within the specified time frames.

   a. If CONTRACTOR engages in marketing activities that the STATE determines, in its discretion, to be a minor or unintentional violation of the marketing guidelines set forth in this Agreement, the STATE may issue a warning letter to the CONTRACTOR.

   b. If CONTRACTOR engages in marketing activities that the STATE determines, in its sole discretion, to be an intentional or serious breach of the marketing guidelines, or engages in a pattern of minor breaches, the STATE may require the CONTRACTOR to implement a corrective action plan acceptable to the STATE within a specified timeframe.

   c. If CONTRACTOR fails to implement a corrective action plan in a timely manner or commits an egregious violation or breach of this Agreement, the STATE may in addition to any other legal remedy available to the STATE in law or equity:

      (i) direct the CONTRACTOR to suspend its marketing activities for a period up to the end of the term of the Agreement;

(ii) suspend new Enrollments, for a period up to the end of the term of the Agreement, terminate this Agreement pursuant to termination procedures set forth herein, and/or decertify CONTRACTOR's Essential Plan(s).

XIII. HIPAA COMPLIANCE / SECURITY

1. CONTRACTOR acknowledges and agrees that it is a Covered Entity, as defined in 45 C.F.R. 160.103.

2. CONTRACTOR acknowledges and agrees that the Marketplace is not a Business Associate of the CONTRACTOR in performing its statutorily required functions pursuant to 45 C.F.R. 155.200.[38]

3. CONTRACTOR shall comply with all applicable federal and state laws and regulations to ensure the privacy, security, integrity and availability of information about Enrollees, including but not limited to HIPAA. This includes individual Medical Records and any other health and enrollment information that identifies a particular Enrollee.

4. CONTRACTOR shall comply with the following requirements:

   a. In accordance with 42 C.F.R. Part 431, subpart F, CONTRACTOR is prohibited from disclosing information concerning Enrollees unless such disclosure is permitted by applicable law, including the purposes of treatment, payment, or health care operations;

   b. CONTRACTOR must maintain information in a timely and accurate manner;

   c. CONTRACTOR must specify and make available to any Enrollee requesting it (i) the purpose for which information is maintained or used, and (ii) to whom and for what purposes information will be disclosed; and

   d. Except as provided in federal and state law, CONTRACTOR must ensure that each Enrollee may request a copy of his or her records and information in a designated records set, receive such records and information in a timely manner, and that each Enrollee may request that his or her records be supplemented or corrected.

5. CONTRACTOR shall, following the discovery of any breach in the security of a system used to exchange data in accordance with this Agreement, including Personally Identifiable Information ("PII") or Protected Health Information ("PHI"), immediately notify the Marketplace, and shall immediately commence an investigation in accordance with applicable law to determine the scope of the breach and restore the security of the system to prevent any further breach.

6. CONTRACTOR shall report to the STATE fully and promptly any use or disclosure of Enrollee data not provided for by this Agreement of which CONTRACTOR becomes aware. Further, the CONTRACTOR shall promptly report to the STATE 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, interference with system operations

[38] See, Exchange Final Rule, Fed Reg Vol. 77 No. 59, March 27, 2012, p. 18325

affecting the exchange of data set forth in this Agreement, and data loss due to the loss or misplacement of hardware or storage devices.

XIV. REPORTING / DATA COLLECTION

A. General Requirements

1. CONTRACTOR shall establish and maintain the systems and processes to connect to and transmit data to and from the STATE.

2. CONTRACTOR shall establish and maintain the systems and processes to connect to and transmit data to and from HHS and Reinsurance Entities.

3. CONTRACTOR shall maintain a health information system that collects, analyzes and reports data. The system must be able to report on utilization, claims payment policies and practices, periodic financial disclosures, enrollment and disenrollment information, claim denials, customer service information, rating of provider practices, cost-sharing and payments with respect to out-of-network coverage, prescription drug distribution and cost reporting, quality and customer satisfaction reporting pursuant to the STATE reporting requirements, and any other information requested by the STATE and/or required under applicable federal and state laws or regulations.

4. CONTRACTOR shall submit required reports to the STATE in a manner consistent with federal requirements under Section 45 C.F.R. Part 156, or as otherwise instructed by the STATE. STATE shall provide at least ninety (90) days advance notice of its reporting requirements and consult with CONTRACTOR prior to implementation of such reporting requirements.

B. Encounter Data

CONTRACTOR will be required to submit encounter data for all contracted services obtained by each of their Enrollees. Encounters are records of each face-to-face interaction an Enrollee has with the health care system and includes outpatient visits, inpatient admissions, dental care, emergency room and urgent care visits. Encounters for ordered services such as pharmacy and labs shall also be submitted. An encounter is comprised of the procedure(s) or service(s) rendered during the contact and includes information on site of service and may also include diagnosis information. An encounter should be operationalized in an information system as each unique occurrence of recipient and provider. Encounters are to be submitted on at least a monthly or more frequent basis through the STATE designated vendor in a format and manner to be prescribed by the STATE. STATE shall provide at least ninety (90) days advance notice of its reporting requirements and consult with CONTRACTOR prior to implementation of such reporting requirements.

C. Financial Reporting

1. CONTRACTOR shall submit financial reports to STATE in a manner and form consistent with the Medicaid Managed Care Operating Report, and as required by State and federal laws and regulations.

2. CONTRACTOR shall achieve an eighty-five percent (85%) Medical Loss Ratio beginning January 1, 2016.[39]

[39] 42 CFR 600.415(b)(3)

3. CONTRACTOR must agree to also submit separate Premium and expenditure reports, and any additional relevant financial reports and documents related to its financial condition, in a manner and form required by the STATE. STATE shall provide at least ninety (90) days advance notice of its reporting requirements and consult with CONTRACTOR prior to implementation of such reporting requirements.

4. CONTRACTOR shall comply with all requirements outlined at 45 C.F.R. § 156.280 regarding segregation of funds.

D. Prescription Drug Cost

1. CONTRACTOR shall report to HHS and/or the STATE prescription drug cost and distribution information in the form, manner and timelines specified by HHS, in accordance with 45 C.F.R. 156.295, including:

   a. the percentage of all prescriptions that were provided under the Essential Plan through retail pharmacies compared to mail order pharmacies;

   b. the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type, which includes an independent pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State of New York and that dispenses medication to the general public, that is paid by the CONTRACTOR or the CONTRACTOR's contracted pharmacy benefit manager;

   c. the aggregate amount and type of rebates, discounts or price concessions (excluding bona fide service fees) that the CONTRACTOR or its contracted pharmacy benefit manager negotiates that are attributable to Enrollee utilization under the Essential Plan, and the aggregate amount of rebates, discounts, or price concessions that are passed through to the CONTRACTOR and the total number of prescriptions that were dispensed; and

   d. the aggregate amount of the difference between the amount the CONTRACTOR pays to its contracted pharmacy benefit manager and the amounts that the pharmacy benefit manager pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

E. Transparency Requirements

1. CONTRACTOR must submit in an accurate and timely manner to be determined by HHS, the information set forth below to the STATE, HHS and DFS, and must make such information available to the public in accordance with the requirements of 45 C.F.R. 156.220:[40]

   a. Claims payment policies and practices;
   b. Periodic financial disclosures;
   c. Data on enrollment;

[40] 45 C.F.R. 156.220(b)

d. Data on disenrollment;
e. Data on the number of claims that are denied;
f. Data on rating practices;
g. Information on cost-sharing and payments with respect to any out-of-network coverage; and
h. Information on enrollee rights under Title I of the ACA.

2. CONTRACTOR shall ensure that the above listed information is provided in plain language as defined in 45 C.F.R. 155.20.[41]

3. CONTRACTOR must make available the amount of Enrollee Cost-Sharing for in-network services under the individual's Essential Plan or coverage with respect to the furnishing of a specific item or service by a Participating Provider in a timely manner upon the request of an individual. At a minimum, such information must be made available to such individual through the Internet web site and such other means for individuals without access to the Internet.[42]

XV. INDIANS AND ALASKA NATIVES

1. CONTRACTOR shall comply with all applicable laws, rules and regulations relating to the provision of Health Care Services to any Enrollee who is determined by the STATE to be an eligible Indian or Alaskan Native as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d)). Such requirements include the following:

   a. Indians shall be permitted to enroll in, or change enrollment in, Essential Plans one (1) time per month.[43]

   b. No Cost Sharing shall be imposed on Indians.[44]

   c. CONTRACTOR may not reduce the payment for services to Indian health providers by the amount of any Cost Sharing that would be due from the Indian but for the prohibition in 42 C.F.R. 600.160(b).[45]

2. CONTRACTOR must pay primary to health programs operated by Indian Health Service, Indian tribes, tribal organizations and urban Indian organizations for services covered by an Essential Plan.[46]

3. CONTRACTOR shall comply with other applicable laws, rules and regulations relating to the provision of Health Care Services to American Indians, including, the Indian Health Care Improvement Act Sections 206 (25 U.S.C. 1621e) and 408 (25 U.S.C. 1647a).

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[41] 45 C.F.R. 156.220(c)
[42] 45 C.F.R. 156.220(d)
[43] 42 C.F.R. 600.160(a)
[44] 42 C.F.R. 600.160(b)
[45] 42 C.F.R. 600.160(c)
[46] 42 C.F.R. 600.160(d)

XVI. INDEMNIFICATION

A. Indemnification by Contractor

1. CONTRACTOR shall indemnify, defend and hold harmless the STATE, its officers, agents and employees (the STATE Indemnified Parties) from and against any and all claims, actions, losses, costs, liabilities, damages or deficiencies, including interest, penalties and attorney's fees suffered, incurred or sustained by the STATE Indemnified Parties or to which any STATE Indemnified Parties become subject, resulting from, arising out of or relating to:

   a. any and all claims and losses accruing or resulting to any and all CONTRACTOR's materialmen, laborers, and any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Agreement;

   b. any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by the CONTRACTOR, its officers, agents, employees, or subcontractors, in connection with the performance of this Agreement;

   c. any liability, including costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy by the CONTRACTOR, its officers, agents, employees or subcontractors, arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished under this Agreement, or based on any libelous or otherwise unlawful matter contained in such data.

2. The STATE will provide the CONTRACTOR with prompt written notice of any claim made against the STATE, and the CONTRACTOR, at its sole option, shall defend or settle said claim. The STATE shall cooperate with the CONTRACTOR to the extent necessary for the CONTRACTOR to discharge its obligation under this Section.

3. CONTRACTOR shall have no obligation under this section with respect to any claim or cause of action for damages to persons or property solely caused by the negligence of the STATE, its employees, or agents.

4. The indemnity obligation described in this section shall not limit any other rights or remedies available to the STATE or the CONTRACTOR under this Agreement.

B. Indemnification by the STATE

Subject to the availability of lawful appropriations as required by State Finance Law § 41 and consistent with § 8 of the State Court of Claims Act, the STATE shall hold the CONTRACTOR harmless from and indemnify it for any final judgment of a court of competent jurisdiction to the extent attributable to the negligence of the STATE or its officers or employees when acting within the course and scope of their employment. Provisions concerning the STATE's responsibility for any claims for liability as may arise during the term of this Agreement are set forth in the New York State Court of Claims Act, and any damages arising for such liability shall issue from the New York State Court of Claims Fund or any applicable, annual appropriation of the Legislature of the State of New York.

XVII. CONSEQUENTIAL DAMAGES

Except with regard to claims indemnifiable under the Indemnification section above, or claims arising from the gross negligence or willful misconduct of a Party, neither Party shall be liable to the other Party for any indirect, incidental, special, punitive, exemplary or consequential damages (including, without limitation, any damages arising from loss of use or lost business, revenue, profits, data or goodwill) arising in connection with this Agreement, whether in an action in contract, tort, strict liability or negligence, or other actions, even if advised of the possibility of such damages.

XVIII. OWNERSHIP OF DATA

A. Ownership of Marketplace Data

As between the STATE and CONTRACTOR, all Marketplace Data, as defined below, shall be and will remain the property of the STATE. For purposes of this section, Marketplace Data means data and information created by the Marketplace and relating to the Marketplace, its employees and agents, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the STATE's approval (in its sole discretion), the Marketplace Data will not be (1) used by CONTRACTOR or its subcontractors other than in connection with carrying out its obligations under this Agreement; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by CONTRACTOR or its subcontractors other than in connection with carrying out its obligations under this Agreement; or (3) commercially exploited by or on behalf of CONTRACTOR or its subcontractors. CONTRACTOR hereby irrevocably assigns, transfers and conveys, and will cause its subcontractors to assign, transfer and convey to the STATE without further consideration all of its and their right, title and interest in and to the Marketplace Data. Upon request by the STATE, CONTRACTOR will execute and deliver, and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve, or enable the STATE to enforce its rights with respect to the Marketplace Data. Notwithstanding the foregoing, the CONTRACTOR shall be responsible for compliance with all federal or state requirements regarding the security and privacy of Marketplace Data that is within the CONTRACTOR's custody, including the requirements of HIPAA and the NY State Technology Law.

B. Ownership of Contractor Data

As between the STATE and the CONTRACTOR, all CONTRACTOR Data, as defined below, shall be and will remain the property of the CONTRACTOR. For purposes of this section, CONTRACTOR Data means data and information created by the CONTRACTOR and relating to the CONTRACTOR, its directors, officers, employees and agents, Enrollees, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the CONTRACTOR's approval (in its sole discretion), the CONTRACTOR Data will not be (1) used by the STATE or its subcontractors other than in connection with carrying out its obligations under this Agreement and its obligations pursuant to applicable law; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by the STATE or its subcontractors other than in connection with carrying out its obligations under this Agreement and its obligations pursuant to applicable law; or (3) commercially exploited by or on behalf of the STATE or its subcontractors. The STATE hereby irrevocably assigns, transfers and conveys, and will cause its

subcontractors to assign, transfer and convey, to the CONTRACTOR without further consideration all of its and their right, title and interest in and to the CONTRACTOR Data, provided however, such assignment shall not be construed to prevent or delay the STATE from access to and use of the CONTRACTOR Data to fulfill its obligations with respect to Essential Plan Certification and Recertification, Provider Network Review, monitoring of Quality and Enrollee Satisfaction, Reporting / Data Collection and other functions of the Marketplace as set forth in this Agreement and in federal and state law and regulation. Upon request by the CONTRACTOR, the STATE will execute and deliver, and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve, or enable the CONTRACTOR to enforce its rights with respect to the CONTRACTOR Data. Notwithstanding the foregoing, the STATE shall be responsible for compliance with all federal and state requirements regarding the security and privacy of CONTRACTOR Data that is within the STATE's custody, including the requirements of HIPAA and State Technology Law.

IXX. RECORDS MAINTENANCE / EXAMINATION AND AUDIT

A. Maintenance of Contractor Records

1. The CONTRACTOR shall preserve and retain all records relating to CONTRACTOR performance under this Agreement in readily accessible form during the term of this Agreement and for a period of ten (10) years thereafter except that the CONTRACTOR shall retain Enrollees' Medical Records that are in the custody of the CONTRACTOR for ten (10) years after the date of service rendered to the Enrollee or cessation of CONTRACTOR operation, and in the case of a minor, for ten (10) years after majority. The CONTRACTOR shall require and make reasonable efforts to assure that Enrollees' Medical Records are retained by providers for ten (10) years after the date of service rendered to the Enrollee or cessation of CONTRACTOR operation, and in the case of a minor, for ten (10) years after majority.

2. All provisions of this Agreement relating to record maintenance and audit access shall survive the termination of this Agreement and shall bind the CONTRACTOR until the expiration of a period of ten (10) years commencing with termination of this Agreement or if an audit is commenced, until the completion of the audit, whichever occurs later. If the CONTRACTOR becomes aware of any litigation, claim, financial management review or audit relating to the fulfillment of the terms of this Agreement that is started before the expiration of the ten (10) year period, the records shall be retained until all litigation, claims, financial management reviews or audit findings involved in the record have been resolved and final action taken.

B. Access to Contractor Records

1. CONTRACTOR shall subject itself to audits/reviews by the STATE or its designee, as the Parties deem necessary to determine the accuracy of Enrollee Premium payments. CONTRACTOR also agrees to audit by the STATE on reasonable and customary terms, subject to applicable State and federal law regarding the confidentiality of and release of confidential Protected Health Information of Enrollees.

2. CONTRACTOR acknowledges and agrees that the STATE shall, subject to applicable State and federal law regarding the confidentiality and release of confidential Protected Health Information of Enrollees, have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. CONTRACTOR agrees to

maintain such records for possible audit for a minimum of ten (10) years, unless a longer period of records retention is agreed to. CONTRACTOR agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, CONTRACTOR agrees to include a similar right of the STATE to audit records and interview staff in any subcontract related to performance of this Agreement.

C. Contractor Audits or Reviews

1. CONTRACTOR shall promptly submit to the STATE the results of final financial, market conduct, or special audits/reviews performed by the US Department of Health and Human Services, and/or any other State regulatory entity that has jurisdiction with respect to the services provided by CONTRACTOR to Enrollees.

2. CONTRACTOR shall promptly notify the STATE in writing of any inquiry, audit, investigation, litigation, claim, examination or other proceeding involving CONTRACTOR, or any CONTRACTOR personnel, Participating Provider or other authorized subcontractor that is threatened or commenced by any regulatory agency or other party that a reasonable person might believe could materially affect the ability to perform in accordance with the terms set forth in this Agreement. Such notice shall be provided by CONTRACTOR to the STATE within ten (10) days of CONTRACTOR's receipt of notice regarding such action. CONTRACTOR shall comply with the STATE's reasonable requests for information relating to the inquiry; provided, however than any such exchange of information shall be subject to compliance with law and shall not occur to the extent prohibited by order of the court, administrative agency, or other tribunal or regulatory authority having jurisdiction over the matter or by the laws and regulations governing the action. This section shall not be required with respect to disputes relating to claims and other matters noticed to the STATE in the ordinary course of business pursuant to other terms set forth in this Agreement or required by law.

XX. COMPENSATION

A. Capitation Payments

1. After enrollment is effectuated for an Enrollee(s):

a. STATE shall provide CONTRACTOR with a monthly Capitation Payment for each Enrollee that has enrolled in its Essential Plans. Capitation Rates are based on county in accordance with the rating regions established by STATE. Capitation Payments made to CONTRACTOR must be used in accordance with federal and state laws and regulations, including 42 CFR Part 600.

b. The monthly Capitation Rates are attached hereto as Appendix J and shall be deemed incorporated into this Agreement without further action by the Parties.

c. CONTRACTOR shall invoice and collect Premium and Cost-Sharing payments directly from Enrollees and/or third-party entities on behalf of the Enrollee. Such third-party entities may include the Ryan White HIV / AIDS Programs under Title XXVI of the Public Health

Service Act, Indian tribes, tribal organizations or urban Indian organizations, and State and federal government programs.[47]

d. The monthly Capitation Payments to CONTRACTOR shall constitute full and complete payment to the CONTRACTOR for all services that the CONTRACTOR provides, except for the Premium and Cost-Sharing payments due to CONTRACTOR from individual Enrollees.

B. Modification of Rates During Contract Period

1. Any technical modification to Capitation Rates during the term of the Contract as agreed to by CONTRACTOR, including but not limited to changes in premium groups, eligible populations, or benefit package, shall be deemed incorporated into this Agreement without further action by the Parties upon approval of such modifications by the STATE.

2. Any other modification to Capitation Rates, as agreed to by the STATE and the CONTRACTOR during the term of this Agreement shall be deemed incorporated into this Agreement without further action by the Parties upon approval of such modifications by the STATE and the NY State Division of the Budget as of the effective date of the modified Capitation Rates as established by the STATE and the NY State Division of the Budget.

3. In the event that the STATE and CONTRACTOR fail to reach agreement on modifications to the monthly Capitation Rates, the STATE shall provide formal written notice to the CONTRACTOR of the amount and effective date of the modified Capitation Rates approved by STATE. CONTRACTOR shall have the option of terminating this Agreement in its entirety with respect to specific Essential Plans in a county or counties of CONTRACTOR's service area, if such approved modified Capitation Rates are not acceptable. In such case, the CONTRACTOR shall give written notice to the STATE, or entity designated by the STATE, within thirty (30) days of the date of the formal written notice from the STATE of the modified Capitation Rates; specifying the reasons for and effective date of termination. CONTRACTOR must work in conjunction with the STATE to develop a plan to phase-out its Essential Plan(s) and transition Enrollees to another Contractor in Enrollee's service area. This plan must include notifying Enrollees of other available health plan options at least one hundred and eighty days (180) prior to termination, and providing follow-up letters to remind Enrollees to enroll with another health plan, in addition to any other requirement under New York State law. As a result, the effective date of termination shall be no less than one hundred and eighty (180) days from the date of the CONTRACTOR's written notice, unless the STATE determines that an orderly transfer to another Essential Plan may be accomplished in fewer days. The terms and conditions in the CONTRACTOR's phase-out plan must be accomplished prior to termination. During the period commencing with the effective date of the STATE's modified Capitation Rates through the effective date of termination of the Agreement, the CONTRACTOR shall have the option of continuing to receive Capitation Payments at the expired Capitation Rate or at the modified Capitation Rates approved by the STATE and the NY State Division of the Budget for the rate period.

4. If the CONTRACTOR fails to exercise its right to terminate in accordance with this section, then the modified Capitation Rates approved by the STATE and the NY State Division of the Budget shall be deemed incorporated into this Agreement without further action by the

[47] 42 C.F.R. 600.520(d)

Parties as of the effective date of the modified Capitation Rates as established by the STATE and the NY State Division of the Budget.

C. Rate-Setting Methodology

1. Capitation Rates shall be determined prospectively and shall not be retroactively adjusted to reflect actual Essential Plan data or CONTRACTOR experience for the time period covered by the rates.

2. Notwithstanding the provisions set forth in section C(1) above, the STATE reserves the right to terminate this Agreement in its entirety upon determination by the STATE that the aggregate monthly Capitation Rates are not cost effective pursuant to section 369-gg(2) of the NY State Social Services Law.

D. Payment of Capitation Rate

1. The monthly Capitation Rate for each Enrollee is due to the CONTRACTOR from the effective date of Enrollment until the Effective Date of Disenrollment of the Enrollee, or termination of this Agreement, whichever occurs first.

2. The CONTRACTOR shall receive a full month's Capitation Rate for the month in which Disenrollment occurs.

3. The 834 transactions (benefit enrollment and maintenance for qualified individuals enrolling in coverage) that are generated by STATE and transmitted to CONTRACTOR, and successfully processed by CONTRACTOR as set forth in the 820 Transactions (payment order / remittance advice) that are returned to the STATE by the CONTRACTOR to acknowledge receipt, shall be the enrollment lists for purposes of eMedNY or any successor claims payment system's premium billing and payment, subject to the ongoing eligibility of enrollees as of the first (1st) day of the enrollment month.

E. Denial of Payment of Capitation Rate

In the event that CMS denies payment for new or existing Enrollees based upon a determination that the CONTRACTOR failed to comply with federal statutes and regulatory requirements, the STATE will deny payment of the Capitation Rate to the CONTRACTOR for the same Enrollees for the period of time for which CMS denies payment.

F. State Right to Recover Capitation Payments

1. The Parties acknowledge and agree that the STATE has a right to recover Capitation Payments made to CONTRACTOR for Enrollees who are later determined, for the entire applicable payment month, to have been ineligible for an Essential Plan. Reasons that an Enrollee may be determined ineligible include but are not limited to death, incarceration, or having moved out of the CONTRACTOR's service area. The STATE has the right to recover Capitation Payments from the CONTRACTOR in instances where the Enrollee was inappropriately enrolled into an Essential Plan with a retroactive effective date, or when the enrollment period was retroactively deleted. STATE may only recover Capitation Payments made for Enrollees if it is determined by the STATE that the CONTRACTOR was not at

risk for provision of health care services for any portion of the payment period. Notwithstanding the foregoing, the STATE always has the right to recover duplicate Capitation Payments paid for individual Enrollees inadvertently enrolled in multiple health plans whether or not the CONTRACTOR has made payments to providers. All recoveries will be made pursuant to guidelines developed by STATE.

2. The Parties acknowledge and agree that the STATE has the right to recover Capitation Payments paid to CONTRACTOR for Enrollees where the CONTRACTOR has failed to initiate involuntary disenrollment in accordance with the timeframes and requirements contained in this Agreement, pursuant to applicable law and regulation. The STATE may recover the Capitation Payment effective on the first day of the month following the month in which the CONTRACTOR was required to initiate the involuntary disenrollment.

G. Other Insurance and Settlements

CONTRACTOR is not allowed to pursue cost recovery against personal injury awards or settlements an Enrollee has received. Any recovery against these resources is to be pursued by the STATE, and the CONTRACTOR cannot take action to collect these funds. Pursuit of Worker's Compensation benefits and No-fault insurance by the CONTRACTOR is authorized, to the extent that they cover expenses incurred by CONTRACTOR.

H. Contractor Financial Liability

CONTRACTOR shall not be financially liable for any services rendered to an Enrollee prior to his or her effective date of enrollment or subsequent to disenrollment.

I. No Recourse Against Enrollees

1. With the exception of the Premium and applicable Essential Plan cost-sharing provided for in this Agreement, the CONTRACTOR hereby agrees that in no event, including but not limited to non-payment by the STATE, insolvency of the CONTRACTOR, loss of funding for this program, or breach of this Agreement, shall the CONTRACTOR or a subcontractor bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Enrollee or person acting on his or her behalf for coverage provided in accordance with this Agreement.

2. This subsection shall not prohibit the CONTRACTOR or the subcontractors as specified in their agreements from billing for and collecting any applicable worker's compensation benefits or no-fault insurance. This subsection supersedes any oral or written contrary agreement now existing or hereinafter entered into between the CONTRACTOR and any Enrollee or persons acting on his behalf. This provision shall survive termination of this Agreement for any reason.

Appendix C-1

Marketplace Facilitated Enrollment (FE) Program

For CONTRACTOR that authorizes employees or representatives to provide application assistance to individuals enrolling in Qualified Health Plans (QHPs) and insurance affordability programs (IAPs) through NY State of Health, The Official Health Plan Marketplace (Marketplace), who are referred to as Marketplace Facilitated Enrollers

I. Background

1. The ACA establishes a streamlined enrollment system for QHPs and all IAPs. The NY State of Health, The Official Health Plan Marketplace (Marketplace) of the New York State Department of Health (formerly known as the New York Health Benefit Exchange) ("STATE") has developed an integrated application allowing consumers to enroll in any IAP (Medicaid, Child Health Plus, Advance Premium Tax Credits, Cost-Sharing Reductions, and Essential Plans pursuant to the Basic Health Program (BHP)) and QHP through the Marketplace application. To ensure that consumers have as many opportunities as possible to apply through the Marketplace, STATE is expanding its successful Medicaid and Child Health Plus Health Plan Facilitated Enrollment Program to include QHPs and Essential Plans.

2. Employees and representatives of CONTRACTOR may provide Marketplace application assistance to individuals enrolling in QHPs and IAPs through the Marketplace provided that: (i) each individual is trained and authorized as a Marketplace Facilitated Enroller ("Marketplace FE") prior to providing such assistance, and (ii) such authorized Marketplace FEs abide by the requirements outlined below.

II. Obligation of CONTRACTOR

1. CONTRACTOR agrees to ensure that its employees and representatives complete the Marketplace approved training program regarding QHP options, IAPs, eligibility and benefits rules and regulations governing all IAPs operated in the State, pass an examination to assure successful completion of the training, and are authorized by the Marketplace.

2. CONTRACTOR agrees to ensure its employees and representatives complete any subsequent training required by the Marketplace, which includes successfully completing annual re-authorization training.

3. CONTRACTOR acknowledges and agrees that it may use the "train the trainer" approach for its employees and representatives provided that the employee or

representative of CONTRACTOR providing the training (i) has successfully completed the Marketplace training program, and (ii) uses the training material designated by the Marketplace. Such authorized Marketplace FEs may train and authorize only employees and representatives of their own organization.

4. CONTRACTOR must establish procedures to ensure that it and its Marketplace FEs:

    i. Inform applicants of the functions and responsibilities of Marketplace FEs;
    ii. Disclose to potential applicants any relationships the Marketplace FE has with QHPs or IAPs or other potential conflicts of interest;
    iii. Obtain authorization from the applicant prior to obtaining access to an applicant's personally identifiable information (PII) and maintain a record of the authorization in a form and manner determined by the Marketplace; and
    iv. Inform the applicant that he or she may revoke the authorization at any time.

5. CONTRACTOR must also establish procedures to ensure that its Marketplace FEs:

    i. Provide information to individual and employee applicants about the full range of QHP options and IAPs for which they are eligible, which includes providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process;
    ii. Assist individual and employee applicants in applying for coverage in a QHP and for IAPs;
    iii. Help facilitate enrollment of eligible individuals in QHPs and IAPs;
    iv. Act in the best interest of the applicant assisted; and
    v. Do not misrepresent the options available to the applicant.

6. CONTRACTOR agrees to comply with the Marketplace's privacy and security standards consistent with 45 CFR §155.260 and applicable authentication and data security standards.

7. CONTRACTOR must:

    i. Ensure that only authorized Marketplace FEs submit applications to the Marketplace using their individual identification number. Use of a Marketplace FE identification number by any individual other than the authorized Marketplace FE is strictly prohibited.

ii. Provide its Marketplace FEs with the equipment necessary to provide in-person application assistance. Except in extraordinary circumstances, applications must be submitted on-line through the Marketplace on-line web portal. Computers must be connected to the internet using one of the following browsers: Internet Explorer Versions 7, 8 or 9, Safari Versions 5 or 6, Google Chrome Versions 18 or 19 or Mozilla Firefox Versions 12 or 13. Generally, Marketplace FEs should not provide assistance by telephone. However, under some circumstances, in accordance with guidelines issued by STATE, Marketplace FEs may provide assistance by telephone. This includes but is not limited to collecting follow-up information by telephone if it is more convenient for the applicant.

iii. Identity proof the Marketplace FE using instructions provided by STATE if the Marketplace FE fails the on-line identity proofing process used for the Marketplace.

iv. Register and monitor performance of their individual Marketplace FEs and implement plans of correction for Marketplace FEs who are not adequately performing their duties under the Marketplace FE program.

8. CONTRACTOR agrees to monitor the performance of its Marketplace FEs and to rescind authorization to act as a Marketplace FE from all employees and representatives who are not adequately performing their duties in accordance with the requirements set forth in this appendix or who are out of compliance with the requirements of the program.

9. CONTRACTOR acknowledges and agrees that it must ensure that its Marketplace FEs comply with applicable law and the provisions of the Agreement regarding privacy and security, including HIPAA Compliance and Security.

10. CONTRACTOR must either directly or through an appropriate referral to an IPA/Navigator or non-IPA/Navigator assistance personnel or to NY State of Health Consumer Service Center, provide or have its staff members and volunteers provide information in a manner that is accessible to individuals with disabilities as defined by the Americans with Disabilities Act, as amended, 42 U.S.C. 12101 et. seq. and section 504 of the Rehabilitation Act, as amended, 29.U.S.C. 794.

11. CONTRACTOR must obtain a written attestation from each Marketplace FE regarding his or her commitment to comply with the standards specified in paragraphs II.1, II.2, II.4, II.5, II.6, II.10, and II.13 of this appendix, related to standards of authorization, availability of information, authorization, and fees. CONTACTOR must provide these attestations to STATE upon request.

12. CONTRACTOR must inform STATE within two business days if a Marketplace FE has left his or her position or is on extended leave. After CONTRACTOR has reassigned the Marketplace FE's applicants, CONTRACTOR must inform STATE of the reassignments.

13. CONTRACTOR and its Marketplace FEs are prohibited from:

    i. imposing any charge on applicants for application or other assistance related to the Marketplace;
    ii. providing compensation to Marketplace FEs on a per-application, per-individual-assisted, or per-enrollment basis;
    iii. providing gifts, including gift cards or cash, unless they are of nominal value, to any applicant or potential enrollee as an inducement for enrollment. Gifts, gift cards, or cash may exceed nominal value for the purpose of providing reimbursement for legitimate expenses incurred by a consumer in effort to receive NY State of Health application assistance, such as, but not limited to, travel or postage expenses;
    iv. soliciting any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including "cold calling" inquiries or solicitation. "Cold calling" does not include outreach to individuals enrolled in other products or plans offered by CONTRACTOR or to individuals formerly enrolled in products or plans offered by CONTRACTOR; or
    v. initiate any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where CONTRACTOR has a relationship with the consumer and so long as other applicable State and Federal laws are otherwise complied with.

14. CONTRACTORS using the train the trainer approach for their employees and representatives must submit the following information to STATE in writing upon successful completion of the training program using the format provided by the STATE. This information must include but is not limited to the following:

    i. Name of the trainer;
    ii. Dates trainer was trained:
    iii. Location where trainer was trained;
    iv. Trainee's name;
    v. Trainee's email address;
    vi. Trainee's score on each day of the Marketplace FE examinations; and
    vii. The date(s) and location where the Marketplace FE examination was administered.

Such information must be submitted to the following email address: gabrielle.armenia@health.ny.gov.

15. CONTRACTOR and its Marketplace FEs must refer to the employees and representatives authorized under this appendix only as Marketplace Facilitated Enrollers or Marketplace FEs.

III. Obligations of STATE

1. Provide or approve a comprehensive training program and any subsequent training updates for Marketplace FEs. Training may be delivered by STATE or its designated contractor in person or through the use of on-line training programs, or through a train-the-trainer approach by an authorized Marketplace FE.

2. Provide CONTRACTOR with or approve a training curriculum, including a facilitator guide, for use in training its staff members and volunteers.

3. Provide or approve any forms, applications, brochures or other materials needed to provide application assistance and information about the programs available through the Marketplace.

4. Collect information from CONTRACTOR regarding employees or representatives trained and authorized to provide application assistance so that a unique identifier can be created for each Marketplace FE.

5. Provide CONTRACTOR with or approve a form for Marketplace FEs to disclose conflicts of interest.

6. Provide data and reports to CONTRACTOR for use in monitoring Marketplace FE productivity until such time that the organization can generate this information through the Marketplace.

7. Update the list of trained and authorized Marketplace FEs based on information provided by CONTRACTOR, including terminating Marketplace FE accounts when necessary.

Appendix D

nystateofhealth
The Official Health Plan Marketplace

QUESTIONS AND ANSWERS ON THE 2016 INVITATION
(May 15, 2015)

NOTE: The Invitation in Section 3.1(D) on page 26 has been revised to include a category of individuals eligible for the BHP, which was unintentionally omitted, and to update the name of the BHP products to Essential Plan. Attachment F has also been modified to show the different groups of individuals eligible for the BHP and their respective cost-sharing and reflect the new name for the products. Hereinafter, the "Basic Health Program" shall be known as the "Essential Plan Program" and "Basic Health Plans" shall be known as "Essential Plans."

NOTE: Attachment A to the Invitation has been updated to reflect a modification to coverage for external prosthetic devices.

I. QHP AND SADP QUESTIONS AND ANSWERS

(A) STANDARD PRODUCTS

Posted 4/27/2015

Question: Are NYSOH-participating insurers required to offer both bronze plans (the HSA-compliant one and the non-HSA compliant one) in 2016, or only one or the other?

Answer: Only those insurers that offered a HSA eligible Standard Bronze QHP in 2015 will be permitted to offer an additional Bronze QHP, as set forth in Attachment B (labeled HSA Compliant Bronze), and not have it count towards the limit of 3 non-standard products. If an Applicant did not offer an HSA eligible Standard Bronze product in 2015, it can only offer an HSA Eligible Bronze as a non-standard and the non-standard product will count towards the limitation of 3 non-standard products.

Posted 5/6/2015

Question: How will the renewal process work for members currently enrolled in a standard, HSA eligible Bronze plan? Should the new HSA Compliant Bronze plan be assigned a new HIOS ID?

Answer: No, the new HSA compliant Bronze plan must use the same HIOS ID as the current plan. If a new HIOS ID is assigned current members will not be able to automatically renew their enrollment into the plan.

Posted 5/6/2015

Question: I am writing to follow up on one of the questions included in the Q&A document (dated 4/27). Can you please clarify whether plans that offered a HSA eligible Bronze standard plan in 2015 can choose to only offer a HSA compliant standard Bronze plan for 2016, per highlighted section below? If so, will the plans be required to discontinue the 2015 standard Bronze plan and allowed to migrate those individuals to another non-standard Bronze plan that is different from the additional standard Bronze QHP from the attachment B of the invitation ($3,500 deductible with $6850 OOPM)?

Answer: Applicants that currently have an HSA Standard Bronze Plan can choose to offer only the Alternative HSA Compliant Bronze Plan. Applicants will not be required to discontinue the 2015 standard Bronze plan, but instead can use the current HIOS ID for the HSA Standard Bronze plan. At renewal, eligible members will be automatically renewed into the new HSA Compliant Bronze Plan for 2016.

Current enrollees in a standard plan cannot be mapped to a non-standard plan.

Question: Can you clarify the answer posted on 5/6/2015, and whether an insurer brand new to the Marketplace can offer the alternative HSA Compliant Bronze Plan in 2016?

Answer: The purpose of offering the alternative HSA Compliant Bronze Plan was to allow individuals who had this product to carrier over their HSA from the prior year and still maintain a standard product. Insurers new to the Marketplace in 2016 must offer the Standard Bronze plan that is not HSA compliant, and may choose to also offer an HSA compliant bronze product as a non-standard plan.

Question: If an Applicant does not choose to offer the standard HSA compliant bronze plan, it can still offer up to 3 non-standard HSA compliant bronze plans, correct?

Answer: Yes, the Applicant is not obligated to offer the Standard HSA Compliant Bronze Plan and may offer up to 3 non-standard HSA compliant bronze plans, provided the number of non-standard bronze plans does not exceed the number of non-standard products at any other metal tier.

NEW Post 5/15/2015

Question: Currently for our QHP plans, we have a Limited Cost Share and a Zero Cost Share plan for American Indians and Alaskan Natives (AI/AN) offered on all Standard and Non Standard plans. Since the Silver Cost Share variations at 87% AV and 94% AV are being eliminated, is it also eliminating the need for the Limited Cost-Share plans and Zero Cost-Share Plans?

Answer: Implementation of the BHP means that you will no longer offer your Zero Cost Share and Limited Cost Share AI/AN variations for the Silver Cost Share 87% AV and 94% AV levels. No other AI/AN variations should be eliminated. Insurers must offer these variations at all metal levels.

(B) STAND ALONE DENTAL PLANS

Posted 4/27/2015

Question: Do stand-alone dental plans filing outside the Marketplace need to submit a letter of interest by April 24, 2015? Or, is the letter of interest required only for plans on the Marketplace?

Answer: The letter of interest is required for those plans that participate on the Marketplace only. Questions related to outside the Marketplace, should be directed to the NYS Department of Financial Services (DFS).

(C) HEALTH INSURER APPLICANT PRODUCT OFFERINGS

Posted 4/27/2015
Question: Will the formulary for the Individual Marketplace and the Small Business Marketplace be based upon Oxford benchmark as previous years?

Answer: Yes, the benchmark plan for the Essential Health Benefits has not changed for 2016.

II. BASIC HEALTH PROGRAM (BHP)

(A) INVITATION SUBMISSION

Posted 5/6/2015

Question: As a BHP ONLY Plan, are we required to submit a product benefit template by May 29th?

Answer: No, the BHP templates have not been released. We expect them to be available by mid-May with submissions due back to DOH no later than August 31, 2015.

Posted 5/6/2015

Question: Please confirm that the Stand-Alone Dental Plan (SADP) due dates are different than the due date for the BHPs Plus Vision/Dental. For example, if a health plan proposes to have an available dental/vision program for the non-Aliessa population, the Stand-alone Dental Applicant Forms and Rates due to DFS on April 30 would not apply. If correct, any and all dental related information would be supplied based on BHP scheduled dates only.

Answer: That is correct. The BHP Plus Vision/Dental products are not related to the SADPs that are sold on the Marketplace. DFS Form and Rate submissions do not apply. The DOH will set the capitation rates paid to the insurers offering the BHPs Plus Vision/Dental.

Posted 5/6/2015

Question: Some responders to the BHP invitation will be new to the Marketplace and therefore will not have had the necessary time to develop the requested URLs (Attachment I – Question 5) prior to the response deadline of May 22nd. In this instance, please confirm plans can provide confirmation of our understanding of the requirements for each and assurance that these would be available prior to acceptance of final rates (August).

Answer: BHP participation proposals are due by May 22nd. The required templates which include URLs are not required at this time. We expect the templates to be submitted to DOH by August 31st. Prior to the submission date, as we are testing the system, DOH may request testing URLs and/or screen shots of web sites until final URLs are developed.

Posted 5/6/2015

Question: Can you please clarify what the Invitation means when referencing Basic Health Plan (BHP) "templates" that are to be submitted to DOH (see, for example, pages 2, 29, and 48)?

Answer: Applicants that decide to participate in the BHP will be required to complete templates developed by DOH that are similar to the SERFF Binder templates. The DOH will be posting the templates and instructions to the NY State of Health website in mid-May.

Posted 4/27/2015

Question: If stand-alone dentals are interested in participating in the BHP, are they required to submit a separate Letter of Interest?

Answer: No, they are not required to submit a separate Letter of Interest. Individuals enrolled in a BHP will be permitted to purchase the same stand-alone dental products that QHP

enrollees can purchase. There is no requirement to submit separate BHP Stand-alone dental products.

(B) BHP BENEFITS

Posted 5/6/2015

Question: On Attachment F, the Emergency Copay section states that –the copay is waived if patient is admitted as an inpatient (including as an observation care unit) directly from the emergency room. Is the omission of "...observation stay" on the BHP Benefit Summary intentional?

Answer: The copayment is waived when the patient is admitted for observation regardless of whether it is to an observation care unit or considered an observation stay.

Posted 5/6/2015

Question: In Attachment F, the reference concerning the Maximum Out-of-Pocket (MOOP) mentions Pediatric Dental and Pediatric Vision, although those are not covered services on BHP. Is this intentional?

Answer: The above reference to pediatric dental and vision was an error. A revised Attachment F removing this reference has been posted.

Posted 4/27/2015

Question: The BHP standard benefits grid lists both "eyewear" and "vision care – lenses and frames." Can you please clarify how these benefit categories differ? Would a Standard BHP Plus Vision/Dental enrollee receive both or only one of these benefit categories?

Answer: This was an error and a corrected Attachment F has been posted. The "eyewear" line with the corresponding cost-share was removed.

NEW Post 5/15/2015

Question: Is there a set dollar limit for the cost of glass frames? If so, are the consumers able to upgrade their frames and pay the difference out of pocket?

Answer: The DOH has not established a set dollar limit on the cost of the glass frames. Cost-sharing is outlined in Attachment F of the Invitation as 10% coinsurance for those making 151-200% FPL and $0 cost-sharing for all others.

NEW Post 5/15/2015

Question: Does the drug formulary for BHP follow Formulary II (State Exchange), FFS Formulary, Medicaid Managed Care approved formulary or a custom formulary?

Answer: Per Section 42 CFR §600.405, the formulary must follow the Essential Health Benefits requirements, which is currently applicable to the commercial QHP market.

NEW Post 5/15/2015

Question: In Part 3, page 26 of the Invitation, it states that the wellness benefit may be substituted for a different wellness benefit. Please provide additional detail.

Answer: Per federal regulation, 42 CFR §600.405 (which references 45 CFR §156.115), the Essential Health Benefits may be substituted when certain requirements are met. The DOH has limited substitution to the wellness benefits. The benchmark plan, which can be found on Attachment A and in more detail on Attachment B, includes a $250 gym reimbursement benefit. This benefit can be either offered as part of the Basic Health Plan, or it may be substituted with an equivalent benefit or a better benefit. Such substitution will be submitted as part of the BHP Plan Information submission and reviewed by DOH.

(C) SUBMISSION OF BHP INFORMATION

Posted 5/6/2015

Question: Will the BHP Plus Adult Vision/Dental plan necessitate a new HIOS ID, or would insurers be allowed to add a 2-digit variation to the Standard BHP HIOS ID?

Answer: The BHP Plus Adult Vision/Dental will require a new HIOS ID. A 2-digit variation cannot be added to the Standard BHP HIOS ID.

NEW Post 5/15/2015

Question: Can insurers add their own product name to the name of the BHP standard naming conventions outlined in Section 3.D.1.d like they do for QHPs?

Answer: No, insurers cannot add their own product name to the name of the BHP standard naming conventions. After considering various options, the DOH has determined that the BHP will be known as the "Essential Plan". Accordingly, the naming conventions for BHP products shall be as follows and consistent with the populations and benefit design shown in Attachment F to the invitation added on May 12, 2015:

- Essential Plan 1
- Essential Plan 2

- Essential Plan 3
- Essential Plan 4

All insurers must use these names for the BHP products, as well as their company name and/or logos.

(D) ENROLLMENT INTO THE BHP

Posted 4/27/2015

Question: With respect to the Basic Health Program, for those that owe premium, will premium be due prior to the coverage start date?

Answer: Yes, premium will be due prior to the initial start date, and the same initial payment grace period of 10 days that applies to QHP will need to be applied to BHPs.

NEW Post 5/15/2015

Question: Are there any ID Card content requirements that are specific to the BHP?

Answer: There are no ID Card content requirements that are specific to the Basic Health Plan. Insurers must comply with all applicable federal and state laws and regulations with respect to ID Card requirements. Individuals who are eligible for BHP and not Medicaid eligible due to immigration status will keep or maintain a Certified Identification Number (CIN) in order to access non-emergency transportation services.

III. QUESTIONS AND ANSWERS APPLICABLE TO ALL APPLICANTS

(A) PROVIDER NETWORK SUBMISSION

Posted 4/27/2015

Question: Do existing issuers who are recertifying for plan year 2016, with no changes to their network, need to resubmit their Provider Network via HCS as part of the recertification, when we have regularly submitted and will continue to submit our Provider Network in HCS through the balance of the current plan year?

Answer: Applicants who are recertifying for plan year 2016 will continue to submit their network filings on a quarterly basis and network will be reviewed on a quarterly basis. The submission prior to the open enrollment period will be the network reviewed as part of the certification process, and will be the submission used for display on the Marketplace during open enrollment period, which begins on November 1, 2015. Per the Invitation, as changes in

the network occur, the insurer is required to submit such changes to the NYSOH within 15 business days of the change.

NEW Post 5/15/2014

Question: Is there a BHP network adequacy standard submission requirement? If so, when is its due date?

Answer: The BHP network adequacy standards are the same as the QHP network adequacy standards, and are described in Section 4B of the invitation (pages 31-32). Networks will need to be initially submitted on July 15, and should be a snapshot of your BHP network as of June 30, 2015. This submission, and all submissions beyond this date, will need to include your 2016 product offerings and 2016 service area. After this, submissions of the BHP networks will follow the regular schedule, with the next submission occurring on August 24, 2015.

(B) CONTRACTING

Posted 5/6/2015

Question: According to the 2016 invitation on page 49, it reads as follows: "d. Vendor Responsibility. On or around the same time Applicants submit Forms and Rates, Applicants that are applying for the first time will be notified of their responsibility to complete the New York State "vendor responsibility" process through the New York State VendRep System." Since we are not first time applicants, do we still complete this for 2016?

Answer: Plans that currently participate in the Marketplace will need to complete and submit either an updated hard copy Vendor Responsibility Questionnaire (VRQ Form AC 3290-S or AC 3291-S) or, update and recertify their Online VRQ. Contracting rules require that Vendor Responsibility Questionnaires be submitted or recertified at least yearly.

(C) ENROLLMENT

Posted 5/6/2015

Question: Will a member's outstanding premium balance apply to their BHP plan? For example, if a QHP enrolled member moves to a BHP 150-200 FPL plan and has a negative premium balance, can this apply on their BHP Standard plan premium balance?

Answer: No, the negative QHP premium balance cannot be applied to the BHP premium balance. Since enrollment into the BHP is enrollment into a new program, premium payments must be treated separately.

Posted 5/6/2015

Question: If a standard 150-200 FPL BHP member has a life changing event and elects a QHP plan with a premium balance, can the insurer apply it to their new QHP plan?

Answer: No, the negative BHP premium balance cannot be applied to the QHP premium balance. Since enrollment into the QHP is enrollment into a new program, premium payments must be treated separately.

NEW Post 5/15/2015

Question: How will individuals transition from the Silver CSR variations of 87% AV and 94% AV to the Basic Health Program? Will they be auto-enrolled and will they be notified that their plan will not offered in 2016?

Answer: For purposes of responding to this question, we define "auto-enrollment" as the transfer of individuals enrolled in one HIOS ID to another HIOS ID of the same insurer without the enrollee taking an affirmative action. The DOH is contemplating allowing auto-enrollment of individuals enrolled in a QHP in 2015 and determined by the Marketplace to be eligible for the BHP in 2016 provided that (1) the insurer in which the individual was enrolled in 2015 offers a BHP product in 2016 and (2) there is reasonable assurance that the provider networks of these two products are comparable so that disruption to the consumer is minimized. Auto-enrollment will be reviewed on a plan by plan basis. NYSOH will issue notices explaining program and plan changes to all consumers transitioning from QHPs to BHPs.

Invitation and Requirements for Insurer Certification and Recertification for Participation in 2016

QUALIFIED HEALTH PLANS, STAND-ALONE DENTAL PLANS AND BASIC HEALTH INSURANCE PLANS

April 17, 2015
REVISED May 15~~2~~, 2015

Schedule of Key Events

Event	Due Date	QHP	SADP	BHP
Invitation Released	April 17, 2015	x	x	x
Letters of Interest Due	April 24, 2015	x	x	x
Written Questions Accepted	April 20 through May 8	x	x	x
Stand-Alone Dental Applicant Forms and Rates Due to DFS	April 30, 2015		x	
Health Insurer Applicant Forms and Rates Due to DFS	May 15, 2015	x		
Stand-Alone Dental Applicant Binders are due in SERFF	May 15, 2015		x	
Health Insurer Applicant Binders are due in SERFF	May 29, 2015	x		
Participation Proposals Due	May 22, 2015	x	x	x
Basic Health Insurance Plan Rates Provided	Approximately July 31, 2015			x
Basic Health Insurance Plan Templates and Subscriber Agreements Due to DOH	August 31, 2015			x
Certification of Plans	September 11, 2015	x	x	x
Approval of Plans in Issuer Portal and no changes permitted to information needed for enrollment renewals	September 25, 2015	x	x	x
All information approved and no changes permitted beyond this date	October 31, 2015	x	x	x

* QHP = Qualified Health Plans; SADP = Stand-Alone Dental Plans; BHP = Basic Health Insurance Plans

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ATTACHMENTS

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The Official Health Plan Marketplace

PART 1

INTRODUCTION AND OVERVIEW

Section 1.1 Issuing Office and Purpose

This Invitation is issued by the New York State Department of Health (DOH) to invite: (i) insurers offering Qualified Health Plans (QHPs) and Stand-Alone Dental Plans through the NY State of Health, the Official Health Plan Marketplace (Marketplace) in 2015 to apply for recertification and, if applicable, certification as a Basic Health Insurance Plan (BHP), and (ii) other insurers that are licensed or certified in New York State to apply for certain health insurance plans to be certified as QHPs and/or Basic Health Plans (BHPs) to be offered on the Marketplace in calendar year 2016.

Following the submission and review of the information required by this Invitation, the DOH will review whether Applicants and individual plans meet all federal minimum participation standards and other requirements necessary for certification as a QHP or a BHP. After Applicants and individual plans have been (i) reviewed and found to satisfy all minimum standards and requirements, and (ii) in the case of Applicants applying for the first time, an Agreement is signed with the DOH, such health plans will be certified as QHPs and/or BHPs available through the Marketplace. This will be the only opportunity for insurers to apply for certification or recertification of plans to be offered on the Marketplace in 2016.

The DOH reserves the right to negotiate with Applicants in the best interest of the Marketplace and its consumers including but not limited to ensuring choice for consumers and small businesses, and to provide continuity of coverage for consumers transitioning between Insurance Affordability Programs.

Section 1.2 Background

A. NY State of Health, the Official Health Plan Marketplace

On March 23 and 30, 2010, President Obama signed The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, respectively. The two laws are collectively referred to as The Patient Protection and Affordable Care Act (ACA). The ACA authorized the creation of state-based and administered Health Benefit Exchanges. On April 12, 2012, Governor Cuomo issued Executive Order No. 42 establishing the New York Health Benefit Exchange, now known as NY State of Health, the Official Health Plan Marketplace, within the DOH. NY State of Health opened on October 1, 2013 for coverage starting on January 1, 2014.

The NY State of Health continues to successfully increase the affordability and accessibility of health insurance coverage in New York. To date it has enrolled more than 2.1 million New Yorkers

into comprehensive, affordable coverage, and has had a significant impact on reducing the state's uninsured rate.

The more than 2.1 million marketplace enrollees as of February 28, 2015 represent a more than two-fold increase from the first enrollment period when 960,762 people enrolled. New Yorkers who have enrolled in coverage through the Marketplace have overwhelmingly reported that they are satisfied with their health insurance (92 percent) and are using their coverage to access care (84 percent). (NYS Health Foundation, November 10, 2014). As a further measure of satisfaction, 86 percent of New Yorkers who enrolled in qualified health plan coverage in 2014 renewed coverage in 2015.

In person assistors continued to play an important role in enrolling New Yorkers into coverage. Consistent with the federal law, the DOH provides grants to qualified organizations to act as Navigators for the Marketplace. The Marketplace has also trained and certified volunteers known as Certified Application Counselors (CACs) and Health Plan Facilitated Enrollers (FEs). Navigators, CACs and FEs provide linguistically and culturally appropriate assistance to those applying for coverage through the Individual Marketplace and/or Small Business Marketplace. In 2015, there were more than 11,000 certified enrollment experts including navigators, certified application counselors, plan enrollers and licensed insurance brokers.

For the second open enrollment period, NY State of Health developed new tools to make it even easier for consumers to understand their health plan options. Tools included a plan preview, or anonymous shopping, tool which allows individuals to shop for a health plan before starting an application NY State of Health's website. The plan preview tool has allowed 2.4 million individuals to get a personalized premium quote without having to enter personal information and complete an application.

In 2015, the NY State of Health increased efforts to reach non-English speakers across the state. In November, the Marketplace debuted a Spanish version of its website, including online application for individuals and families. In addition, the Marketplace translated key outreach and educational materials into 17 additional languages.

B. The Basic Health Program

The ACA provides states with the option to establish a Basic Health Program. New York has elected this option as authorized by Section 369-gg of the Social Services Law, and received approval from the federal government on March 27, 2015 to administer this program.

To be eligible for the Basic Health Program, individuals must meet the following requirements:

- Be less than age 65 at the beginning of the plan year;
- Reside in New York State;

- Not be eligible for Medicaid or Child Health Plus (CHP);
- Not be eligible for affordable Minimum Essential Coverage (MEC); and
- Have incomes between 138%-200% of the FPL or less than 138% and ineligible for Medicaid due to immigration status.

Individuals eligible for the Basic Health Program are not eligible to receive Advance Premium Tax Credits, but will have the option of purchasing a full pay QHP if they elect not to apply for financial assistance on their application.

The federal government provides states with funding in an amount equal to 95 percent of the amount that it would have spent on Advanced Premium Tax Credits and Cost Sharing Reductions had the individuals who enrolled in the state's BHP been enrolled in the Individual Marketplace. Insurers must provide health care services as detailed below and in the attachments to this Invitation. Monthly premium contributions and cost sharing cannot exceed the amount the individual would have paid for QHP coverage in the Marketplace.

nystateofhealth
The Official Health Plan Marketplace

PART 2

Qualified Health Plan and Stand-Alone Dental Plans: Individual Market and Small Business Market

Section 2.1 Participation Requirements

For purposes of this Invitation, references to "Applicant" and Applicants" shall collectively mean insurer applicants that offer medical or dental coverage and apply for QHP certification or recertification. The term "Health Insurer Applicant" shall collectively mean health insurer applicants applying for QHP certification or recertification that offer medical coverage, including CO-Ops; and references to "Stand-Alone Dental Applicants" refers to insurers that are applying for QHP certification or recertification that offer only stand-alone dental coverage.

A. Licensure and Solvency

Pursuant to 45 CFR § 156.200(b)(4), Applicants must:

- Be licensed as an insurer under Articles 42 or 43 of New York State Insurance Law or certified under Article 44 of New York State Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or

- Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to November 1, 2015 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 1, 2015.

B. Choice of Participation

Applicants may apply to participate in the Individual Marketplace and Small Business Marketplace, but are not required to participate in both. Applicants that currently participate only in the Individual or Small Business Marketplace, may apply to participate in both the Individual Marketplace and the Small Business Marketplace for calendar year 2016.

C. Service Area

Applicants must apply to participate in their entire service area as approved by the Department of Financial Services (DFS) or the DOH at the time of application, provided all requirements of this Invitation are met. Applicants may apply to the DOH for an exception to this requirement by submitting a written request to the DOH explaining the facts that justify the exception. The DOH reserves the right to grant exceptions to this requirement on a case-by-case basis when it determines that granting such exception is necessary, non-discriminatory and in the best

interest of the Marketplace. Pursuant to 45 CFR § 155.1055, Applicants seeking participation must cover geographic areas that are established without regard to racial, ethnic, language, or health status-related factors, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

D. Applicant-Specific Requirements

1. Health Insurer Applicant Product Offerings

a. Essential Health Benefits. Health Insurer Applicants must agree to provide the Essential Health Benefits (EHB) specified by the DOH for calendar year 2016, and delineated on Attachment A. The EHBs must be included in the calculation of the actuarial values of the products.

b. Metal Levels. Each product in each metal level must meet the following specified actuarial value (AV) levels based on the cost-sharing features of the product and determined using the HHS AV calculator.

Bronze:	60% AV
Silver:	70% AV
Silver CSR	73% AV (200-250% Federal Poverty Level)
Gold:	80% AV
Platinum:	90% AV

Consistent with federal rules, a *de minimus* variation of +/- 2% AV is permissible, except with respect to the Silver CSR (cost-share reduction) variation, which only permits a variation of +/- 1% AV. Due to the implementation of the Basic Health Program in the Marketplace, the Silver CSR variations of 87% AV and 94% AV will not be required as offerings in 2016. Eligible individuals will instead qualify for the Basic Health Program and will be presented with the option to enroll in that program.

c. Standard Products. Health Insurer Applicants must offer one (1) standard product in each metal level and in every county of its Marketplace service area. The standard product offered by Health Insurer Applicants must include the benefits and visit limits as delineated in Attachment A and the cost-sharing limitations delineated in Attachment B, with the exception that the wellness benefit may be substituted for a different wellness benefit(s) in accordance with federal and state regulation and guidance, as well as DFS review and approval. This requirement applies to the Individual Marketplace and the Small Business Marketplace. The Standard Products for 2016 are listed in Attachment B.

Note on Standard Product Changes for 2016: HHS updated the AV calculator for the first time in 2015. This update reflects two years of cost growth, which is a 13 percent increase. As a result, the actuarial values of the Marketplace's standard products increased (e.g., because fixed deductibles and cost sharing would satisfy a smaller share of total charges). This change in the AV calculator required New York to revise the Silver CSR variation that is at 73% to have a higher deductible, and caused the Bronze Standard product to no longer be HSA eligible. In 2016, Health Insurer Applicants that offered a Bronze QHP that was HSA eligible in 2015 will be permitted to offer an additional Bronze QHP, as set forth in Attachment B (labeled HSA Compliant Bronze), to ensure that the HSA can carry over for their respective enrollees.

d. Child Only offerings. In accordance with federal regulation, Health Insurer Applicants must agree to offer a child-only product at each metal level described in Section 2.1(D)(1)(b), above, in the Individual Marketplace. The child-only product must conform to the benefits and visit limits delineated in Attachment A and the same cost sharing limitations delineated in Attachment B. In other words, it must be the Standard Product required in Section 2.1(D)(1)(c), above, offered at the child-only rate outlined in Section 2.2(c)(5)(b). Only one child only product is required per metal level. Health Insurer Applicants' participation in the State's Child Health Plus program does not satisfy this requirement.

e. Catastrophic Plans. Health Insurer Applicants must agree to offer at least one standard catastrophic product in each county of the Applicant's service area in the Individual Marketplace. The standard catastrophic plan can be found in Attachment B. As part of the Participation Proposal which is attached as Attachment E, the DOH will require Health Insurer Applicant's affirmative intent to offer or continue to offer a catastrophic product. In the event that the DOH determines there is adequate catastrophic coverage in a particular county, the DOH may in its sole discretion allow other Health Insurer Applicants in the same county the option of not offering the Catastrophic Plan. The DOH will inform the Health Insurer Applicant of this option during the certification process and the decision regarding inclusion/exclusion of the Catastrophic Plan will be made by the DOH prior to certification. In the event there is not adequate coverage in a particular county, all Health Insurer Applicants in that county will be obligated to offer the Catastrophic Plan.

f. Out-of-Network Offerings. An "out-of-network" product is a product that provides coverage for services rendered by health care providers that are not in the health insurer's network. Health Insurer Applicants that offer an out-of-network product outside the Marketplace must offer the out-of-network product on the Marketplace at the silver and platinum levels. This requirement applies to both the Individual Marketplace and the Small Business Marketplace. Health Insurer Applicants that do not offer an out-of-network product outside the Marketplace are strongly encouraged to offer a QHP on the Marketplace with an out-of-network benefit, so consumers have an

option to purchase such a product should they chose to do so. An Applicant may use an additional or different license to offer an out-of-network QHP, provided the different or additional license is for an entity within the same family of companies.

g. Nonstandard Products. Health Insurer Applicants may opt to offer up to three (3) "non-standard" products at any metal level, and in all or any part of its service area, in accordance with the requirements below and any applicable DFS instruction or guidance.

(i) Non-standard products offered for the first time on the Marketplace must have meaningful differences from each other and from the standard QHPs. Non-standard QHPs are considered to be meaningfully different when additional benefits not included in the Essential Health Benefits are covered (e.g., adult dental, adult vision, acupuncture), or, as determined by DOH, when the non-standard product allows consumers to easily identify the differences between the non-standard product and standard products to determine which plan provides the highest value at the lowest cost to address their needs. All non-standard plans must comply with federal and state law and regulations and guidance and shall be subject to DFS and Marketplace review and approval.

(ii) In addition, to ensure the Marketplace offers consumers non-standard choices at various metal levels, Health Insurer Applicant may elect to offer the following number of non-standard products:

A. The same number of non-standard products at every metal level (e.g., 2 bronze, 2 silver, 2 gold, 2 platinum); or

B. At least one and not more than 3 non-standard products. However, the number of Bronze non-standard products may not exceed the number of non-standard products at any other metal tier, except that Health Insurer Applicants that offered a Bronze QHP that was HSA eligible in 2015 will be permitted to offer the HSA Compliant Bronze set forth in Attachment B to ensure the HSA can carry over for their respective enrollees

(iii) Child only products, catastrophic products, out of network offerings, and the HSA Compliant Bronze product set forth in Attachment B will not be counted towards the three (3) non-standard product maximum.

h. QHP Naming Convention. To assist consumers in identifying products and differences between products, Health Insurer Applicants must use the following naming conventions to identify all QHPs offered on the Marketplace in the order as presented below. Note that the absence of field name indicates the product DOES NOT include such coverage.

Individual Market:

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	
Metal Tier	Bronze, Silver, Gold, Platinum, Child Only, Catastrophic	Indicate metal tier using entire word for metal level
Standard/Non-Standard	ST or NS	Indicate Standard or Non-standard by using "ST" for standard and "NS" for non-standard
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Indicate the type of dental coverage embedded within the QHP
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29
Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, other significant details	List the general categories of variances from standard benefits in alphabetical order separated by commas. Do not enter for Standard Plans

Examples of permissible QHP names are shown below:
ABC Product, Platinum, ST, INN, Dep25
ABC Product, Gold, ST, INN, Dep29
ABC Product, Silver, NS, OON, Family Dental, Dep29, Family Vision

Small Business Marketplace:

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	
Metal Tier	Bronze, Silver, Gold, Platinum,	Indicate metal tier using entire word for metal level
Standard/Non-Standard	ST or NS	Indicate Standard or Non-standard by using "ST" for standard and "NS" for non-standard

Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Indicate the type of dental coverage embedded in the QHP
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29
Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, other significant details	List the general categories of variances from standard benefits in alphabetical order separated by commas. Do not enter for Standard Plans
Domestic Partner	DP	Include only if domestic partners are eligible for coverage
Family Planning	FP	Include only if the family planning benefit is covered

Examples of permissible QHP names are shown below:
ABC product, Platinum, ST, INN, Dep25
ABC product, Platinum, ST, INN, Dep29, FP
ABC product, Gold, OON, NS, Adult Dental, Dep29, DP, FP

i. Prescription Drug Coverage. As required under the federal rules, prescription drug coverage must cover at least the greater of (i) one drug in every United States Pharmacopeia (USP) category and class; or (ii) the same number of prescription drugs in each category and class of the benchmark plan chosen by the State. All prescription drug information must be submitted to DFS for its review. This requirement is not intended to limit the number of drugs that the Health Insurer Applicant may cover in a drug category or class. Health Insurer Applicants are encouraged to develop formularies that exceed the federal requirements when it is determined to be in the best interest of their members.

j. Dental Coverage. Federal law requires coverage for pediatric dental services and permits such services to be covered by health insurers or stand-alone dental carriers. Health Insurer Applicants have the option of embedding pediatric dental coverage within their QHPs, offering QHPs without pediatric dental coverage, or both. In the event the DOH determines that there is no pediatric stand-alone coverage available

in a particular county, all Health Insurer Applicants in that county will be obligated to offer a QHP with embedded pediatric dental coverage.

Health Insurer Applicants will also have the option of offering adult/family dental, and/or supplemental pediatric dental benefits as an additional benefit per Section 2.2(D)(1)(g), above. In the event the Health Insurer offers a family dental benefit, the pediatric component must include at least the same pediatric dental benefits as outlined in Attachment A.

k. Effective Dates. All initial and recertified products offered through the Marketplace will have effective dates of January 1, 2016 in the Individual Marketplace and Small Business Marketplace. Qualified Employers will be able to purchase coverage through the Small Business Marketplace at any point during the year, and may modify the effective date of coverage for any 12-month period. Health Insurer Applicants, however, will not be able to establish and offer new products at any time during the year. Products to be offered during calendar year 2016, must be established and submitted to DOH and DFS through this Invitation.

2. Stand-Alone Dental Applicants

Stand-Alone Dental Applicants shall offer products through the Marketplace in accordance with federal and state laws and regulations, and in accordance with the following participation requirements:

a. Essential Health Benefits. The Stand-alone Dental Applicant must agree to provide the pediatric dental benefits outlined Attachment A. The pediatric dental benefits are minimum benefits and the Stand-alone Dental carrier may add benefits.

b. Standard Product. The Stand-alone Dental Applicant must offer one standard pediatric stand-alone dental product in every county of its service area. The standard product offered by the Stand-alone Dental Applicant must include the same pediatric benefits as delineated in Attachment A. The Standard product must comply with federal regulation and DFS guidance. This requirement applies to both the Individual Marketplace and the Small Business Marketplace.

c. Non-Standard products. The Stand-alone Dental Applicant may opt to offer up to two (2) non-standard products. The non-standard product may be an adult/family dental plan or a second pediatric dental product offering. This requirement applies to both the Individual Marketplace and the Small Business Marketplace.

d. Other Applicable Provisions. Stand-Alone Dental Applicants must meet the requirements set forth in Section 2.1(D)(1)(k) and 2.2(D), below.

3. Consumer Operated and Oriented Plans (CO-OPs)

Applicants designated as CO-OPs must adhere to the standards and processes set forth in this Invitation. Once a CO-OP has met all the standards set forth in this Invitation, DOH will make a determination whether to certify the CO-OP's QHPs and inform the Center for Consumer Information and Insurance Oversight (CCIIO) of its determination. Once the CO-OP is certified, federal regulations require it to be deemed certified for two (2) years, with recertification determined by DOH. The CO-OP entity will be subject to the DOH decertification criteria, and any recommendation of decertification will be made to CCIIO.

4. Small Business Marketplace

In addition to the above participation requirements, Applicants seeking to participate in the Small Business Marketplace agree to adhere to the following requirements:

a. Definition of a Small Group. For calendar year 2016, the definition of a small group shall mean a group of one hundred (100) or fewer employees with at least one common law employee as defined federal regulation, (see 26 CFR 31.3121(d)-1(c)). An employee does not include a sole proprietor or the sole proprietor's spouse. The Small Business Marketplace will determine the size of the employer by following the definitions set forth by the Department of Financial Services, which can be found on their website at:
http://www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm

b. Employer Choice. Through the Small Business Marketplace, Qualified Employers will have flexibility of choice when determining the products to offer their employees, including the following options:

- Selecting one metal level and all products within that metal level;
- Selecting one specific health insurer and one specific metal level offered by such insurer;
- Selecting one specific health insurer and offering multiple products from such insurer;
- Selecting all metal levels and all health insurer products.

The Small Business Marketplace will also permit the ability to offer an "employee choice" model through defined contribution mechanisms. Qualified Employers will have similar options available to them for stand-alone dental products.

c. Minimum Participation & Employer Contribution Standards. There are no minimum participation requirements or minimum employer contribution requirements in the Small Business Marketplace.

d. Payment and Grace Period. Applicants must adhere to the methodology and processes developed by the Small Business Marketplace for payment and remittance of premium. Applicant must provide employers purchasing health care coverage through the Small Business Marketplace with a thirty (30) day payment grace period.

5. Health Savings Accounts and Health Reimbursement Accounts

Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs) are financial mechanisms created under law and regulated by the Internal Revenue Service (IRS) that provide individuals with tax advantages to offset healthcare costs. HSAs are accounts held by a trustee or custodian (i.e., a bank) on behalf of individuals. HRAs are accounts held solely by an employer on behalf of an employee. For more information, visit http://www.irs.gov/uac/Publication-969,-Health-Savings-Accounts-and-Other-Tax-Favored-Health-Plans.

Applicants will be permitted to offer high deductible health plans that meet the IRS requirements and may arrange for the applicable HSA and HRA, if requested by the consumer and/or employer.

6. Non-Discrimination

Applicants must not, with respect to their QHPs, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Section 2.2 Premium Rate and Policy Form Filing

A. New York State Department of Financial Services (DFS) Statutory Authority

Pursuant to sections 3201, 3231, 4235, and 4308 of New York State Insurance Law, the New York State Department of Financial Services (DFS) is authorized and directed to review and approve policy forms and premium rates before such policy forms may be issued or delivered. HHS has determined that New York State has an effective rate review mechanism and, as such, New York State is authorized to conduct rate review pursuant to State standards. Accordingly, pursuant to the requirements of the State Insurance Law, Applicants must file with DFS proposed policy forms and premium rates for Marketplace products and obtain the Superintendent's approval of such policy forms and premium rates prior issuing or delivering such contracts and prior to QHP Certification or Recertification.

B. Policy Form Filings

1. All policy form filings for Marketplace products must be received by DFS by April 30, 2015 for Stand-Alone Dental Applicants and May 15, 2015 for Health Insurer Applicants.

2. All policy forms for Marketplace products shall be submitted to DFS for approval through the System for Electronic Rate and Form Filing (SERFF) in accordance with instructions established by DFS and HHS.

3. DFS will update a checklist and instructions for policy form filings, which will be available on the DFS website. Applicants should use the checklist and instructions to ensure that all policy form submissions are complete.

4. DFS will develop updated model policy form language for Marketplace products, which will be available on the DFS website. All Applicants must use the model language.

C. Rate Filings

1. All premium rate applications for Marketplace products must be received by DFS by April 30, 2015 for Stand-Alone Dental Applicants and May 15, 2015 for Health Insurer Applicants.

2. All premium rate applications for Marketplace products shall be submitted to DFS through SERFF in accordance with instructions established by DFS, DOH, and HHS.

3. DFS will develop a checklist and instructions for premium rate filings, which will be available on the DFS website. Applicants should use the checklist and instructions to ensure that all rate application submissions are complete.

4. Health Insurer Applicants must use the updated federal AV calculator when determining whether the Marketplace products meet the actuarial values required for the respective products. HHS has updated the AV calculator, so Applicants will have to rerun their products through the updated AV calculator to make sure that the products meet the proper AV levels. To the extent the AV calculator is not built into the rate templates, Applicants must include in the rate application a printout from the AV calculator for each Marketplace product submitted and a clear benefit description for each product submitted. The federal AV calculator can be found at http://www.cciio.cms.gov/resources/regulations/index.html#hie.

5. Provisions Applicable to Health Insurer Applicants

a. Rating Tiers. Individual and small groups products in New York are community rated in accordance with state laws, regulations and guidance, and Health Insurer

Applicants cannot take into account age, sex, health status, occupation or tobacco use when establishing premium rates. All products shall be initially priced to reflect four tiers with the following relativities:

Tier	Relativities
Single person	1.00
Singe + spouse	2.00
Single + child(ren)	1.70
Single + spouse + child(ren)	2.85

These relativities shall apply to 2016 rates in the Individual Marketplace and Small Business Marketplace. The Superintendent of DFS will review and may adjust the relativities for subsequent years.

b. Child-only Products. In addition to the tiers specified above, Health Insurer Applicants must offer child-only products in conjunction with the standard product designs. Only one child-only product is required per metal level. Separate policy forms must be created and provided to enrollees of child-only products. The child-only rate must be set at 41.2% of the corresponding single rate product. The Superintendent of DFS will review this requirement and may adjust the factor for subsequent years.

c. Risk Adjustment and Reinsurance. The Marketplace has elected to utilize the federal risk adjustment methodology and reinsurance methodology. Health Insurer Applicant's premium rates should reflect the anticipated impact of these programs.

d. Single Risk Pool Inside and Outside the Marketplace. Under the ACA and applicable regulations, Health Insurer Applicants must consider all of the enrollees in all non-grandfathered products offered by the Applicant to be members of a single risk pool in the Individual market and the small group market, respectively. This requirement applies to products offered both inside and outside of the Marketplace for each market. Consequently, if the Health Insurer Applicant offers a small group or individual product on the Marketplace, it should coordinate its rate application filings with the rate filings for non-grandfathered small group or individual products outside the Marketplace. DFS will issue instructions as to how to coordinate the filings. Catastrophic plans will have their own risk pool.

6. Premium Rate Periods

a. Small Business Products. Applicants may use quarterly rolling rates for Marketplace products offered through the Small Business Marketplace, with a one year guarantee for the employer. For example, if the employer's plan year begins April 1, 2016, the rate provided to

that employer will be guaranteed for all employees through March 31, 2017, as well as new employees or special enrollments that occur during the plan year through March 31, 2017.

b. Individual Marketplace Products. Premium rates for Marketplace products offered in the Individual Marketplace Market must run on a calendar year basis, from January 1 to December 31 of the applicable year.

7. Rating Regions. When submitting products for rate review, Applicants must adhere to the rating regions set forth on Attachment C.

D. Role of Brokers and Agents

To maximize access to health insurance coverage for residents of New York State, brokers and agents (collectively, "Producers") will be permitted to assist both small businesses and individuals in purchasing coverage through the Marketplace.

1. Producer Certification. Producers who have successfully completed the training certification program for each applicable marketplace and entered into an agreement with the Marketplace will be deemed certified to conduct business in the Marketplace. Such agreements will require Producers to be licensed and in good standing with the DFS. For the sale of Marketplace products, the Applicant must contract with Producers that have successfully completed the required training program and have entered into agreements with the Marketplace.

2. Producer Compliance. Producers will be required to comply with all applicable provisions of federal and state law related to the provision of assistance to consumers, employers and employees in the Marketplace and must have required privacy and security measures in place.

3. Producer Compensation. All of Health Insurer Applicants' compensation arrangements, including bonus arrangements and all other arrangements that relate to compensation to Producers must be the same inside and outside of the Marketplace, and must comply with all applicable provisions of State law. For example, the commission for a small group product offered on the Small Business Marketplace must be the same as the commission and bonuses for a small group product offered outside of the Marketplace. In addition, if compensation is provided, Health Insurer Applicants must provide the same compensation at all metal levels.

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PART 3

Basic Health Insurance Plans

Section 3.1 Participation Requirements

For the purposes of this Invitation, references to "BHP Applicant" or "BHP Applicants" shall mean an insurer that is applying to offer BHPs.

A. Licensure and Solvency

Pursuant to 42 CFR § 600.415(a) and NY State Social Services Law, Section 369-gg(1)(a), BHP Applicants must:

- Be licensed as an insurer under Articles 42 or 43 of New York State Insurance Law or certified under Article 44 of New York State Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or

- Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to November 1, 2015 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 1, 2015.

B. Choice of Participation

Applicants that apply to participate in the Basic Health Program may also apply to participate in both the Individual Marketplace and Small Business Marketplace, but are not required to participate in either. BHP Applicants may participate with the Medicaid or Child Health Plus programs but are not required to participate in either program.

C. Service Area

BHP Applicants must apply to participate in their entire service area as approved by the Department of Financial Services (DFS) or the DOH at the time of application, provided all requirements of this Invitation are met. BHP Applicants may apply to the DOH for an exception to this requirement by submitting a written request to the DOH explaining the facts that justify the exception. The DOH reserves the right to grant exceptions to this requirement on a case-by-case basis when it determines that granting such exception is necessary, non-discriminatory and in the best interest of the Marketplace. BHP Applicants seeking participation must cover geographic areas that are established without regard to racial, ethnic, language, or health status-related factors, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

Pursuant to 42 CFR § 600.420(a), the DOH reserves the right to negotiate service area with BHP Applicants in order to ensure compliance with the federal requirement of choice of BHP insurer in each county of the state.

D. Applicant-Specific Requirements

1. BHP Benefits, Cost Sharing and Individual Premium Contributions

a. Standard BHPs. BHP Applicants must agree to offer three variations of BHP products based on enrollee income as a percentage of FPL and other factors as described below, and delineated in Attachment F (hereinafter referred to as the "Standard BHP"). All Standard BHPs below are based on the Essential Health Benefits benchmark plan specified by DOH for calendar year 2016, with the following exceptions: pediatric dental will not be included in the benefit, and the wellness benefit may be substituted for a different wellness benefit(s) in accordance with federal and state regulation and guidance, as well as DOH review and approval. All BHPs offered shall include only in-network options, and at no time shall BHP Applicant impose cost-sharing with respect to preventive health services or items, as defined in 45 CFR 147.130.

(i) Individuals with Incomes greater than 150% and less than or equal to 200% of FPL ("Essential Plan 1" in Attachment F). BHP Applicants must provide the Standard BHP. Individual enrollees will pay $20 per individual per month for the Standard BHP.

(ii) Individuals with Incomes greater than 138% and less than or equal to 150% of FPL ("Essential Plan 2" in Attachment F). BHP Applicants must provide the Standard BHP. Enrollees will not have a monthly premium for the Standard BHP.

(iii) Individuals with Incomes greater than 100% and less than or equal to ~~at or below~~ 138% of FPL Not Eligible for Medicaid Due to Immigration Status ("Essential Plan 3" in Attachment F). BHP Applicant must provide the Standard BHP. As required under Section 369-gg of the NY State Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 138% of federal poverty, and who previously qualified for NY Medicaid benefits, BHP Applicants must include the following additional benefits: non-prescription drugs, orthotic devices, orthopedic footwear, adult vision care, adult dental. Non-emergency transportation will be covered but administered by DOH. Individuals will not pay any monthly premium for BHP coverage.

(iv) Individuals with Incomes at or below 100% of FPL Not Eligible for Medicaid Due to Immigration Status ("Essential Plan 4" in Attachment F). BHP Applicant must provide the Standard BHP. As required under Section 369-gg of the NY State Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 138% of federal poverty, and who previously qualified for NY Medicaid benefits,

BHP Applicants must include the following additional benefits: non-prescription drugs, orthotic devices, orthopedic footwear, adult vision care, adult dental. Non-emergency transportation will be covered but administered by DOH. Individuals will not pay any monthly premium for BHP coverage and will have no cost-sharing on benefits.

b. Standard BHP Plus Adult Vision/Dental. For individuals who qualify for a BHP in Sections 3.1(D)(1)(a)(i) and (ii), above, BHP Applicants may also elect to offer **one** additional BHP product that offers the same benefits and cost sharing as the Standard BHP, but that also includes coverage for adult dental and vision benefits as defined in Attachment F ("Standard BHP Plus Adult Vision/Dental"). These are the only additional benefits that may be added and both benefits must be added. Individual enrollees will pay the applicable Standard BHP premium per individual per month, plus any additional costs for the dental and vision coverage. All BHP Applicants must complete Attachment I confirming their commitment to offer the Standard BHP and indicating whether they will offer the Standard BHP Plus Adult Vision/Dental. Applicants that elect to offer the Standard BHP Plus Adult Vision/Dental must make the option available to enrollees at both of the income levels set forth in Section 3.1(D)(1)(a)(i) and (ii), above.

c. Additional Features of BHPs. BHP Applicants must include in the Standard BHP and the Standard BHP Plus Adult Vision/Dental the following features per 42 CFR 600.410(d):

(i) Care coordination and care management for enrollees, with a particular focus on enrollees with chronic health conditions;

(ii) Foster patient involvement in their health care decision-making, including the use of incentives for appropriate health care utilization and patient choice of provider;

(iii) Incentives for the use of preventive services.

d. BHP Naming Convention. To assist consumers in easily identifying the BHP Plans, all BHP Applicants must use the same names for their products, and the Marketplace will attach the insurer logo and/or company name on its website to identify the particular insurer. The BHPs must be labeled as follows (see Attachment F):

~~(i) Standard BHP – This is to be used for all populations~~
~~(ii) Standard BHP Plus Vision/Dental – This is to be used for the populations who are eligible to purchase these additional benefits set forth in Section 3.1(D)(1)(a)(i) and (ii), above~~

- Essential Plan 1
- Essential Plan 2
- Essential Plan 3
- Essential Plan 4

2. Effective Date

a. Enrollment Prior to January 1, 2015. Individuals who enroll in BHPs offered through the Marketplace from November 1, 2015 through December 15, 2015 (for individuals who qualify for BHP under Sections 3.1(D)(1)(a)(i) and (ii), above), or through December 31, 2015 (for individuals who qualify for BHP under Section 3.1(D)(1)(a)(iii) and (iv)), will have an initial effective date of January 1, 2016. Eligibility for BHP will be recertified every 12 months.

b. Enrollment On or After January 1, 2015. For individuals who enroll on or after January 1, 2016, effective dates for enrollment will be handled as follows:

(i) For individuals who have incomes at or below 138% of the FPL, and do not qualify for Medicaid due to immigration status, the effective date of BHP coverage will be the first of the month in which they selected a BHP plan. For example, an individual who enrolls in a BHP on February 15, 2016, will have coverage in the BHP starting February 1, 2016.

(ii) For individuals who have incomes above 138% of the FPL, the effective date shall follow the "15th of the month" rule, which means these individuals who select a BHP plan between the first and the 15th of the month will have coverage that begins the 1st of the next month; and individuals who select a plan between the 16th and the last day of the month, will have coverage on the first day of the second month following the month in which they select a BHP plan.

Enrollment in the Basic Health Program will be open all year. Eligibility for BHP will be recertified every 12 months.

3. Compensation

a. Capitation Payment. BHP Applicants will receive from DOH a monthly capitation payment for each member that has enrolled in its BHPs, and will separately collect the applicable premium payment made from enrollees. The capitation payments made to the insurer must be used in accordance with federal and state laws and regulations, including 42 CFR Part 600. BHP Applicants will be informed of their monthly capitation payment amount on or around July 31, 2015. The BHP Applicant will have ten (10) business days following the determination of its capitation rate to notify the DOH of its final determination on whether to participate in the Basic Health Program for 2016.

b. Premium Payment. BHP Applicant must accept premium and cost-sharing payments made from third party entities on behalf of the member, including payment from the Ryan White HIV/AIDS Programs under title XXVI of the Public Health Service Act, Indian tribes and tribal organizations, and state and federal government programs.

c. Rating Regions and Risk Adjustment. Capitation payments will be made to BHP Applicant on a county basis and in accordance with the nine rating regions set forth in Attachment G to this Invitation. The DOH will begin risk adjusting the capitation payments beginning in 2017.

4. Non-Discrimination.

BHP Applicants must not, with respect to their BHPs, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

E. Policy Form Filings and Plan Information Submissions

1. Policy Form Filings. BHP Applicants must use the model policy forms that will be provided to BHP Applicant shortly after the release of this Invitation. Revisions to the model language will be limited to the bracketed sections of the model policy forms. However, BHP Applicants can include their logos and numerical contract-identifying information on the policy forms. The policy forms must be submitted to the DOH by August 31, 2015.

2. Plan Information. BHP Applicant must submit the required BHP templates to DOH that provide, prescription drug information, links to plan information, service area information, plan rates and contact information. The templates must be submitted to DOH by August 31, 2015.

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PART 4

Requirements Applicable to Qualified Health Plans, Stand-Alone Dental Plans and Basic Health Insurance Plans

For purposes of this Part 4, "Applicant" and "Applicants" shall refer to all Health Insurer Applicants, Stand-Alone Dental Applicants, and BHP Applicants. Every section below applies to all Applicants, unless otherwise expressly stated.

Section 4.1 Network Adequacy

Applicants will establish and maintain a network of Participating Providers that is consistent with 45 CFR § 156.230 and existing DOH managed care network adequacy standards. Specifically, Applicant must adhere to the following:

A. General Standards

a. In establishing the network, the Applicant must consider the following: anticipated enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services covered in each product, the number of providers who are not accepting new patients, and the geographic location of the providers and enrollees.

b. To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the enrollee population and to assure that all services will be accessible without undue delay. This includes being geographically accessible (i.e., meeting time/distance standards) and being accessible for people with disabilities.

c. The DOH may, on a case-by-case basis, defer any of the contracting requirements set forth in this Section II.F if it determines there is sufficient access to services in a county. The DOH reserves the right to rescind the deferment at any time should access to services in a county change.

B. Specific Standards Applicable to Health Insurer Applicants and BHP Applicants

a. Network Composition. The Health Insurer Applicant's and BHP Applicant's network must contain all of the provider types necessary to furnish the Marketplace products, including but not limited to: hospitals, physicians (primary care and specialists), mental health and substance abuse providers, allied health professionals, ancillary providers, Durable Medical Equipment (DME) providers, home health providers, and pharmacies. Specifically, the Health Insurer Applicant's network must meet the following:

(i) Each county network must include at least one hospital; however, for the following counties and boroughs, the network must include at least 3 hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, Manhattan, Queens;

(ii) Each county network must include the core provider types and ratios established through the Provider Network Data System (PNDS);

(iii) Provide a choice of three (3) primary care physicians (PCPs) in each county, but more may be required based on enrollment and geographic accessibility;

(iv) Include at least two (2) of each required specialist provider types in each county, but more may be required based on enrollment and geographic accessibility;

(v) meet the following time and distance standards:

A. Primary Care Providers

- Metropolitan Areas – 30 minutes by public transportation for primary care providers;
- Non-Metropolitan Areas – 30 minutes or 30 miles by public transportation or by car for primary care providers;
- In rural areas, transportation requirements may exceed these standards if justified.

B. Other Providers

- It is preferred, but not required, that the Health Insurer Applicant meet the 30 minute or 30 mile standard

(vi) per 45 CFR 156.1110, beginning January 1, 2015, Health Insurer Applicants and BHP Applicants can only include hospitals that have 50 or more beds when the hospitals meet the patient safety standards set forth in such regulation.

b. Essential Community Providers. Health Insurer Applicant and BHP Applicants are required to have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in Health Insurer Applicants' and BHP Applicants' service area. The Health Insurer Applicant and BHP Applicant must make every good faith effort to include in its network the essential community providers defined under federal regulation, and at a minimum, must include in each county network a federally qualified health center and a tribal operated health clinics, to the extent such providers are available.

c. Behavioral Health Providers. The Health Insurer Applicant and BHP Applicant is required to include individual providers, outpatient facilities, residential treatment facilities, and inpatient facilities in its behavioral health network. The network must include facilities that provide inpatient and outpatient mental health and inpatient and outpatient alcohol and substance use services. Facilities providing inpatient alcohol and substance use services must be capable of providing detoxification and rehabilitation services.

C. Specific Standards Applicable to Dental Benefits and Stand-Alone Dental Carriers

The Applicant's dental network shall include geographically accessible general dentists sufficient to offer each enrollee a choice of two (2) primary dentists in their service area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 enrollees. Networks must also include at least one (1) pediatric dentist and at least one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders (TMD) and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral. The network must include dentists with expertise serving special needs populations (e.g. HIV+ and developmentally disabled patients).

D. Sanctioned Providers

The Applicant shall not include in its network any provider who

a) has been sanctioned or prohibited from participation in Federal health care programs under either Section 1128 or Section 1128A of the SSA; or

b) has had his/her licensed suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

E. Method of Review

Network adequacy shall be reviewed by the DOH on a county-by-county basis. For some network adequacy purposes, however, the county may be extended by approximately ten (10) miles beyond the county in the event the Applicant demonstrates a lack of health care resources or demonstrates that utilization patterns of consumers typically reside outside the county. In such cases, and for rural areas in particular, Applicants may contract with providers in adjacent counties to fulfill the network adequacy requirements.

F. Frequency of Review

The DOH shall review the adequacy of an Applicant's network upon submission of the application and on a quarterly basis thereafter. The frequency of submission and review will be increased incrementally to monthly submissions. Until the frequency increases to a monthly submission, Applicants are required to submit to the Marketplace changes in their networks as soon as they occur (e.g., addition or termination of a hospital or large physician practice) but no later than fifteen (15) days from the date of occurrence.

G. Submission of the Network

The Applicant shall submit its network through the Health Commerce System (HCS) in accordance with the Provider Network Submission Instructions set forth in Attachment J, or

through any successor provider network system developed and implemented by the DOH after consultation with health plans and other stakeholders. Submission must include out-of-state providers within the Applicant's network and must include arrangements with specialty centers and centers of excellence. The DOH reserves the right to ask for further explanations and/or details in the event the system is not able to capture or accurately identify particular service providers.

H. Identification and Use of Existing Network for the Basic Health Plan

To the extent the BHP Applicant intends to use an existing network to satisfy the network adequacy requirements of the Basic Health Program, the Applicant shall identify such intent and the corresponding network. The existing network being used to support the BHPs must be the same network that is approved by NYSOH or DOH.

Section 4.2 Administrative Requirements

A. Enrollment and Member Services

1. Enrollment Periods for QHPs and Stand-Alone Dental Plans. Health Insurer Applicants and Stand-Alone Dental Applicants must adhere to the open enrollment periods established under 45 CFR § 155.410, 45 CFR § 155.725, and the special enrollment periods established under 45 CFR § 155.420. Enrollment is not effectuated until receipt of initial payment of premium from the prospective Enrollee. However, once payment is received, the Applicant must adhere to the grace period standards set forth in federal regulation and DFS guidance for those Enrollees receiving Advance Premium Tax Credit assistance. For Enrollees in the Individual Market that do not receive Advance Premium Tax Credit assistance, once the initial premium is paid, the Applicant must provide a thirty (30) day grace period to pay premiums in accordance with DFS guidance.

2. Enrollment Periods for BHPs. Individuals who enroll in BHPs offered through the Marketplace from November 1, 2015 through December 15, 2015 (for individuals who qualify for BHP under Sections 3.1(D)(1)(a)(i) and (ii), above), or through December 31, 2015 (for individuals who qualify for BHP under Section 3.1(D)(1)(a)(iii) and (iv)), will have an initial effective date of January 1, 2016. For individuals who enroll on or after January 1, 2016, effective dates for enrollment will be handled as follows:

a. For individuals who have incomes at or below 138% of the FPL, and do not qualify for Medicaid due to immigration status, the effective date of BHP coverage will be the first of the month in which they selected a BHP plan. For example, an individual who enrolls in a BHP on February 15, 2016, will have coverage in the BHP starting February 1, 2016.

b. For individuals who have incomes above 138% of the FPL, the effective date shall follow the "15th of the month" rule, which means these individuals who select a BHP plan between the first and the 15th of the month will have coverage that begins the 1st of the next month; and individuals who select a plan between the 16th and the last day of the month, will have coverage on the first day of the second month following the month in which they select a BHP plan.

Enrollment in the Basic Health Program will be open all year. Eligibility for BHP will be recertified every 12 months.

The BHP Applicant must provide a 30-day grace period to pay the premium. If an Enrollee fails to pay their premium within the grace period, the Enrollee will lose coverage on the first of the following month. BHP Applicant will continue to receive a capitation payment for the grace period month and BHP Applicant will be obligated to cover claims for services incurred during the grace period.

3. Enrollment/Disenrollment Transactions. Enrollment transactions (also known as "834 transactions") are the mechanism in which individuals obtain information to pay their premium and get their ID cards. Disenrollment transactions are the transactions identifying that the person has not enrolled in coverage or is no longer enrolled in coverage, and insurers send these when premium payment has not been made or the payment grace periods have expired. As such, Applicants must be able to send and receive HIPAA Compliant 834 and 999 transactions in accordance with the 834 and 999 companion guide developed by the DOH and CMS pursuant to law, regulation and guidance. In addition, the NYSOH provides these transactions to insurers on a daily basis and Applicants must process these transactions regularly, and more specifically in accordance with the following timeframes:

a. Transaction files, including maintenance and termination transactions, must be picked up daily.

b. Acknowledgement transactions (999 transactions) must be sent within 24 hours of picking the files up.

c. Effectuation transactions must be sent within five (5) business days of receipt of payment, and must include the insurer-assigned Member Identification number.

d. Terminations and Cancellations must be sent within five (5) business days of the grace period end date.

e. Error files are sent to insurers on a daily basis; error files must be reviewed and errors corrected on a regular basis, but no less often than once a week.

4. Member Services General Functions. The Applicant must agree to operate a Member Services Department during regular business hours, which must be accessible to Marketplace Enrollees via a toll-free telephone line. Personnel must also be available via a toll-free telephone line (which can be the member services toll-free line or separate toll-free lines) not less than during regular business hours to address complaints and utilization review inquiries. In addition, the Applicant must have a telephone system capable of accepting, recording or providing instruction in response to incoming calls regarding complaints and utilization review during other than normal business hours and measures in place to ensure a response to those calls the next business day after the call was received. The DOH may require the Applicant to periodically report member services call statistics such as the number of calls received related to the Marketplace, the number of calls answered and caller wait times. Applicants must be prepared to adjust member services staff to meet expected performance levels on peak Marketplace volume days.

5. Accessibility. Information must be provided to prospective enrollees and enrollees in plain language and in a manner that is accessible and timely to individuals with disabilities, including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. In particular, the Applicant and its contractors must:

a. Provide written materials in a prose that is understood by an eighth-grade reading level and must be printed in at least ten (10)-point type.

b. Make available written materials and other informational materials in a language other than English whenever at least five (5%) of the applicants and/or enrollees of the Issuer in any county of the service area speak that particular language and do not speak English as a first language; or, alternatively, provide taglines in common non-English languages indicating the availability of written translation of materials in any language the prospective or current enrollee speaks.

c. Make available verbal interpretation services in any language to current or potential enrollees who speak a language other than English as a primary language. Interpreter services must be offered in person where practical, but otherwise may be offered by telephone.

d. Have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include assistive technologies for the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies.

To the extent HHS establishes standards on written materials and/or verbal materials for the Marketplace that provides greater protections than the standards set forth above, Applicant shall adhere to such HHS standards.

6. Consumer Complaints. Consumer complaints received through the Marketplace and sent to the Applicant require a response from the Applicant no later than three (3) business days from the day the Marketplace sends the complaint. If the matter involves an urgent coverage issue, the Applicant must respond and act upon the complaint within 24 hours of issuance by the Marketplace. These timeframes apply regardless of whether the complaint is generated as a result of technical problems with the Applicant's system or technical problems with the Marketplace system. In the event the complaint involves a technical error by the Marketplace or the Applicant needs a technical transaction to resolve the complaint, the Applicant will work cooperatively and diligently with the Marketplace to ensure the consumer's coverage is not delayed in any way as a result of waiting for the technical issues to be resolved.

B. Marketing Standards

1. Marketplace Marketing and Outreach. The DOH is implementing a multi-faceted marketing and outreach campaign focused on connecting New Yorkers with quality, affordable health insurance through its user-friendly website. The DOH will engage in targeted outreach to consumers through navigators, consumer advocates, small businesses, brokers, Regional Advisory Committee members and other stakeholders to promote the use of the Marketplace. The DOH will also continue an annual advertising campaign designed to publicize the access to quality, affordable health insurance.

2. Applicant Responsibilities

a. Applicant may conduct advertising campaigns, including television, radio, billboards, subway and bus posters. The Applicant may distribute marketing materials in local community centers, health fairs and other areas where potential enrollees are likely to gather.

b. The Applicant shall use the logo and branding designated by the DOH in referring to Marketplace products in marketing and outreach activities including any printed materials. Such materials must prominently display the Marketplace website and toll-free telephone number. Applicant will cooperate in good faith with DOH's marketing and outreach activities, including the development of advertising materials and descriptive literature for its Marketplace products.

c. Applicant may not employ marketing practices that will have the effect of discouraging the enrollment of individuals or small businesses with significant health needs in their Marketplace products.

d. The Applicant shall comply with all provisions of federal and State law regulating advertising material and marketing practices. The Applicant's advertising materials must accurately reflect general information that would be applicable to an Marketplace Enrollee. Materials must not contain false or misleading information. Applicants may not offer incentives to potential enrollees to enroll in a Marketplace product or renew their coverage.

e. The Applicant is prohibited from door-to-door solicitations of potential enrollees or distribution of material, and may not engage in "cold calling" inquiries or solicitation. The Applicant may not require participating providers to distribute Applicant-prepared communications to their patients. Marketing may not take place in patient rooms or treatment areas.

f. Applicant will provide copies of advertising materials and/or descriptions of its advertising campaigns to the DOH upon request.

C. Consumer Network Protections

1. Access to Out-of-Network Providers and Information. Consistent with Part H of Chapter 60 of the Laws of 2014 ("2014 Out-of-Network Bill"), Health Insurer Applicant and BHP Applicants must adhere to the following:

a. Health Insurer Applicant and BHP Applicants must hold its members harmless from liability for all out-of-network emergency (ER) bills. In addition, Health Insurer Applicant and BHP Applicant must hold its member harmless from liability for non-emergency (non-ER) surprise out-of-network bills: (i) for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center where an in-network provider is unavailable, or a non-participating physician renders services without a member's knowledge, or unforeseen medical circumstances arise (unless a participating physician is available and the member chose to obtain services from a non-participating physician); or (ii) whenever a participating physician refers a member to an out-of-network provider without the member's written consent.

b. Health Insurer Applicant and BHP Applicant shall allow its members to request a referral to an out-of-network provider, or request prior authorization to have a service provided by an out-of-network provider, when there is not an appropriate in-network provider available to the member.

c. Health Insurer Applicants and BHP Applicants must allow members to request:

- A standing referral to a specialist provider when the enrollee's condition requires ongoing care from the specialist provider;
- A referral to a specialist responsible for providing or coordinating the member's care when the member has a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which may require specialized medical care for a prolonged period of time; and
- Direct access to primary care services and preventive obstetric and gynecologic services within the network of providers without having to obtain a referral.

d. Health Insurer Applicant and BHP Applicant will provide its members with all grievance, utilization review and external appeal rights, including the ability to appeal a denial for an out-of-network referral and external appeal rights to denials for an out-of-network referral.

e. Health Insurer Applicant and BHP Applicant will provide to its members and to DOH information on cost-sharing and payments to providers with respect to any out-of-network coverage pursuant to 45 CFR 156.220(a)(7) and consistent with the 2014 Out-of-Network Bill. Health Insurer Applicant and BHP Applicant may use a treatment cost calculator to provide estimates of out of pocket expenses for receiving services at an out-of-network provider, provided such calculators provide the information required in 2014 Out-of-Network Bill. Upon request, Health Insurer Applicant and BHP Applicant will provide a URL link to its out-of-network treatment cost calculator.

2. Enhancements to Network Information. In addition to the Network Adequacy provisions set forth in Section II.F., all Applicants shall adhere to the following, unless otherwise specified:

a. Provider Directories. The Applicant shall maintain an up-to-date listing of providers, including facilities and specialty providers, participating in the QHPs offered through the Marketplace (the "Marketplace Provider Directory"). The Marketplace Provider Directory must include names, office addresses, telephone numbers, board certification for physicians any affiliations with participating hospitals, information on language capabilities and wheelchair accessibility of participating providers. The Marketplace Provider Directory should also identify providers that are considered Primary Care Physicians and identify providers that are not accepting new patients. Consistent with the 2014 Out-of-Network Bill, such directories shall be updated within

fifteen (15) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

The Applicant must make available to DOH a URL link that provides access to the Applicant's Marketplace Provider Directory. The directory must clearly identify the network of providers participating in the Marketplace QHPs or BHPs. If multiple network configurations are offered by the Health Insurer Applicant, the directories must clearly identify the network(s) for the particular QHP product(s). For example, if one network is used for an Applicant's standard QHP products, but a different network is used for one particular non-standard QHP product, the provider directory for the standard product and non-standard product must be distinct and identifiable to a consumer. The directories must distinguish this network(s) from other networks offered by the Applicant so a consumer using the directory can clearly and easily access the correct directory via the URL link provided to the Marketplace. For tiered networks, the directory must clearly identify the tier in which the provider participates.

b. Verification of Networks. The Applicant shall implement a system to periodically verify the accuracy of its reported Marketplace provider network(s). Such system may include, but not be limited to, direct outreach to providers listed by the Applicant as participating in Marketplace networks. The Applicant shall provide to the DOH the method and frequency with which it will carry out such verifications and report to the DOH the results of such verification efforts within a timeframe specified by DOH. The goals of such system are to validate participation by providers and to make sure providers are aware of their participation in Marketplace network(s).

c. Addressing Provider Directory Disputes. Applicants must develop and implement protocols to effectively address inquiries and complaints concerning provider directories. Applicants shall provide to the DOH the protocols developed within a timeframe specified by DOH.

d. Treatment Cost-Calculators for Participating Providers. The Health Insurer Applicant must have in place a treatment cost calculator available through an Internet Web site and such other means for individuals without access to the Internet. Such treatment cost calculators must be able to demonstrate enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual.

3. Prescription Drug Formularies. The Health Insurer Applicant and BHP Applicant must make available to DOH a URL link that provides access to the Applicant's Marketplace formulary. The link must be to an up-to-date listing of all covered drugs, and must clearly identify that the listing is applicable to Marketplace products. For example, if a formulary is used for the Individual Marketplace products and a separate formulary is used for the Small

Business Marketplace products, the lists must be distinct and clearly identifiable to the consumer. In addition, the formulary must clearly identify the applicable cost-sharing of the drugs, so that the consumer can easily identify that a particular drug will have the same cost sharing as the tier identified on the Marketplace or the drug is considered a preventive drug and has no cost-sharing. In addition, Health Insurer Applicants and BHP Applicants must comply with NY State Public Health Law Section 4406-c, and Insurance Law Sections 3216(i)(27), 3221(a)(16) and 4303(jj). Formularies will be reviewed to ensure the intent of the state law is being followed. Health Insurer Applicants and BHP Applicants should not place all prescription drugs to treat a specific condition on the highest tier, or should provide information to DOH or DFS to demonstrate that they are otherwise in compliance with 45 CFR §156.125 which prohibits discriminatory benefit designs.

D. Quality and Enrollee Satisfaction

The DOH will monitor the quality of care delivered by certified QHPs and BHP insurers. Monitoring will be ongoing and determined through use of a variety of quality, utilization and satisfaction metrics that have been validated, have clinical relevance to the populations served, and are widely in use by health plans serving other populations in New York State. Measuring performance across a wide range of quality metrics will ensure Marketplace members across the age spectrum and with various health conditions are included in this assessment. This process will also help to establish the DOH's active agenda for continuous quality improvement. Public reporting of Insurers' performance will also be a central feature of the DOH plan for quality oversight.

Outlined below are the DOH expectations related to quality of care and enrollee satisfaction for which the Health Insurer Applicant and BHP Applicant must adhere:

1. Develop and Maintain a Quality Strategy. Health Insurer Applicants and BHP Applicants must develop a quality strategy that encompasses all the requirements set forth in 1311(g) of the ACA. This strategy must be implemented, updated annually with progress reported to the designated office of the DOH. The quality strategy should describe how the Applicant will address the following:

a. The implementation of quality improvement activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

b. The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

c. The implementation of activities to improve health outcomes, and patient safety, as well as to reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

d. The implementation of wellness and health promotion activities;

e. The implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings; and

f. A description of any current or proposed innovative programs to expand access to mental health services including but not limited to telepsychiatry or consultative services for co-management of common behavioral health conditions in children and adults.

2. Quality Assurance Reporting Requirements. Applicant will be required to participate in the DOH Quality Assurance Reporting Requirements (QARR). The quality indicators in QARR are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance's (NCQA) Health Care Effectiveness Data and Information Set (HEDIS) with New York State-specific measures added to address health issues of importance to the State. QARR data will be used as a major component of Insurer quality rankings that will appear on the Marketplace website and will also be used in identifying clinical best practices, as well as, areas of concern with respect to quality of care and administering the health plan benefit package. The QARR data collected from Insurer will also be posted on the DOH website in eQARR and related publications.

The QARR technical specifications are released annually during the fall season of the measurement year, with reporting of QARR data due on or about the following June 15.

Applicant will be required to report quality measures as well as all other required member-level files. QARR reporting will require all Applicants to have:

(a) HEDIS Volume 2

(b) Programming for all required measures (either in-house capability of through a vendor)

(c) A HEDIS audit conducted by a licensed audit organization of their QARR data prior to submission to the DOH.

(d) A certified and federally approved CAHPS vendor to administer CAHPS

3. Consumer Assessment of Health Care Providers and Systems (CAHPS). Applicants will also be required to annually survey a sample of their Marketplace eligible members using the standardized CAHPS Health Plan Survey tool. The CAHPS Health Plan Survey allows the DOH to assess many aspects of the members' experience of care, including their access to care and services and their interactions with their providers and health plan. The DOH may add New York State-specific questions to the tool to aid the state in learning about newly insured's experience and/or to provide additional information. Like QARR, the DOH uses CAHPS data to identify any opportunities for improvement and DOH analyses of CAHPS data may require some plans to develop and implement quality improvement strategies.

4. Quality Improvement Initiatives. Applicants must have the infrastructure in place (or the ability to contract for such services) which allows them to implement their Quality Strategy and related improvement activities as well as participate in a variety of DOH sponsored quality improvement work. This could include administration of member's surveys, offering member education/outreach or incentive programs, offering physician training and/or incentive programs, supporting systematic changes at the practice level and practice level assessments among other things. Applicants will also be welcome to participate in DOH sponsored statewide improvement initiatives that target issues of importance such as readmissions, coordinated care for members with chronic disease, and other topics.

For Insurers with performance that falls outside normal ranges for quality or satisfaction performance, a barrier analysis and an improvement plan will need to be developed and operationalized once approved by the designated DOH office.

5. Accreditation. The DOH will not require Applicants to be accredited as a condition of participation in 2016.

E. Reporting

1. General. The Applicant will maintain a health information system that collects, analyzes and reports data. The system must be able to report on utilization, claims payment policies and practices, periodic financial disclosures, enrollment and disenrollment information, claim denials, customer service information, rating of provider practices, cost-sharing and payments with respect to out-of-network coverage, prescription drug distribution and cost reporting, quality and customer satisfaction reporting pursuant to the DOH reporting requirements, and any other information requested by the DOH and/or required under applicable federal and state laws or regulations.

2. Timing and Instructions for Reporting. The Applicant must submit required reports to the DOH in a manner consistent with federal requirements under Section 45 CFR Part 156, or as otherwise instructed by the DOH.

3. Encounter Data. Applicants will be required to submit encounter data for all contracted services obtained by each of their members. Encounters are records of each face-to-face interaction a member has with the health care system and includes, outpatient visits, inpatients admissions, dental care, emergency room and urgent care visits. Encounters for ordered services such as pharmacy and labs shall also be submitted. An encounter is comprised of the procedure(s) or service(s) rendered during the contact and includes information on site of service and may also include diagnosis information. An encounter should be operationalized in an information system as each unique occurrence of recipient and provider. Encounters are to be submitted on at least a monthly or more frequent basis through the DOH designated vendor in a format and manner to be prescribed by the DOH.

4. Financial Reporting. Applicant shall submit financial reports, including certified annual financial statements, and make available documents relevant to its financial condition to the DOH and DFS in a timely manner as required by State and federal laws and regulations. Applicant must agree to also submit separate premium and expenditure reports, and any additional relevant financial reports and documents related to its financial condition, in a manner and form required by the DOH.

F. Certification, Recertification and Decertification Process

1. Certification. The Marketplace will grant certification through SERFF and/or email notice. All Applicants that meet the requirements set forth in this Invitation, will have their health plans certified to be offered through the Marketplace.

2. Decertification. A Certified Insurer may be decertified if it fails to adhere to the certification standards set forth in this application, fails to resolve state agency sanctions, fails to comply with any applicable corrective action plan, or fails to recertify, and for any other reason set forth in the Agreement between DOH and the Insurer. Decertification shall occur in accordance with all applicable laws and regulations governing the removal of a product from the market, including notification to enrollees.

3. Non-renewal. Insurers may opt not to renew participation or products in the Marketplace. The Insurer must notify DOH of its decision to not renew in a manner and timeframe that consistent with existing state law, and in accordance with the Agreement between DOH and the Insurer. The Insurer must follow applicable laws and regulations in terminating the respective Insurer from the Marketplace, including notification to enrollees. The DOH will monitor the transition process, coordinating processes with Marketplace Customer Service and DFS to facilitate transition.

4. Suspension. The DOH may suspend enrollment in a health plan in the event a respective state agency requires suspension, or in the event the DOH determines it is in the

best interest of the public. Notification of such suspension shall occur in accordance with applicable laws and regulations.

SECTION 4.3 Federal and State Laws and Regulations

A. Federal Laws, Regulation and Guidance

The Applicant shall at all times strictly adhere to all applicable federal laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted, including the following:

- The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, respectively. The two laws are collectively referred to as the Affordable Care Act (ACA).
- 45 C.F.R. Parts 155 and 156 (2012) Marketplace establishment standards and other related standards under the Affordable Care Act, insurance standards under the Affordable Care Act, including standards related to Exchanges.
- Health Information Technology for Economic and Clinical Health Act of 2009
- Health Insurance Portability and Accountability Act of 1996
- The Privacy Act of 1974
- 42 CFR Part 600 and other related guidance and instruction

B. State Laws and Regulations

The Applicant shall at all times strictly adhere to all applicable state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted. Applicant acknowledges that such laws include, but are not limited to the following:

a) Contracts/Insurance Companies and Non-Profit Medical and Dental Indemnity Corporations

- N.Y. Insurance Law § 3201, 11 N.Y.C.R.R. 52.1, et. seq. (Approval of policy forms)
- N.Y. Insurance Law § 3231 (Rating of individual and small group health insurance policies; approval of superintendent)
- N.Y. Insurance Law § 4235, 11 N.Y.C.R.R. 52.2 (Group Accident and Health Insurance)
- N.Y. Insurance Law § 4308 (Supervision of Superintendent)

b) Access to Care

- N.Y. Public Health Law § 4403(5)(a), 10 N.Y.C.R.R. 98-1.13(b) (Health Maintenance Organizations, network adequacy)
- N.Y. Public Health Law § 4403(6)(a), 10 N.Y.C.R.R. 98-1.13(a)(Health Maintenance Organizations, access to appropriate providers)
- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.13(j)(Health Maintenance Organizations, emergency health services)
- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.6, 10 N.Y.C.R.R. 98-1.12 (Health Maintenance Organizations, quality management program)
- N.Y. Insurance Law § 4325 (Prohibitions)
- N.Y. Insurance Law § 3224-a (Standards for prompt, fair and equitable settlement of claims for health care and payments of health care services)
- The Out of Network Law, Chapter 60 of the Laws of 2014
- Health Insurance Coverage for the Treatment of Gender Dysphoria, DFS Insurance Circular Letter No. 7 (2014) (found here: http://www.dfs.ny.gov/insurance/circltr/2014/cl2014_07.pdf)
- Changes in Utilization Review Standards for Substance Use Disorder Treatment Pursuant to Chapter 41 of the Laws of 2014

c) Access to Information

- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.16 (Disclosure and filing)
- N.Y. Public Health Law § 4405-b (Duty to report)
- N.Y. Public Health Law § 4408 (Disclosure of information)
- N.Y. Public Health Law § 4910 (Right to external appeal)
- N.Y. Insurance Law § 4323 (Marketing material)
- N.Y. Insurance Law §§ 3217-a and 4324 (Disclosure of information)

C. Medicaid and Child Health Plus Programs

Applicants that also participate in the Medicaid Managed Care Program and the Child Health Plus Program shall adhere to the requirements of the respective programs. Nothing contained herein shall be interpreted to supersede the laws, regulations, guidance or instructions issued under the Medicaid Managed Care Program and Child Health Plus Program.

Section 4.4 Application Process

A. Issuing Agency
As stated in Part 1, this Invitation is issued by the DOH. DOH is responsible for the requirements specified herein and for processing all Applications in partnership with the DFS. This Invitation has been posted on the DOH Marketplace informational website.

DOH shall review Applications in an objective, comprehensive manner designed to benefit both the Marketplace and Applicants. The DOH intends that all Applications will be reviewed uniformly and consistently. For the purpose of its review, the DOH may seek assistance from any person, other than one associated with an Applicant.

B. Letters of Interest
Applicants are requested to submit non-binding Letters of Interest as soon as possible but no later than the date set forth in the Schedule of Key Events timetable contained on page 2 of this Invitation, via electronic or regular mail at the addresses set forth in paragraph C below. Submission of the Letter of Interest does **not** bind a prospective Applicant to submit an Application. If an Applicant would like to receive e-mail notification of updates/modifications to the Invitation, including the issuance of DOH responses to questions raised regarding the Invitation, the Applicant may include such request in their Letter of Interest. Form Letters of Interest are attached to this Invitation as Attachment D (Health Insurer Applicants and Stand-Alone Dental Applicants) and Attachment H (BHP Applicants). Applicants intending to offer both QHPs and BHPs must submit both Attachments.

C. Inquiries
All responses and requests for information concerning this Invitation by a prospective Applicant or an Applicant, or a representative or agent of a prospective Applicant or Applicant, should be directed to the contact listed below. In order for DOH to address questions efficiently, prospective Applicants are requested to send their inquiry in writing by email to the email address below. Inquiries of a technical nature may result in either a written response or a referral to the appropriate individual for a verbal response (e.g., guidance and assistance regarding use of the HCS System). To the extent possible, written questions concerning a specific requirement of the Invitation should cite the relevant section of the Invitation for which clarification is sought. Questions of this nature will be responded to by the DOH in writing and such questions and answers will be posted on the NY State of Health website (nystateofhealth.ny.gov), unless the party submitting a question maintains that the question/answer will contain confidential and/or proprietary information.

NAME: Invitation Administrator
EMAIL: nyhxpm@health.ny.gov

ADDRESS: NY State of Health
NYS Department of Health
Corning Tower, Suite 2378
Albany, New York 12237

D. Changes to the Application

The DOH reserves the right to:

1. Withdraw the Invitation at any time, at the DOH's sole discretion.
2. Disqualify any Applicant whose conduct and/or Application fails to conform to the requirements of this Invitation.
3. Seek clarifications and revisions of Applications. The DOH may require clarification from individual Applicants to assure a complete understanding of the Application and/or to assess the Applicant's compliance with the requirements in this Invitation.
4. At any time during the Invitation process, amend the Invitation to correct errors or oversights, and to supply additional information. Prospective Applicants are advised that at any time during the course of this application process, pertinent federal and state laws, regulations, and rules may change, and the protocol for using required systems such as SERFF and HCS may change. In addition, scheduled dates may need to be adjusted. All Prospective Applicants and Applicants will be informed of such changes, and Applicants may be directed to supply additional information in response to such amendments.

E. Submission of the Application

1. Application. As part of the certification process, Applicants are required to submit the following, which collectively constitutes the Application:

a. For Health Insurer Applicants and Stand-Alone Dental Plan Applicants:

(i) Participation Proposal
(ii) Submission of Policy Form and Rates to DFS for QHP Applicants
(iii)Submission of Policy Forms and SERFF Binders to DOH for BHP Applicants
(iv)Submission of Provider Network Information

b. For BHP Applicants:

(i) Participation Proposal
(ii) Submission of Policy Form
(iii) Submission of BHP Information Templates to DOH
(iv) Submission of Provider Network Information

Each of the component parts must be received by the due dates set forth in the Schedule of Key Events listed in this Invitation. Late submissions may not be accepted.

2. Instructions:

a. Participation Proposals. Applicants shall submit two (2) original, signed copies of the Participation Proposal by mail or hand delivery to the address listed above in Section 4.4 (c). Electronic submissions are also required and can be sent to the email address noted in Section 4.4 (c). Participation Proposals will not be accepted by fax. The Participation Proposal must be signed and executed by an individual with capacity and legal authority to bind the Applicant to the authenticity of the information provided. The Participation Proposal Form to be completed and submitted by Applicants is attached to this Invitation as Attachment E (Health Insurer Applicants and Stand-Alone Dental Applicants) and Attachment I (BHP Applicants). Applicants). Applicants applying to offer both QHPs and BHPs must complete both Attachments.

b. Submission of Policy Form and Rates to DFS for QHP Applicants. As set forth in Section 2.2, Marketplace products, rates and policy forms must be submitted to DFS per DFS instruction, which will be available on the DFS website.

c. Submission of Policy Form and Plan Information to DOH BHP Applicants. As set forth in Section3.1 (E), BHP Applicants will be required to submit BHP Policy Forms to DOH. BHP Applicants will also be required to submit Plan Information via DOH required templates. Policy Forms and Plan Information must be sent directly to the Applicant's assigned Plan Manager by August 31, 2015. .

d. Submission of Provider Network Information. As set forth in Section 4.1(G), Applicants shall submit their network through the Health Commerce System (HCS) in accordance with the Provider Network Submission Instructions contained in Attachment J to this Invitation.

e. Vendor Responsibility. On or around the same time Applicants submit Forms and Rates, Applicants that are applying for the first time will be notified of their responsibility to complete the New York State "vendor responsibility" process through the New York State VendRep System. The VendRep System Instructions are available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at https://portal.osc.state.ny.us. For direct VendRep System user assistance, the OSC Help Desk may be reached at 866-370-4672 or 518-408-4672 or by email at helpdesk@osc.state.ny.us.

F. Public Information

Disclosure of information related to this Invitation process and resulting contracts shall be permitted consistent with the laws of the State of New York and specifically the Freedom of Information Law (FOIL) contained in Article 6 of the Public Officers Law. Information constituting trade secrets or information that if disclosed would cause substantial injury to the competitive position of the subject enterprise for purposes of FOIL shall be clearly marked and

identified as such by the Applicant upon submission. Determinations regarding disclosure will be made when a request for such information is received by the DOH Records Access Office.

Section 4.5 Agreement with DOH

Following completion of the activities outlined in this Invitation and having been determined to have met all the requirements, the DOH will offer Applicants that are applying for the first time with the opportunity to enter into an Agreement. The Agreement resulting from this Invitation will be effective only upon approval of the New York State Office of the Attorney General (OAG) and the Comptroller of the State of New York (OSC). Applicants must enter into an Agreement with the DOH in order for their products to be certified and to offer such health plans through the Marketplace.

New York Essential Health Benefits

SERVICE	LIMIT
Outpatient Services	
PCP Office Visits (Injury or Illness)	No Limit
Specialist Visits	No Limit
Other Practitioner Office Visit (Nurse, Physician Assistant)	No Limit
Outpatient Surgery Physician/Surgical Services	No Limit
Hospice Services	210 days/year; also includes 5 Bereavement Counseling sessions for members family either before or after the death of the member.
Home Health Care Services	40 visits/year
Emergency Services	
Emergency Room Services	No Limit
Urgent Care Centers or Facilities	No Limit
Emergency Transportation/Ambulance	No Limit
Hospitalization	
Preadmission Testing	No Limit
Inpatient Hospitalization	No Limit
Inpatient Physician and Surgical Services	No Limit
Skilled Nursing Facility	200 days/year
Delivery and all Inpatient Services for Maternity Care	No Limit
Mental Health and Substance Use Disorder Services	
Mental/Behavioral Health Outpatient Services	No Limit
Mental/Behavioral Health Inpatient Services (including residential treatment)	No Limit
Substance Use Disorder Outpatient Services	No Limit
Substance Use Disorder Inpatient Services (including residential treatment)	No Limit
Prescription Drugs	
Enteral Formulas	No Limit
Generic Drugs	30 day supply per month *Mail Order up to a 90 day supply optional benefit
Preferred Brand Drugs	30 day supply per month *Mail Order up to a 90 day supply optional benefit
Non-Preferred Brand Drugs	30 day supply per month *Mail Order up to a 90 day supply optional benefit
Specialty Drugs	30 day supply per month *Mail Order up to a 90 day supply optional benefit
Off Label Cancer Drugs	30 day supply per month

SERVICE	LIMIT
Rehabilitative and Habilitative Services and Devices	
Outpatient Rehabilitation Services	60 visits per condition per lifetime
Habilitation Services	60 visits per condition per lifetime
Chiropractic Care	No Limit
Durable Medical Equipment	**Coverage for standard equipment only. DME defined as Equipment which is 1) Designed and intended for repeated use, 2) primarily and customarily used to serve a medical purpose, 3) Generally not useful to person in the absense of disease or injury, and 4) is appropriate for use in the home.
Inpatient Rehabilitation Services	1 consecutive 60 day period per condition per lifetime in a rehabilitation facility. * Inpatient Short Term Rehabilitative Services (Physical, speech and occupational therapy).
Hearing Aids	Limited to a single purchase (including repair/replacement) every three years. *Bone anchored hearing aids are excluded except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.
Prosthetic Devices - External	One (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts. Coverage includes wigs for members suffering from severe hairloss due to injury or disease or treatment of a disease (e.g. chemotherapy); coverage is available only for synthetic wig materials unless member is allergic to all synthetic wig materials
Internal Prosthetic Devices	Covered if improves or restores function of internal body part; includes implanted breast protheses; includes repair and replacement.
Laboratory and Imaging Services	
Diagnostic Test (X-Ray and Lab Work)	No Limit
Imaging (CT/PET Scans, MRI'I)	No Limit

SERVICE	LIMIT
Preventive and Wellness Services and Chronic Disease Management	
Preventive Care/Screening/Immunization	Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. per NYS mandates and ACA.
Gym Membership Reimbursement	$200/$100 every 6 months for member/spouse * Partial reimbursement for facility fees every 6 months if member attains at least 50 visits. ** May be substituted for other wellness benefits
Prenatal and Postnatal Care	No Limit
Pediatric Vision	
General Pediatric Services	Emergency, preventive and routine vision care
Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	The vision examination may include, but is not limited to: * Case history * Internal and External examination of the eye * Ophthalmoscopic exam * Determination of refractive status * Binocular balance * Tonometry tests for glaucoma * Gross visual fields and color vision testing * Summary findings and recommendations for corrective lenses
Prescription Lenses	At a minimum, quality standard prescription lenses provided by a physician, optometrist or optician are to be covered once in any twelve month period, unless required more frequently with appropriate documentation. The lenses may be glass or plastic lenses.
Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation.
Contact Lenses	Covered when medically necessary.
Pediatric Dental	
Emergency Dental Care	Includes emergency treatment required to alleviate pain and suffering caused by dental disease and trauma.
Checkup for Children (Preventive Dental Care)	Includes procedures which help prevent oral disease from occurring, including but not limited to: * Prophylaxis: scaling and polishing teeth at 6 month intervals * Topical fluoride application at 6 month intervals where local water supply is not fluorinated * Sealants on unrestored permanent molar teeth

SERVICE	LIMIT
	* Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed detention to maintatin space for normally developing permanent teeth.
Basic Dental Care - Child (Routine Dental Care)	* Dental examinations, visits and consultations covered once within 6 month consecutive period (when primary teeth erupt)
	* X-ray, full mouth x-rays or panoramic x-ray at 36 month intervals, bitewing x-rays at 6-12 month intervals; and other x-rays as required (once primary teeth erupt)
	* All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including preoperative care and postoperative care
	* In office conscious sedation
	* Amalgam, composite restorations and stainless steel crowns
	* Other restorative materials appropriate for children
Major Dental Care - Child (Endodontics and Prosthodontics and Periodontics)	Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.
	Removable: Complete or partial dentures including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.
	Fixed: Fixed bridges are not covered unless
	1) Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
	2) Required for cleft-palate treatment or stabilization; or
	3) Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
Orthodontia (Orthodontics)	NOTE: Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.
	Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.
	Orthodontia coverage is not covered if the child does not meet the criteria described above.
	Procedures include but are not limited to:
	* Rapid Palatal Expansion (RPE)
	* Placement of component parts (e.g. brackets, bands)
	* Interceptive orthodontic treatment

SERVICE	LIMIT
	* Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted) * Removable appliance therapy * Orthodontic retention (removal of appliances, construction and placement of retainers)
Other Services	
Infertility Treatment	Member must be between ages of 21 and 44.
	* Covered services include: initial evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram, treatment of ovulatory dysfunction, ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy and laparotomy, semen analysis, laboratory evaluation, endometrial biopsy, pelvic ultrasound, sono-hystogram, testis biopsy, blood test
	** Advanced Infertility is not covered.
Elective Termination of Pregnancy	1 treatment/year
	* Therapeutic termination of pregnancy unlimited
Family Planning Service for Women	No Limit
Sterilization Procedures for Men	No Limit
Chemotherapy	No Limit
Dialysis	No Limit
Breast reconstructive surgery following mastectomy, lumpectomy, or lymph node dissection	No Limit
Mastectomy Care	Length of stay for lymph node dissection, lumpectomy or mastectomy as determined by the patient and physician.
Diabetic equipment, supplies, education and self-management	No Limit
Autism spectrum disorder screening, diagnosis and treatment	Coverage includes ABA treatment and Assistive Communication Devices
Reconstructive and corrective surgery	Surgery to correct a congenital birth defect of dependent child or incidental to surgery or follows surgery necessitated by trauma, infection or disease.
Second Opinion (surgical)	Second surgical opinion on the need for surgery.
Second Opinion (Specialist - cancer)	Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer.
Medical Supplies	As required for the treatment of a disease or injury, including maintenance supplies

SERVICE	LIMIT
Transplants	No Limit
	* Solely for transplants for surgeries determined to be non-experimental and non-investigational.
Oral Surgery	No Limit
	* Oral Surgery due to injury is limited to sound natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a severe functional impairement and surgical/nonsurgical medical procedures for temporomandibular joint discorders and orthognathic surgery

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART (4-15-2015)

NOTE: The standard plan design descriptions are based on current understanding of HHS Regulations and the Actuarial Value Calculator (Final version for 2016) and NYS Laws/Regulations.
The Catastrophic plan design was revised to reflect the official OOP maximum of $6,850 (single) for calendar year 2016.

TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	Silver CSR 200 - 250 % FPL (AV = 0.72 to 0.74)	Bronze (AV = 0.58 to 0.62)	HSA Compliant Bronze * (AV = 0.58 to 0.62)	Catastrophic	Indian CSR $0 Cost Sharing <= 300% FPL
DEDUCTIBLE (single)	$0	$600	$2,000	$1,500	$3,500	$4,000	$6,850	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	$4,000	$5,500	$5,450	$6,850	$6,450	$6,850	$0
COST SHARING - MEDICAL SERVICES								
Inpatient Facility/SNF/Hospice	$500 per admission	$1,000 per admission	$1,500 per admission	$1,500 per admission	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Outpatient Facility-Surgery, including freestanding surgicenters	$100	$100	$100	$100	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	$100	$100	$100	$100	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery. See also "Maternity delivery and post natal care-physician/midwife" under "physician services".							
PCP	$15	$25	$30	$30	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Specialist	$35	$40	$50	$50	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
PT/OT/ST - rehabilitative & habilitative therapies	$25	$30	$30	$30	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
ER	$100	$150	$150	$150	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Ambulance	$100	$150	$150	$150	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Urgent Care	$55	$60	$70	$70	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
DME/Medical supplies	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hearing aids	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Eyewear	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
INPATIENT HOSPITAL SERVICES								
Observation stay/observation care unit	ER copay per case, copay is waived if direct transfer from outpatient surgery setting to an observation care unit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hospital services - non-maternity	Inpatient Facility copay per admission #				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Maternity care stay (covers mother and well newborn combined)	Inpatient Facility copay per admission #				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	Inpatient Facility copay per admission #				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Detoxification	Inpatient Facility copay per admission #				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	Inpatient Facility copay per admission #				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Skilled nursing facility	Inpatient Facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hospice (inpatient)	Inpatient Facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
EMERGENCY MEDICAL SERVICES								
Facility charge - Emergency Room	ER copay per case - copay is waived if patient is admitted as an inpatient (including as an observation stay or to an observation care unit) directly from the emergency room				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART (4-15-2015)

TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	Silver CSR 200 - 250 % FPL (AV = 0.72 to 0.74)	Bronze (AV = 0.58 to 0.62)	HSA Compliant Bronze * (AV = 0.58 to 0.62)	Catastrophic	Indian CSR $0 Cost Sharing <= 300% FPL
Physician charge - Emergency Room visit	$0 copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Facility charge - Freestanding urgent care center	Urgent Care copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Physician charge - Free standing urgent care center visit	$0 copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Prehospital emergency services/ transportation, includes air ambulance	Ambulance copay per case				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
OUTPATIENT HOSPITAL/FACILITY SERVICES								
Outpatient facility surgery - hospital facility charge, including freestanding surgicenters	Outpatient Facility-Surgery copay per case				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Pre-admission/pre-operative testing	$0 copay				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Home care	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hospice	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
PREVENTIVE & PRIMARY CARE SERVICES								
Bone density testing Cervical cytology Colonoscopy screening Gynecological exams Immunizations Mammography Prenatal maternity care Prostate cancer screening Routine exams Women's preventive health services	NOTE: For preventive care visits/services as defined in section 2713 of ACA no deductible or cost sharing applies. Otherwise the cost sharing indicated below applies to all services in this benefit service category. PCP/Specialist copay per visit (based on type of physician performing the service)				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
PHYSICIAN/PROFESSIONAL SERVICES								
Inpatient hospital surgery - surgeon	Surgeon copay per case				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Outpatient hospital and freestanding surgicenter - surgeon	Surgeon copay per case				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing applies				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Additional surgical opinion	Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART (4-15-2015)

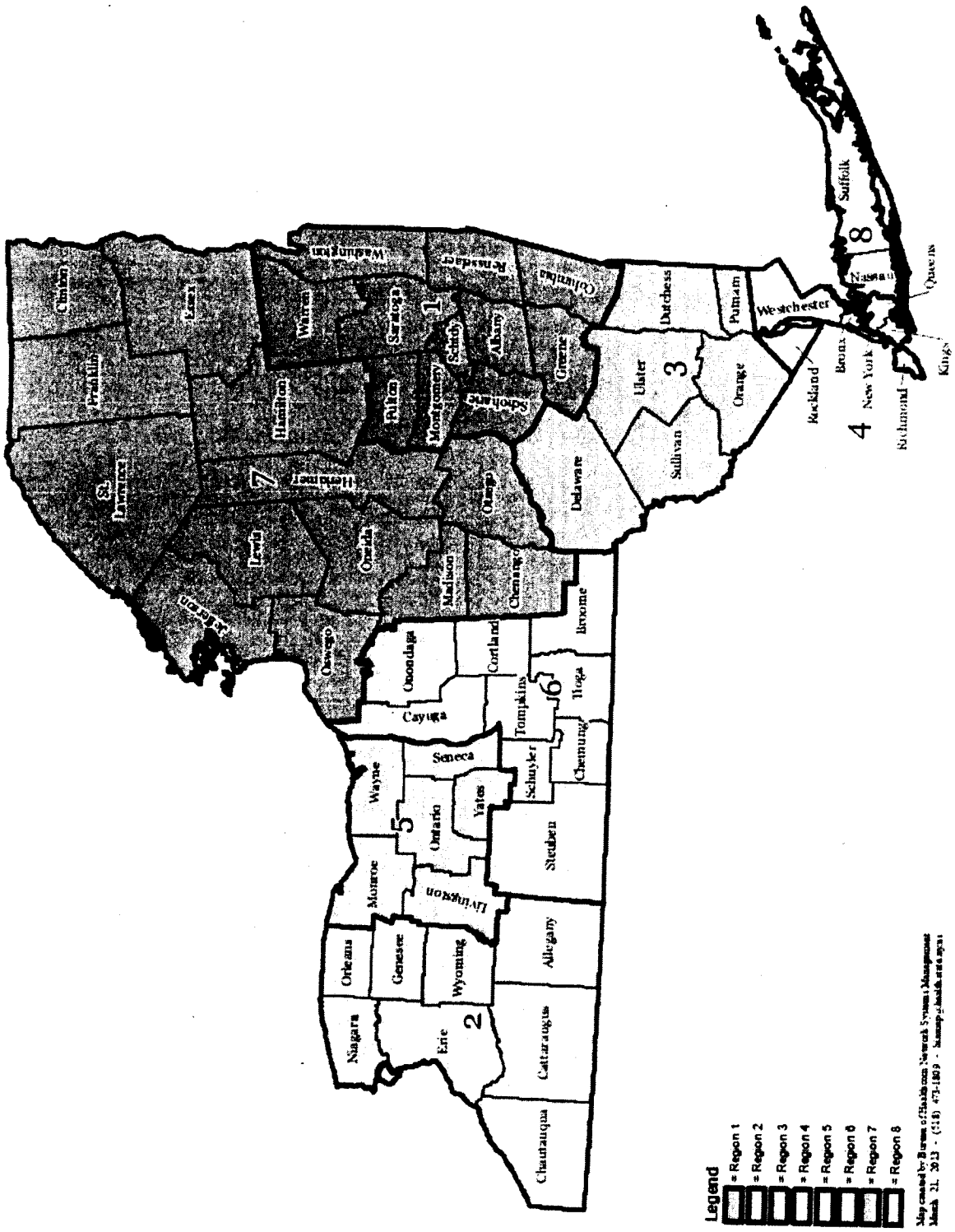
TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	Silver CSR 200 - 250 % FPL (AV = 0.72 to 0.74)	Bronze (AV = 0.58 to 0.62)	HSA Compliant Bronze * (AV = 0.58 to 0.62)	Catastrophic	Indian CSR $0 Cost Sharing <= 300% FPL
Second medical opinion for cancer	Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Maternity delivery and post natal care - physician or midwife	Surgeon copay per case for delivery and post natal care services combined (only one such copay per pregnancy)				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
In-hospital physician visits	$0 copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	PCP/Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Allergy testing	PCP/Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Allergy shots	PCP/Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Office/outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Chiropractic care	Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
ADDITIONAL BENEFITS/SERVICES								
ABA treatment for Autism Specturm Disorder	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Assistive Communiciation Devices for Autism Spectrum Disorder	PCP copay per device				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hearing evaluations/testing	Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hearing aids	Hearing aid coinsurance cost sharing applies				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Diabetic drugs and supplies	PCP copay per 30 days supply				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Diabetic education and self-management	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Home care	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member/spouse. Partial reimbursement for facility fees every six months if member attains at least 50 visits.							
PEDIATRIC DENTAL SERVICES								
Dental office visit	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
PEDIATRIC VISION SERVICES								
Eye exam visit	PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Prescribed lenses and frames	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Contact lenses	Eyewear coinsurance cost sharing applies				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
PRESCRIPTION DRUGS								
Generic or Tier 1	$10	$10	$10	$10	$10	$10	0% cost sharing	0% cost sharing
Formulary Brand or Tier 2	$30	$35	$35	$35	$35	$35	0% cost sharing	0% cost sharing
Non-Formulary Brand or Tier 3	$60	$70	$70	$70	$70	$70	0% cost sharing	0% cost sharing
Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic Plans) for a 90 day supply								

Attachment B   STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART (4-15-2015)

<u>Additional Instructions:</u>

The following applies to the Platinum, Gold, Silver and Silver-CSR Plans:
For an inpatient admission the only copay that applies during an inpatient stay is the inpatient facility per admission copay, and if surgery is performed a surgeon copay, and if a maternity delivery is performed a maternity delivery copay which is the same as the surgeon copay if this copay has not already been collected as part of another maternity related claim.
There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc.
For a maternity stay the inpatient per admission copay covers charges for the mother and a well newborn.
The inpatient facility copay per admission is waived for a re-admission within 90 days of a previous discharge for the same or a related condition.
For all the standard plan designs, the deductible must be met first, and then the cost sharing copay or coinsurance is applied to the remainder of the allowed amount until the maximum out of pocket limit is reached.
If the copay payable is more than the allowed amount (or remainder of the allowed amount), the copay payable is reduced to the allowed amount (or to the remainder of the allowed amount).
The maximum out of pocket limit is an aggregate over all covered services (medical, pediatric dental, pediatric vision, and prescription drugs), and includes the deductible.
The deductible is over a calendar year for individual products and over the calendar year or plan year (option of insurer) for small group products.
For the Platinum, Gold, Silver and Silver-CSR Plans the deductible applies only to medical, pediatric dental, and pediatric vision services (including lenses/frames), and does not apply to prescription drugs.
For the Bronze and Catastrophic Plans the deductible applies to all services combined (medical, pediatric dental, pediatric vision (including lenses/frames), and prescription drugs).
No deductible or cost sharing applies to the preventive care visits/services defined in section 2713 of ACA.
Per ACA the Catastrophic Plan must include 3 primary care visits per calendar year to which the deductible does not apply.
These 3 primary care visits are in addition to the ACA mandated preventive services for which no cost sharing can apply.
These 3 primary care visits are covered in full by the insurance plan (i.e., no deductible and no cost sharing).
The family deductible is two times the single deductible and the family out-of-pocket limit is two times the single maximum out-of-pocket limit. The plan designs below are non-HSA plan designs and each family member is subject to a maximum deductible equal to the single deductible and to a maximum out-of-pocket limit equal to the single out-of-pocket limit. Once all members of the family in aggregate meet the family deductible amount (or family out-of-pocket limit amount) then no family member needs to accumulate any more dollars towards the deductible (or out-of-pocket limit).
Note: The pediatric dental cost sharing indicated is when pediatric dental is included as part of the standard design medical QHP plan. A stand-alone pediatric dental plan will have its own deductible and cost sharing arrangements and associated premium.

* HSA Compliant Bronze plan satisfies the maximum out-of-pocket limit of $6,450 set by IRS for calendar year 2015.


Legend
= Region 1
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Suffolk
Nassau
Queens
Kings
Westchester
Putnam
Dutchess
Ulster
Orange
Rockland
Bronx
New York
Richmond
Sullivan
Delaware
Broome
Tioga
Chemung
Schuyler
Seneca
Tompkins
Cortland
Onondaga
Cayuga
Oswego
Madison
Chenango
Otsego
Herkimer
Oneida
Lewis
St. Lawrence
Franklin
Clinton
Essex
Hamilton
Fulton
Montgomery
Schoharie
Schenectady
Albany
Greene
Columbia
Rensselaer
Washington
Warren
Saratoga
Livingston
Steuben
Allegany
Cattaraugus
Chautauqua
Erie
Niagara
Orleans
Genesee
Wyoming
Monroe
Ontario
Yates
Wayne

REVISED ATTACHMENT C

New York Standardized Rating Regions

Qualified Health Plans and Stand-Alone Dental Plans

Region 1 (Albany Area) Albany Columbia Fulton Greene Montgomery Rensselaer Saratoga Schenectady Schoharie Warren Washington	**Region 2 (Buffalo Area)** Allegany Cattaraugus Chautauqua Erie Genesee Niagara Orleans Wyoming	**Region 3 (Mid-Hudson Area)** Delaware Dutchess Orange Putnam Sullivan Ulster
Region 4 (New York City Area) Bronx Kings New York Queens Richmond Rockland Westchester	**Region 5 (Rochester Area)** Livingston Monroe Ontario Seneca Wayne Yates	**Region 6 (Syracuse Area)** Broome Cayuga Chemung Cortland Onondaga Schuyler Steuben Tioga Tompkins
Region 7 (Utica/Watertown Area) Chenango Clinton Essex Franklin Hamilton Herkimer Jefferson Lewis Madison Oneida Oswego Otsego St. Lawrence	**Region 8 (Long Island Area)** Nassau Suffolk	

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ATTACHMENT D
LETTER OF INTEREST FOR QUALIFIED HEALTH PLAN OR STAND ALONE DENTAL PLAN PARTICIPATION IN THE NY STATE OF HEALTH

The following form should be completed and returned to the Authorized Contact person no later than the time set forth in the Invitation.

I, _____, an authorized representative of _____, Applicant, have read the Invitation and Requirements for Application or Recertification for Participation in the NY State of Health (Marketplace) and I am submitting this Letter of Interest to participate in the Marketplace for calendar years 2016 on behalf of Applicant.

Name:
Title:
Company:
Address:
Telephone:
E-mail Address:
Date:
Signature:

☐ Check this box if you would like notification of schedule changes, updates and other modifications of the Invitation to Participate in the NY State of Health sent to the above e-mail address.

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The Official Health Plan Marketplace

ATTACHMENT E

2016 PARTICIPATION PROPOSAL
QUALIFIED HEALTH PLANS AND STAND ALONE DENTAL PLANS

All Applicants must submit the following information to the e-mail address set forth in Section 4.4 (C) of the Invitation. Answers should be completed within this Participation Proposal Form, unless otherwise directed.

1. Participation.

Indicate below whether Applicant is participating in the Individual Marketplace, Small Business Marketplace or both, and the type of Applicant. If the Applicant is applying as both a Health Insurer Applicant and a Stand-Alone Dental Applicant, submit two separate participation proposals.

PARTICIPANT TYPE	EXCHANGE
☐ Health Insurer Applicant	☐ Individual
☐ Stand-Alone Dental Applicant	☐ SHOP
☐ CO-OP	

2. Organization

a) Identify below the legal entity that will be responsible for offering products in each Exchange and its current license or certification. If Applicant anticipates licensure prior to November 15, 2015, identify what type of licensure is anticipated.

b) Identify whether the same legal entity currently contracts with the State Department of Health for the Child Health Plus and/or Medicaid Program, and if so, identify the program(s).

c) Identify any entities that will be involved in the administration of the QHPs and briefly describe the roles of such entities. Include in this section any entity the Applicant is using to satisfy coverage of essential health benefits (e.g., pediatric vision), and for Health Insurer Applicants, any entity used to satisfy the provision of offering out-of-network benefits.

3. Summary of Products Offered

Health Insurer Applicants, indicate the total number of products at each metal level (do not include catastrophic products and child-only products) that you are applying to offer in the Marketplace:

INDIVIDUAL EXCHANGE		SHOP EXCHANGE	
Metal Tier	Number	Metal Tier	Number
Bronze		Bronze	
Silver		Silver	
Gold		Gold	
Platinum		Platinum	

Identify whether the Bronze Standard offered in 2015 was HSA eligible:

☐ Yes ☐ No

Identify whether Health Insurer Applicant will be offering an additional Bronze product in 2016 to maintain HSA eligibility:

☐ Yes ☐

Stand-Alone Dental Carrier Applicants, provide the anticipated number of products that you are applying to offer in the Marketplace:

INDIVIDUAL EXCHANGE		SHOP EXCHANGE	
Category	Number	Category	Number
Pediatric		Pediatric	
Pediatric		Pediatric	
Adult/Family (NS)		Adult/Family (NS)	
Adult/Family (NS)		Adult/Family (NS)	

4. Addendum Submissions

A. Health Insurer Applicants:

a) Provide the following information:

- *Addendum 1* - For each Standard and Non-Standard Product offered through the Individual Marketplace, provide the Name of the Applicant and place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2016, highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2016 (i.e. a new non-standard product), highlight the column in yellow indicating the new product

- *Addendum 2* - For each Non-standard product, regardless of whether it was offered in 2016, complete Addendum 2, 2016 Non-Standard Product Descriptions, to describe how the benefit is being modified per Section 2.1 (D)(1)(g) of the Invitation.

- Provide a list of each standard and non-standard product offered in the Marketplace by using the Product Name (including the naming convention outlined in the Invitation) and the 14 digit HIOS ID. The listing must be provided in excel spreadsheet format and one tab must be used for the Individual Marketplace and a separate tab for the Small Business Marketplace as applicable.

b) DOH reserves the right to request a copy of all final documents submitted through SERFF and approved by DFS as part of the Rate and Form Filings. Copies may be needed by the DOH for review of consistency with this Application, archival purposes, and to ensure that benefit and rate information is displayed accurately and timely on the Marketplace.

d) Indicate below your intent to offer a Catastrophic Plan in each county of Applicant's service area:

☐ Yes, Health Insurer Applicant intends to offer a catastrophic plan

☐ No, Health Insurer Applicant prefers not to offer a catastrophic plan

C. Stand-alone Dental Products

a) Provide the following information:

- *Addendum 3* - Provide the name of Applicant and place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2016, highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2016 (i.e. a new non-standard product), highlight the column in yellow indicating the new product. Note that each Applicant must provide a Pediatric Dental Product in each county of the Applicant's service area

- Provide a list of each standard and non-standard product offered in the Marketplace by using the Product Name and the 14 digit HIOS ID. The listing must be provided in excel spreadsheet format and one tab must be used for the Individual Marketplace and a separate tab for the Small Business Marketplace as applicable. Clearly identify the products as Pediatric only or Adult/Family.

5. URL links

Provide URL links for the following areas:

- Plan Brochures/QHP Descriptions (if applicable)
- Summary(ies) of Benefits
- Provider Directory
- Pharmacy Formulary
- Treatment Cost Calculator

6. Plan Contacts

Provide a contact who will be responsible for each of the areas identified below. Include their name, title, telephone number and email address:

- Product/form submissions
- Network adequacy
- Provider Directories
- Quality submissions
- Customer Service/Call Center Issues
- Pharmacy submissions
- Enrollment Transactions
- Billing issues
- Encounter submissions

The following must be signed and executed by an individual with the capacity and legal authority to bind the Applicant to the authenticity of the information provided.

I, _____, hereby attest that I have been duly authorized to execute this Participation Proposal on behalf of Applicant, and to the best of my knowledge, the information and data provided by Applicant in response to the Invitation and Requirements for Participation in the NY State of Health, the Official health Plan Marketplace (the "Invitation") is accurate, true, and complete. I understand that the NY State of Health will rely on my statements above in reviewing the Participation Proposal and the related information and data submitted in response to the Invitation. In completing the certification process set forth in the Invitation, Applicant shall at all times strictly adhere to all applicable federal and state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted.

_____
Print Name

_____
Print Title

_____
Signature

_____
Date

ATTACHMENT F - BHP PRODUCT OFFERING AND COST-SHARING

Cost Sharing Chart

TYPE OF SERVICE	Essential Plan1 150 - 200% FPL	Essential Plan 2 139 - 150% FPL	Essential Plan 3 100-138% FPL	Essential Plan 4 Below 100% FPL
DEDUCTIBLE (single)	$0	$0	$0	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	$200	$200	$200
COST SHARING - MEDICAL SERVICES				
Inpatient Facility/SNF/Hospice	$150 per admission	$0 per admission	$0 per admission	$0 per admission
Outpatient Facility-Surgery, including freestanding surgicenters	$50	$0	$0	$0
Surgeon - Inpatient facilty, outpatient facility, including freestanding surgicenters	$50	$0	$0	$0
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient			
PCP	$15	$0	$0	$0
Specialist	$25	$0	$0	$0
PT/OT/ST - rehabilitative & habilitative therapies	$15	$0	$0	$0
ER	$75	$0	$0	$0
Ambulance	$75	$0	$0	$0
Urgent Care	$25	$0	$0	$0
DME/Medical supplies	5% cost sharing	$0	$0	$0
Hearing aids	5% cost sharing	$0	$0	$0
Non-emergency transportation	N/A	N/A	$0	$0
Non-prescription drugs	N/A	N/A	$1	$0
Adult dental (Preventive Dental Care; Routine Dental Care and Major Dental Care)	$15	$0	$0	$0
Vision care - Exams	$15	$0	$0	$0
Vision care - Lenses and Frames	10% Coinsurance	$0	$0	$0
Vision care - Contact Lenses	10% Coinsurance	$0	$0	$0
INPATIENT HOSPITAL SERVICES				
Observation stay/observation care unit	ER copay per case, copay is waived if direct transfer from outpatient surgery setting to an observation care unit			
Hospital services - non-maternity	Inpatient Facility copay per admission#			
Maternity care stay (covers mother and well newborn combined)	Inpatient Facility copay per admission#			
Mental health/Behavorial health care	Inpatient Facility copay per admission#			
Detoxification	Inpatient Facility copay per admission#			
Substance abuse disorder services	Inpatient Facility copay per admission#			
Skilled nursing facility	Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility			
Hospice (inpatient)	Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility			
EMERGENCY MEDICAL SERVICES				
Facility charge - Emergency Room	ER copay per case - copay is waived if patient is admitted as an inpatient (including as an oberservation care unit) directly from the emergency room			
Physician charge - Emergency Room visit	$0 copay per visit			
Facility charge - Freestanding urgent care center	Urgent care copay per visit			
Physician charge - Free standing urgent care center visit	$0 copay per visit			
Prehospital emergency services/ transportation, includes air ambulance	Ambulance copay per case			

ATTACHMENT F - BHP PRODUCT OFFERING AND COST-SHARING

Cost Sharing Chart

TYPE OF SERVICE	BHP Cost-Sharing 1 150 - 200% FPL	BHP Cost-Sharing 2 139 - 150% FPL	BHP Cost-Sharing 3 100-138% FPL	BHP Cost-Sharing 4 Below 100% FPL
OUTPATIENT HOSPITAL/FACILITY SERVICES				
Outpatient facility surgery - hospital facility charge, including freestanding surgicenters	Outpatient Facility-Surgery copay per case			
Pre-admission/pre-operative testing	$0 copay			
Diagnostic and routine laboratory and pathology	Specialist copay per visit			
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	Specialist copay per visit			
Imaging: CAT/PET scans, MRI	Specialist copay			
Chemotherapy	PCP copay per visit			
Radiation therapy	PCP copay per visit			
Hemodialysis/Renal dialysis	PCP copay per visit			
Mental health/Behavorial health care	PCP copay per visit			
Substance abuse disorder services	PCP copay per visit			
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit			
Home care	PCP copay per visit			
Hospice	PCP copay per visit			
PREVENTIVE & PRIMARY CARE SERVICES				
Bone density testing	NOTE: For preventive case visits/servics as defined in section 2713 of ACA no deductible or cost sharing applies. Otherwise the cost sharing indicated below applies to all services			
Cervical cytology				
Colonoscopy screening				
Gynecological exams				
Immunizations	PCP/Specialist copay per visit (based on type of physician performing the service)			
Mammography				
Prenatal maternity care				
Prostate cancer screening				
Routine exams				
Women's preventive health services				
PHYSICIAN/PROFESSIONAL SERVICES				
Inpatient hospital surgery - surgeon	Surgeon copay per case			
Outpatient hospital and freestanding surgicenter - surgeon	Surgeon copay per case			
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)			
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing applies			
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit			
Additional surgical opinion	Specialist copay per visit			
Second medical opinion for cancer	Specialist copay per visit			
Maternity delivery and post natal care - physician or midwife	Surgeon copay per case for delivery and post natal care services combined (only one such copay per pregnancy)			
In-hospital physician visits	$0 copay per visit			
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)			
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit			
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	PCP/Specialist copay per visit			
Imaging: CAT/PET scans, MRI	Specialist copay per visit			
Allergy testing	PCP/Specialist copay per visit			
Allergy shots	PCP/Specialist copay per visit			
Office/outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)			
Mental health/Behavorial health care	PCP copay per visit			
Substance abuse disorder services	PCP copay per visit			
Chemotherapy	PCP copay per visit			
Radiation therapy	PCP copay per visit			
Hemodialysis/Renal dialysis	PCP copay per visit			
Chiropractic care	Specialist copay per visit			

ATTACHMENT F - BHP PRODUCT OFFERING AND COST-SHARING

Cost Sharing Chart

TYPE OF SERVICE	BHP Cost-Sharing 1 150 - 200% FPL	BHP Cost-Sharing 2 139 - 150% FPL	BHP Cost-Sharing 3 100-138% FPL	BHP Cost-Sharing 4 Below 100% FPL
ADDITIONAL BENEFITS/SERVICES				
ABA treatment for Autism Specturm Disorder	PCP copay per visit			
Assistive Communiciation Devices for Autism Spectrum Disorder	PCP copay per visit			
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies			
Hearing evaluations/testing	Specialist copay per visit			
Hearing aids	Hearing aid coinsurance cost sharing applies			
Diabetic drugs and supplies	PCP Copay per 30 days supply			
Diabetic education and self-management	PCP copay per visit			
Home care	PCP copay per visit			
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member. Partial reimbursement for facility fees every six months if member attains at least 50			
PRESCRIPTION DRUGS				
Generic or Tier 1	$6	$1	$1	$0
Formulary Brand or Tier 2	$15	$3	$3	$0
Non-Formulary Brand or Tier 3	$30	$3	$3	$0
Above are retail copay amounts; mail order copays are 2.5 times retail for a 90 day supply				

Additional Instructions:

*Benefits identified in *italics* are available to individuals who purchase a Standard BHP Plus Vision/Dental and to individuals at or below 138% of FPL not eligible to Medicaid due to immigration status

* For an inpatient admission the only copay that applies during an inpatient stay is the inpatient facility per admission copay, and if surgery is performed a surgeon copay, and if a maternity delivery is performed a maternity delivery which is the same as the surgeon copy if this copay has not already been collected as part of another maternity related claim

* There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc.

*For a maternity stay the inpatient per admission copay covers charges for the mother and a well newborn.

*The inpatient facility copay per admission is waived for a re-admission within 90 days of a previous discharge for the same or a related condition.

*If the copay payable is more than the allowed amount (or remainder of the allowed amount), the copay payable is reduced to the allowed amount (or to the remainder of the allowed amount).

*The maximum out of pocket limit is an aggregate over all covered services (medical and prescription drugs).

*No cost sharing applies to the preventive care visits/services defined in section 2713 of ACA.

REVISED ATTACHMENT G
New York Standardized Rating Regions
Basic Health Plan

Region 1 (NYC Metro) Bronx Kings New York Queens Richmond	**Region 2** (Long Island) Nassau Suffolk	**Region 3** (Northern Metro) Putnam Rockland Westchester
Region 4 (Mid-Hudson) Dutchess Orange Sullivan Ulster	**Region 5** (Northeast) Albany Fulton Montgomery Rensselaer Saratoga Schenectady Warren Washington	**Region 6** (Utica-Adirondack) Clinton Essex Franklin Hamilton Herkimer Jefferson Lewis Oneida Oswego St. Lawrence
Region 7 (Central) Cayuga Chenango Columbia Cortland Delaware Greene Madison Onondaga Otsego Schoharie Tompkins	**Region 8** (Finger Lakes) Allegany Broome Cattaraugus Chautauqua Chemung Livingston Ontario Schuyler Seneca Steuben Tioga Wayne Yates	**Region 9** (Western) Erie Genesee Monroe Niagara Orleans Wyoming

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ATTACHMENT H
LETTER OF INTEREST FOR BASIC HEALTH INSURANCE PLAN PARTICIPATION

The following form should be completed and returned to the Authorized Contact person no later than the time set forth in the Invitation.

I, _____, an authorized representative of _____, Applicant, have read the Invitation and Requirements for Recertification for Participation in the NY State of Health (Marketplace) and I am submitting this Letter of Interest to participate in the Basic Health Program for calendar years 2016 on behalf of Applicant.

Name:
Title:
Company:
Address:
Telephone:
E-mail Address:
Date:
Signature:

☐ Check this box if you would like notification of schedule changes, updates and other modifications of the Invitation to Participate in the NY State of Health sent to the above e-mail address.

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ATTACHMENT I

2016 PARTICIPATION PROPOSAL
BASIC HEALTH INSURANCE PLANS

All Applicants must submit the following information to the e-mail address set forth in Part 3 of the Invitation. Answers should be completed within this Participation Proposal Form, unless otherwise directed. Completion of this Participation Proposal does not bind the Applicant to participate in the Basic Health Program (BHP). Per Section 3.1(D)(3)(a), Applicant will have ten (10) business days following the determination of its capitation rate to notify the DOH of its final determination to participate in BHP.

1. Participation.

Indicate below whether Applicant is also participating in the Individual Marketplace, Small Business Marketplace or both, and the type of Applicant. If the Applicant is applying as both a Health Insurer Applicant and a BHP Applicant, two separate participation proposals must be sent to DOH.

PARTICIPANT TYPE		EXCHANGE	
☐	Health Insurer Applicant	☐	Individual
☐	CO-OP	☐	SHOP

2. Organization

a) Identify below the legal entity that will be responsible for offering products in each Exchange and its current license or certification. If Applicant anticipates licensure prior to November 15, 2015, identify what type of licensure is anticipated.

b) Identify whether the same legal entity currently contracts with the State Department of Health for the Child Health Plus and/or Medicaid Program, and if so, identify the program(s).

c) Identify any entities that will be involved in the administration of the BHP Plan and briefly describe the roles of such entities. Include in this section any entity the Applicant is using to satisfy coverage of the BHP benefits (e.g., adult vision), and any entity the Applicant is using to accept and transmit enrollment information.

3. Summary of Products Offered

Identify whether BHP Applicant will be offering the BHP Standard Plan, or both the BHP Standard Plan and the BHP Standard Plus Adult Vision/Dental.

☐ BHP Standard Plan ☐ Both BHP Standard Plan and BHP Standard

4. Identification of Service Area

A. Service Area. Identify whether BHP Applicant will be using its Commercial Service Area or its Medicaid Service Area.

☐ Commercial Service Area ☐ Medicaid Service Area

B. Identification of Counties: Provide the following information on *Addendum 1* - For the Standard and Standard Plus Adult Vision/Dental Product offered, provide the Name of the Applicant and place an x in each box indicating each product you will offer in each county.

5. URL links

Provide URL links for the following areas:

- Plan Brochures/QHP Descriptions (if applicable)
- Summary(ies) of Benefits

- Provider Directory
- Pharmacy Formulary
- Treatment Cost Calculator

6. Plan Contacts

Provide a contact who will be responsible for each of the areas identified below. Include their name, title, telephone number and email address:

- Product/form submissions
- Network adequacy
- Provider Directories
- Quality submissions
- Customer Service/Call Center Issues
- Pharmacy submissions
- Enrollment Transactions
- Billing issues
- Encounter submissions

ATTESTATION TO PARTICIPATION PROPOSAL

The following must be signed and executed by an individual with the capacity and legal authority to bind the Applicant to the authenticity of the information provided.

I, ____, hereby attest that I have been duly authorized to execute this Participation Proposal on behalf of Applicant, and to the best of my knowledge, the information and data provided by Applicant in response to the Invitation and Requirements for Participation in the NY State of Health, the Official health Plan Marketplace (the "Invitation") Basic Health Program is accurate, true, and complete. I understand that the NY State of Health will rely on my statements above in reviewing the Participation Proposal and the related information and data submitted in response to the Invitation. In completing the certification process set forth in the Invitation, Applicant shall at all times strictly adhere to all applicable federal and state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted.

____
Print Name

____
Print Title

____
Signature

____
Date

Instructions: Place an x in each box indicating each product you will offer in each county.

Addendum I.1 - BHP - 2016 Counties

Applicant Name:

	BHP Standard	BHP ST + Adult Vision/Dental
Albany		
Allegany		
Bronx		
Broome		
Cattaraugus		
Cayuga		
Chautauqua		
Chemung		
Chenango		
Clinton		
Columbia		
Cortland		
Delaware		
Dutchess		
Erie		
Essex		
Franklin		
Fulton		
Genesee		
Greene		
Hamilton		
Herkimer		
Jefferson		
Kings		
Lewis		
Livingston		
Madison		
Manhattan		
Monroe		
Montgomery		
Nassau		
Niagara		
Oneida		
Onondaga		
Ontario		
Orange		
Orleans		
Oswego		
Otsego		
Putnam		
Queens		
Rensselaer		

Instructions: Place an x in each box indicating each product you will offer in each county.

Addendum I.1 - BHP - 2016 Counties

Applicant Name:

	BHP Standard	BHP ST + Adult Vision/Dental
Richmond		
Rockland		
St. Lawrence		
Saratoga		
Schenectady		
Schoharie		
Schuyler		
Seneca		
Steuben		
Suffolk		
Sullivan		
Tioga		
Tompkins		
Ulster		
Warren		
Washington		
Wayne		
Westchester		
Wyoming		
Yates		

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ATTACHMENT J
Provider Network Submission Instructions

A. Participating Provider Network Reports:

The Provider Network Data System (PNDS) was implemented by the New York State Department of Health (DOH) in December of 1996 to gather information about the provider and service networks contracted to Health Insurers operating in New York State. PNDS is accessed through an Internet connection to the Health Commerce System (HCS), also known as the Health Provider Network (HPN), a secure Intranet site requiring an ID and password.

The primary purpose for the PNDS is to collect data needed to evaluate the provider networks including physicians, hospitals, labs, home health agencies, durable medical equipment providers, etc., for all types of Health Insurers in New York State.

Applicants shall submit electronically, to the Health Commerce System (HCS), an updated provider network report on a quarterly basis for all plan types offered through the NYSOH. Applicants shall also submit an annual notarized attestation that the providers listed in each submission have executed an agreement with the NYSOH Participant to serve the Participant's Enrollees. The report submission must comply with the Provider Network Data Dictionary. Networks must be reported separately for each county in which the Applicant operates and on a product-by-product basis.

B. Uses of PNDS Data:

1. Provider eligibility assessment:
PNDS data is matched against information on professional licensing, Office of Professional Medical Care sanctions, and Medicaid and Medicare provider eligibility, to assure that only qualified providers are delivering health care to plan members. Facilities are checked for valid operating certificate numbers, verifying that operating certificate numbers match the type of facility indicated.

2. Comprehensive services assessment:
DOH conducts network assessments to assure that comprehensive health services are available as required under Section 4403 of the Public Health Law. The NY State of Health uses data from the PNDS to assess whether a plan has contracted with an appropriate range of primary care practitioners, clinical specialists and service facilities (hospitals, labs, etc.) within the plan's service area. Evaluations are completed on plans serving all populations.

3. Provider Directory Look-up Tool for NYSOH:
The information supplied through the PNDS system is presented to consumers as a tool they can use to select a QHP. Consumers have the ability to search for their provider and obtain a listing of QHPs in which the provider participates.

C. Connection to the Health Commerce System (HCS) and Provider Network Data System (PNDS)

Connection to the PNDS is through a secure connection within the Health Commerce System, at *https://commerce.health.state.ny.us/hcsportal/appmanager/hcs/*home. All users must have an HCS account, and access to the PNDS page. The first time a user attempts to access the PNDS page they will be prompted with an access permission form, which they must fill out and submit. It takes about ten (10) days to obtain an HCS account once the notarized forms are received by the Department of Health. PNDS access forms are processed daily. NYSOH Applicants having difficulty accessing the PNDS page can contact Joe Gagnon at (518) 486-9158 for further assistance.

D. Data Submission Schedule

Provider network submissions are a snapshot of the network taken the week of the quarter in which the last day falls. For the purposes of the NYSOH PNDS submissions, quarters end on approximately January 31, April 30, July 31, and October 31. The snapshot week includes the last day wherever it falls in the week. For example, if the 31st is a Wednesday, the week would be the 29th through the 2nd.

NYSOH Certified QHP Insurers will have at least 15 business days after the end of each quarter, to submit their regular data files. Test submissions may be submitted at any time. Other submissions, including corrections and service area expansions, are submitted on an as needed basis and may be requested by contacting the Office of the New York State of Health at nyhxpm@health.state.ny.us, or by contacting Joe Gagnon at **Joseph.Gagnon@health.ny.gov**

E. Updates to Provider Network Information

Consistent with the 2014 Out-of-Network Bill, such directories shall be updated within fifteen (15) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

Essential Plan Program (EPP) Template Submission Instructions

The EPP templates are available on the NYSoH Plan Invitation page with the exception of the prescription drug template that can be found on the CMS website. The instructions for submitting the templates are included below. Each issuer should submit ONE set of templates for all of the EPP products they are offering i.e. both the standard and the EPP plus Vision and Dental versions. The templates are required for the information to be displayed on the NYSOH web portal, the review process, for enrollment transmission, and for payment by eMedNY.

Once all of the templates are completed, place the templates in a password encrypted zipped folder and email the folder to your plan manager followed by an email to your plan manager with the password. The templates should be in the file format indicated in the instructions below. The naming convention for each template should be Issuer ID_TemplateName i.e. 12345_AdminTemplate.csv

General Instructions for EPP Template Submission

Submission Requirements: Each issuer must submit the following templates:

Admin Template	Collects general company and contact information.
Plans Template	Collects plan IDs, plan type, and other information.
Prescription Drug Template	Collects formulary data for plans.
Service Area Template	Information identifying an issuer's geographic service area.
Rate Template	Collects rates necessary for display on the web portal.

Template Instructions

Admin Template

General Instructions: This template must be submitted to in csv format.

The chart below contains a listing of all fields that are included on the Admin Template. The column headings below contain the following data:

- Field Name – this is the name of the data element used by the NYSOH.
- Field Size – this indicates the type of data allowed (9, X or datesize) and provides the maximum field length (the number in parentheses). 9 = numeric (should be all numbers). X = alpha-numeric (can have numbers and letters). Date size = a date in YYYY/MM/DD format.

- R/O – indicates if the field is required or optional.
- Field Description – provides the description of the field including any specific valid values that may be allowed or additional rules that may apply.

TEMPLATE COLUMN	FIELD NAME	FIELD SIZE	R/O	FIELD DESCRIPTION
A	HIOS Issuer ID	9(5)	R	Entry must be the 5 digit HIOS Issuer ID assigned by HIOS or by NYSoH Plan Management for those that do not offer QHPs through the Marketplace.
B	Company Legal Name	X(1000)	R	Enter the full legal name of the insurance company, service or organization.
C	FEIN	X(9)	R	Enter the Federal Employer Identification Number (FEIN) or Tax Identification Number (TIN) of the Issuer.
D	Issuer Marketing Name	X(1000)	R	Enter the name of the company used for marketing purposes.
E	Issuer Address1	X(200)	R	Enter the address of the Issuer.
F	Issuer Address2	X(200)	O	Enter the address of the Issuer.
G	Issuer Address3	X(200)	O	Enter the address of the Issuer.
H	Issuer City	X(50)	R	Enter the city of the Issuer's address.
I	State	X(2)	R	Enter the state abbreviation of the Issuer's address. Must be alpha (A-Z) uppercase. Must be a valid state abbreviation.
J	Zip Code	X(5)	R	Enter the zip code of the Issuer's address.
K	Lock Box Address 1	X(200)	R	Enter the address used to receive payment of EPP premium.
L	Lock Box Address 2	X(200)	O	Enter address 2 if appropriate.
M	Lock Box City	X(50)	R	Enter the city of the address used to receive payment of EPP premium.
N	Lock Box State	X(2)	R	Enter the state of the address used to receive payment of EPP premium. Must be alpha (A-Z). Must be a valid state abbreviation.
O	Zip Code	X(5)	R	Enter the zip code of the address used to receive payment of EPP premium.
P	Issuer State of Domicile	X(2)	R	Enter the state abbreviation to identify the state where the Issuer is legally located. Must be alpha (A-Z) uppercase. Must be a valid state abbreviation.
Q	Consumer Facing Website URL	X(250)	R	Enter the URL for the company consumer-facing web site. Must be in valid URL format as per market standards. Must begin with "http" or "https".

Plans Template

General Instructions: You will complete one row with each these fields completed for EACH HIOS Plan ID you are submitting. This template must be submitted in csv format.

The chart below contains a listing of all fields that included on the Plans Template. The column headings below contain the following data:

- Field Name – this is the name of the data element used by the NYSOH.
- Field Size – this indicates the type of data allowed (9, X, or datesize) and provides the maximum field length (the number in parentheses). 9 = numeric (should be all numbers). X = alpha-numeric (can have numbers and letters). Date size = a date in YYYY/MM/DD format.
- R/O – indicates if the field is required or optional.
- Field Description – provides the description of the field including any specific valid values that may be allowed or additional rules that may apply.

TEMPLATE COLUMN	FIELD NAME	FIELD SIZE	R/O	FIELD DESCRIPTION
A	HIOS Plan ID	X(17)	R	This ID is 17 characters and will be assigned by Plan Management. It must be exactly 17 characters. First 5 digits of this ID must match the HIOS Issuer ID. The next 2 characters will be EP to identify EPP. The next 7 digits are as follows: 0000001 for Standard EPP plans and 0000002 for Non-Standard EPP plans (the plans with Vision and Dental). Last 2 digits must contain a value of -50-55 for Standard Plans and -52-55 for Non-Standard Plans. The -50-55 variant must be used for the corresponding population identified in the Example set forth below.
B	Standard vs Non-Standard Plan	X(20)	R	Entry will be the word "Standard" or "Non-Standard"; Non-Standard will be used for plans with Vision and Dental
C	Plan Year	9(4)	R	Enter the 4 digit plan year to identify the coverage year. This entry must be 2016.
D	Plan Marketing Name	X(400)	R	Enter the name of the product used by the Issuer for marketing purposes i.e. Essential Plan 1, Essential Plan 1 Plus Vision and Dental
E	Service Area ID	X(6)	R	Enter the corresponding Service Area ID assigned in the Service Area Template. This entry will be NYS001.
F	Plan Type	X(20)	R	Enter EPP to identify the Essential Plan Program.
G	URL for Enrollment and Payment	X(250)	O	Enter the URL that can be used by the member if they need information on where to make a payment. If

				populated, must be in valid URL format as per market standards. Must begin with "http" or "https".
H	Plan Effective Start Date	Date Size	R	Enter 2016/01/01 in this exact format.
I	Plan Effective End Date	Date Size	R	Enter 2016/12/31 in this format.
J	Customer Service Toll Free Number	X(15)	R	Enter the customer service toll free telephone number. Numbers separated by dashes.
K	Customer Service TTY	X(15)	R	Enter the customer service TTY telephone number. Numbers separated by dashes.
L	Formulary URL	X(250)	R	Enter the URL for this formulary or prescription drug list. Must be in valid URL format as per market standards. Must begin with "http" or "https".
M	Provider URL	X(250)	R	Enter the provider search URL. Must be in valid URL format as per market standards. Must begin with "http" or "https".
N	Plan Status			Leave this field blank

Example of HIOS Plan IDs

Based on the instructions above, issuers must submit at least the following HIOS Plan IDs, and the variants set forth below must be assigned to the population identified.

Standard EPP HIOS Plan IDs	
Aliessa 0 – 100% FPL	12345EP0000001-50
Aliessa 100-138% FPL	12345EP0000001-51
EPP 138 – 150% FPL AI/AN	12345EP0000001-52
EPP 138 – 150% FPL	12345EP0000001-53
EPP 150 – 200% FPL AI/AN	12345EP0000001-54
EPP 150 – 200% FPL	12345EP0000001-55
Non-Standard EPP (EPP Plus Vision and Dental) HIOS Plan IDs	
EPP 138 – 150% FPL AI/AN	12345EP0000002-52
EPP 138 – 150% FPL	12345EP0000002-53
EPP 150 – 200% FPL AI/AN	12345EP0000002-54
EPP 150 – 200% FPL	12345EP0000002-55

Service Area Template

1. Enter the 14 digit HIOS Issuer ID and State. Each variation of the HIOS ID will use the same service area.

2. Click the Create Service Area IDs button. Each issuer should have only ONE service area as they must offer their EPP products in every county of their service area.
3. After inputting the HIOS Issuer ID and state the template will create NYS001 in the Service Area ID column. Select that service area ID.
4. Enter the Service Area Name: EPP Service Area
5. Indicate whether the Service Area covers the entire state.
6. If the Service Area does not cover the entire state, then select a county that is within the Service Area.
7. Repeat steps 3-6 for every county within the Service Area.
8. Once you have entered each county in the service area, click the "validate" button to confirm that the template is filled out completely.
9. Once the template is validated, click the "Finalize" button on the template to create the XML version the template. You will need to submit the XML version of the template to NYSoH along with the XLS version.

Prescription Drug Template

1. Enter the HIOS Issuer ID and State.
2. Click the Create Formulary IDs button. A pop up box will ask the issuer to indicate the number of formularies it has. An issuer can create as many Formulary IDs as needed to reflect the varying cost-sharing for prescription drugs. The cost-sharing has a one to one match with the Formulary ID. The same drug list can be reused for each formulary or additional drug lists can be created for different Formulary IDs.
3. Select the Formulary ID in the first box from the drop down menu.
4. Enter the URL for the Formulary on the issuer's website. If a working URL has not yet been developed for the particular Formulary identified, a test link URL will be sufficient for the SERFF submission. For the NYSOH filings, the URL must clearly identify the formulary is for the Marketplace and/or the Marketplace QHPs, and a working URL will be needed prior to certification.
5. Switch to the Drug List sheet. Enter the RXCUI on the drug list and indicate the tier level of the drug. Indicate whether the drug requires preauthorization or step therapy.
6. Add as many drug lists as needed.
7. Switch back to the Formulary Tiers sheet. Select the Drug List ID from the drop down menu.
8. Indicate the number of tiers on the formulary. A formulary may not contain more than three tiers.
9. Indicate the drug tier type from the menu of choices. Select all that apply.
10. Fill in the remaining cost sharing information as appropriate. Leave any cost sharing fields (out-of-network fields for example) blank that do not apply.
11. The Standard Benefit Design Mail Order Cost-Sharing template will not accept values that are not whole numbers. Round up any cost sharing amounts to whole numbers.
12. Inadequate Count in a Category or Class of Prescription Drugs: If the issuer determines that the formulary they are submitting has an inadequate number of prescription drugs in a category or class, then the issuer must provide an explanation. For example, if vaccines are covered as a medical benefit, rather than a prescription drug, an explanation is required. The explanation may be submitted as a separate document attached on the Supporting Documentation Tab.

Rate Template

General Instructions: This template should be submitted in XLSX format. Enter each HIOS ID in column A, followed by the applicable Rating Area ID in column B, followed by the Rate in Column C and the amount the consumer will owe in Column D. You will have at a minimum 6 rows if you only offer the standard plan in one region. You will have a maximum of 81 rows if you offer the standard and non-standard plan in all 9 rating regions. The listing of the EPP Rating Regions can be found on the NYSoH Plan Invitation Page.

The chart below contains a listing of all fields that included on the Rates Template. The column headings below contain the following data:

- Field Position: This is the cell where the Field Name is located
- Field Name – this is the name of the data element used by the NYSOH.
- Field Size – this indicates the type of data allowed (9,X or datesize) and provides the maximum field length (the number in parentheses). 9 = numeric (should be all numbers). X = alpha-numeric (can have numbers and letters). Date size = a date in YYYY/MM/DD format.
- R/O – indicates if the field is required or optional.
- Field Description – provides the description of the field including any specific valid values that may be allowed or additional rules that may apply.

FIELD POSITION	FIELD NAME	FIELD SIZE	R/O	FIELD DESCRIPTION
B6	HIOS Issuer ID	9(5)	**R**	Entry must be the 5 digit HIOS Issuer ID assigned by HIOS or by DOH Plan Management for those that do not use SERFF.
B7	FEIN	X(9)	**R**	Enter the Federal Employer Identification Number (FEIN) or Tax Identification Number (TIN) of the Issuer.
B8	Rate Effective Date	Date Size	**R**	Enter the effective date of the rate for this plan. YYYY/MM/DD Format. This field must have the special character "/" and will be 2016/01/01
B9	Rate Expiration Date	Date Size	**R**	Enter the expiration date of the rate for this plan. YYYY/MM/DD Format. This field must have the special character "/" and will be 2016/12/31.
A14 – 19 (minimum for standard plan in one rating region)	HIOS Plan ID	X(17)	**R**	This ID is 17 characters assigned by Plan Management.
B14 -19 (minimum for standard plan in one rating region)	Rating Area ID	X	**R**	This field will be a drop down populated with values for the nine EPP rating areas as follows:

				Rating Area 1 Rating Area 2 Rating Area 3 Rating Area 4 Rating Area 5 Rating Area 6 Rating Area 7 Rating Area 8 Rating Area 9
C14 – 19 (minimum for standard plan in one rating region)	Subsidized Rate	9(10,2)	**R**	Enter the premium amount DOH will pay the issuer for this plan minus any consumer responsibility for the HIOS ID in A14 in the region listed in B14. Example: if the HIOS ID is for a plan variation where the consumer pays $20 and the full premium is 400, the amount in this field should be 380.
D14 -19 (minimum for standard plan in one rating region)	Consumer Responsibility	9(6,2)	**O**	Must contain dollar amount or blank. Do not include dollar signs. Standard plans would have the following inputs: -50: blank -51: blank -52: blank -53: blank -54: 20 -55: 20

2016 Service Area v5.02

*All fields with an asterisk (*) are required*

To validate, press the Validate button or Ctrl + Shift + I. To finalize, press the Finalize button or Ctrl + Shift + F
Click Create Service Area IDs button (or Ctrl + Shift + R) to create service area ids based on your state
Service Area IDs will populate in the drop-down box in Service Area ID column
For each row, enter one County for that Service Area ID (unless the Service Area covers entire state)

HIOS Issuer ID:*	
Issuer State:*	

Service Area ID*	Service Area Name*	State*	County Name	Partial County
Required: Enter the Service Area ID	**Required:** Enter the Service Area Name	**Required:** Does this Service Area cover the entire state?	**Required if State is "No":** Select the County - FIPS this Service Area covers	**Required if State is "No":** Does this Service Area include a partial county?

2016 Rates Table Template v1.0

HIOS Issuer ID	
Federal TIN	
Rate Effective Date	
Rate Expiration Date	

Plan ID **Required:** Enter the 17-character Plan ID	**Rating Area ID** **Required:** Select the Rating Area ID	**Subsidized Rate** **Required:** Enter the premium set by DOH	**Consumer Responsibility** **Required** Enter the rate that is the consumer responsibility amount

HIOS Issuer ID	Company Legal Name	FEIN	Issuer Marketing Name	Issuer Address 1	Issuer Address 2	Issuer Address 3	Issuer City	State	Zip Code	Lock Box Address 1	Lock Box Address 2	Lock Box City	Lock Box State	Zip Code	Issuer Stat Domicil

HIOS Plan ID	Standard vs Non-Standard Plan	Plan Year	Plan Marketing Name	Service Area ID	Plan Type	URL for Enrollment and Payment	Plan Effective Start Date	Plan Effective End Date	Customer Service Toll Free Number	Customer Service TTY

Instructions: Place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2016 highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2016 (i.e. a new non-standard product), highlight the column indicating the new NS product.

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Addendum E II: Qualified Health Plan by County - SHOP Exchange

Applicant Name:

	Bronze Standard	Silver Standard	Gold Standard	Platinum Standard	Bronze Standard w Child Dental	Silver Standard w Child Dental	Gold Standard w Child Dental	Platinum Standard w Child Dental	Bronze NS1	Silver NS1	Gold NS1	Platinum NS1	Bronze NS1 w Child Dental	Silver NS1 w Child Dental	Gold NS1 w Child Dental	Platinum NS1 w Child Dental	Bronze NS2	Silver NS2	Gold NS2	Platinum NS2	Bronze NS2 w Child Dental	Silver NS2 w Child Dental	Gold NS2 w Child Dental	Platinum NS2 w Child Dental	Bronze NS3	Silver NS3	Gold
Albany																											
Allegany																											
Bronx																											
Broome																											
Cattaraugus																											
Cayuga																											
Chautauqua																											
Chemung																											
Chenango																											
Clinton																											
Columbia																											
Cortland																											
Delaware																											
Dutchess																											
Erie																											
Essex																											
Franklin																											
Fulton																											
Genesee																											
Greene																											
Hamilton																											
Herkimer																											
Jefferson																											
Kings																											
Lewis																											
Livingston																											
Madison																											
Manhattan																											
Monroe																											

Instructions: Place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2016 highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2016 (i.e. a new non-standard product), highlight the column indicating the new NS product.

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Attachment E1 - Qualified Health Plans by County - SHOP Exchange

Applicant Name:

	Bronze Standard	Silver Standard	Gold Standard	Platinum Standard	Bronze Standard w Child Dental	Silver Standard w Child Dental	Gold Standard w Child Dental	Platinum Standard w Child Dental	Bronze NS1	Silver NS1	Gold NS1	Platinum NS1	Bronze NS1 w Child Dental	Silver NS1 w Child Dental	Gold NS1 w Child Dental	Platinum NS1 w Child Dental	Bronze NS2	Silver NS2	Gold NS2	Platinum NS2	Bronze NS2 w Child Dental	Silver NS2 w Child Dental	Gold NS2 w Child Dental	Platinum NS2 w Child Dental	Bronze NS3	Silver NS3	Gold
Montgomery																											
Nassau																											
Niagara																											
Oneida																											
Onondaga																											
Ontario																											
Orange																											
Orleans																											
Oswego																											
Otsego																											
Putnam																											
Queens																											
Rensselaer																											
Richmond																											
Rockland																											
St. Lawrence																											
Saratoga																											
Schenectady																											
Schoharie																											
Schuyler																											
Seneca																											
Steuben																											
Suffolk																											
Sullivan																											
Tioga																											
Tompkins																											
Ulster																											
Warren																											
Washington																											

Instructions: Place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2016, highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2016 (i.e. a new non-standard product), highlight the column indicating the new product.

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Addendum E: Qualified Health Plans by County and Individual Exchange

Applicant Name:

	Bronze Standard	Silver Standard	Gold Standard	Platinum Standard	Catastrophic	Bronze Standard w Child Dental	Silver Standard w Child Dental	Gold Standard w Child Dental	Platinum Standard w Child Dental	Catastrophic w Child Dental	Bronze Child Only	Silver Child Only	Gold Child Only	Platinum Child Only	Bronze NS1	Silver NS1	Gold NS1	Platinum NS1	Bronze NS1 w Child Dental	Silver NS1 w Child Dental	Gold NS1 w Child Dental	Platinum NS1 w Child Dental	Bronze NS2	Silver NS2	Gold NS2	Platinum NS2	Bronze NS2 w Child Dental	Silver NS2 w Child Dental	Gold NS2 w Child Dental	Platinum NS2 w Child Dental	Bronze NS3	Silve NS3
Wayne																																
Westchester																																
Wyoming																																
Yates																																

Instructions: Place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2016, highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2016 (i.e. a new non-standard product), highlight the column indicating the new product.

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Addendum E.1 Qualified Health Plan by County - Individual Exchange

Applicant Name:

	Bronze Standard	Silver Standard	Gold Standard	Platinum Standard	Catastrophic	Bronze Standard w Child Dental	Silver Standard w Child Dental	Gold Standard w Child Dental	Platinum Standard w Child Dental	Catastrophic w Child Dental	Bronze Child Only	Silver Child Only	Gold Child Only	Platinum Child Only	Bronze NS1	Silver NS1	Gold NS1	Platinum NS1	Bronze NS1 w Child Dental	Silver NS1 w Child Dental	Gold NS1 w Child Dental	Platinum NS1 w Child Dental	Bronze NS2	Silver NS2	Gold NS2	Platinum NS2	Bronze NS2 w Child Dental	Silver NS2 w Child Dental	Gold NS2 w Child Dental	Platinum NS2 w Child Dental	Bronze NS3	Silve NS3
Albany																																
Allegany																																
Bronx																																
Broome																																
Cattaraugus																																
Cayuga																																
Chautauqua																																
Chemung																																
Chenango																																
Clinton																																
Columbia																																
Cortland																																
Delaware																																
Dutchess																																
Erie																																
Essex																																
Franklin																																
Fulton																																
Genesee																																
Greene																																
Hamilton																																
Herkimer																																
Jefferson																																
Kings																																
Lewis																																
Livingston																																
Madison																																
Manhattan																																
Monroe																																

Instructions: Place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2016, highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2016 (i.e. a new non-standard product), highlight the column indicating the new product.

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Addendum B – Qualified Health Plan by County Individual Exchange

Applicant Name:

	Bronze Standard	Silver Standard	Gold Standard	Platinum Standard	Catastrophic	Bronze Standard w Child Dental	Silver Standard w Child Dental	Gold Standard w Child Dental	Platinum Standard w Child Dental	Catastrophic w Child Dental	Bronze Child Only	Silver Child Only	Gold Child Only	Platinum Child Only	Bronze NS1	Silver NS1	Gold NS1	Platinum NS1	Bronze NS1 w Child Dental	Silver NS1 w Child Dental	Gold NS1 w Child Dental	Platinum NS1 w Child Dental	Bronze NS2	Silver NS2	Gold NS2	Platinum NS2	Bronze NS2 w Child Dental	Silver NS2 w Child Dental	Gold NS2 w Child Dental	Platinum NS2 w Child Dental	Bronze NS3	Silve NS2
Montgomery																																
Nassau																																
Niagara																																
Oneida																																
Onondaga																																
Ontario																																
Orange																																
Orleans																																
Oswego																																
Otsego																																
Putnam																																
Queens																																
Rensselaer																																
Richmond																																
Rockland																																
St. Lawrence																																
Saratoga																																
Schenectady																																
Schoharie																																
Schuyler																																
Seneca																																
Steuben																																
Suffolk																																
Sullivan																																
Tioga																																
Tompkins																																
Ulster																																
Warren																																
Washington																																

Instructions: Place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2016 highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2016 (i.e. a new non-standard product), highlight the column indicating the new NS product.

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Addendum E - Qualified Health Plans by County - SHOP Exchange

Applicant Name:

	Bronze Standard	Silver Standard	Gold Standard	Platinum Standard	Bronze Standard w Child Dental	Silver Standard w Child Dental	Gold Standard w Child Dental	Platinum Standard w Child Dental	Bronze NS1	Silver NS1	Gold NS1	Platinum NS1	Bronze NS1 w Child Dental	Silver NS1 w Child Dental	Gold NS1 w Child Dental	Platinum NS1 w Child Dental	Bronze NS2	Silver NS2	Gold NS2	Platinum NS2	Bronze NS2 w Child Dental	Silver NS2 w Child Dental	Gold NS2 w Child Dental	Platinum NS2 w Child Dental	Bronze NS3	Silver NS3	Gold
Wayne																											
Westchester																											
Wyoming																											
Yates																											

APPENDIX D-1

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ATTACHMENT I

2016 PARTICIPATION PROPOSAL
BASIC HEALTH INSURANCE PLANS

All Applicants must submit the following information to the e-mail address set forth in Part 3 of the Invitation. Answers should be completed within this Participation Proposal Form, unless otherwise directed. Completion of this Participation Proposal does not bind the Applicant to participate in the Basic Health Program (BHP). Per Section 3.1(D)(3)(a), Applicant will have ten (10) business days following the determination of its capitation rate to notify the DOH of its final determination to participate in BHP.

1. Participation.

Indicate below whether Applicant is also participating in the Individual Marketplace, Small Business Marketplace or both, and the type of Applicant. If the Applicant is applying as both a Health Insurer Applicant and a BHP Applicant, two separate participation proposals must be sent to DOH.

PARTICIPANT TYPE		EXCHANGE	
■	Health Insurer Applicant	■	Individual
☐	CO-OP	☐	SHOP

HIP Health Plan of New York, an EmblemHealth company ("HIP") is pleased to apply to participate in the New York State of Health Marketplace (referred to herein as the "Marketplace"). All initial products proposed within this application are in adherence with the

Appendix D-1

Essential Health Benefits specified by the DOH in Attachment A of the Invitation, for the calendar year 2016.

2. Organization

a) Identify below the legal entity that will be responsible for offering products in each Exchange and its current license or certification. If Applicant anticipates licensure prior to November 15, 2015, identify what type of licensure is anticipated.

The legal entity that will be responsible for offering products on the Individual Marketplace is HIP Health Plan of New York (HIP), an EmblemHealth company doing business as EmblemHealth on the Marketplace (licensed under Article 43 and certified to operate a managed care organization under Article 44 (NAIC #55247). HIP maintains accreditation with the National Committee for Quality Assurance (NCQA).

b) Identify whether the same legal entity currently contracts with the State Department of Health for the Child Health Plus and/or Medicaid Program, and if so, identify the program(s).

HIP is the legal entity that currently contracts with the State Department of Health for both Child Health Plus (C022798) and Medicaid (C027185).

c) Identify any entities that will be involved in the administration of the BHP Plan and briefly describe the roles of such entities. Include in this section any entity the Applicant is using to satisfy coverage of the BHP benefits (e.g., adult vision), and any entity the Applicant is using to accept and transmit enrollment information.

Please see **Attachment I: Entity Listing for Medical Coverage** to this Proposal for all entities that will be involved in the administration of the Marketplace products. Attachment I includes all the entities being used to satisfy essential health benefits for medical coverage in the Individual products, including the proposed BHP benefits of adult vision and adult dental. HIP does not use any entity to accept and transmit enrollment information.

3. Summary of Products Offered

Identify whether BHP Applicant will be offering the BHP Standard Plan, or both the BHP Standard Plan and the BHP Standard Plus Adult Vision/Dental.

☐ BHP Standard Plan ■ Both BHP Standard Plan and BHP Standard

Appendix D-1

4. Identification of Service Area

A. Service Area. Identify whether BHP Applicant will be using its Commercial Service Area or its Medicaid Service Area.

☐ Commercial Service Area ■ Medicaid Service Area

B. Identification of Counties: Provide the following information on *Addendum 1* - For the Standard and Standard Plus Adult Vision/Dental Product offered, provide the Name of the Applicant and place an x in each box indicating each product you will offer in each county.

HIP will offer BHP products on the NY State of Health in the following counties: Suffolk, Nassau, Westchester, Bronx, Kings, New York, Queens and Richmond. Please see **Attachment II: Addendum I.1 – BHP – 2016 Counties**.

5. URL links

Provide URL links for the following areas:

- Plan Brochures/QHP Descriptions (if applicable): http://www.emblemhealthreform.com/individual/plans
- Summary(ies) of Benefits: http://www.emblemhealthreform.com/individual/plans
  - The summary of benefits appears within each respective plan box, under tab "Summary of Benefits"
- Provider Directory: http://www.emblemhealth.com/en/Find-a-Doctor.aspx
- Pharmacy Formulary: http://www.emblemhealth.com/Pharmacy/See-Covered-Drugs.aspx
- Treatment Cost Calculator: http://www.emblemhealthreform.com/individual/plans
  - The treatment cost calculator appears as an option in the drop-down menu under "EmblemHealth Select Care"

6. Plan Contacts

Provide a contact who will be responsible for each of the areas identified below. Include their name, title, telephone number and email address:

- Product/Form submissions:
  - Paul Zurlo, Vice President of Small Group & Individual Business
    Telephone: 646-447-7225
    Email: pzurlo@emblemhealth.com
- Network Adequacy:

- Carl Lund, Vice President of Facility Contracting
  Telephone: 646-447-5830
  Email: clund@emblemhealth.com
- Philip Gillich, Vice President of Network Management
  Telephone: 646-447-6648
  Email: pgillich@emblemhealth.com

- Provider Directories:
  - Paul Zurlo, Vice President of Small Group & Individual Business
    Telephone: 646-447-7225
    Email: pzurlo@emblemhealth.com
- Quality Submissions:
  - Karen Smith-Hagman, Vice President of Medical Management
    Telephone: 646-447-4594
    Email: ksmithhagman@emblemhealth.com
- Customer Service/Call Center Issues:
  - Suzanne Ronner, Vice President of Customer Experience
    Telephone: 212-615-4091
    Email: sronner@emblemhealth.com
- Pharmacy Submissions:
  - Munish Khaneja, Vice President of Medical Management Operations
    Telephone: 646-447-5893
    Email: mkhaneja@emblemhealth.com
- Enrollment Transactions:
  - Jose Diaz, Vice President of Membership
    Telephone: 212-615-0777
    Email: jdiaz@emblemhealth.com
- Billing Issues:
  - Jose Diaz, Vice President of Membership
    Telephone: 212-615-0777
    Email: jdiaz@emblemhealth.com
- Encounter Submissions:
  - Jose Diaz, Vice President of Membership
    Telephone: 212-615-0777
    Email: jdiaz@emblemhealth.com

ATTESTATION TO PARTICIPATION PROPOSAL

The following must be signed and executed by an individual with the capacity and legal authority to bind the Applicant to the authenticity of the information provided.

I, Frank J. Branchini, hereby attest that I have been duly authorized to execute this Participation Proposal on behalf of Applicant, and to the best of my knowledge, the information and data provided by Applicant in response to the Invitation and Requirements for Participation in the NY State of Health, the Official health Plan Marketplace (the "Invitation") Basic Health Program is accurate, true, and complete. I understand that the NY State of Health will rely on my statements above in reviewing the Participation Proposal and the related information and data submitted in response to the Invitation. In completing the certification process set forth in the Invitation, Applicant shall at all times strictly adhere to all applicable federal and state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted.

Frank J. Branchini

Print Name

Chairman and Chief Executive Officer

Print Title

Frank Branchini

Signature

5. 20. 2015

Date

Appendix D-1

Appendix E-1

NYSIF New York State Insurance Fund

Workers' Compensation & Disability Benefits Specialists Since 1914

199 CHURCH STREET, NEW YORK, N.Y. 10007-1100
Phone: (212) 587-2149

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

^^^^^^ 131828429
EMBLEMHEALTH INC
C/O PAULETTE TAYLOR
55 WATER ST 04B10
NEW YORK NY 10041

POLICYHOLDER	CERTIFICATE HOLDER
HEALTH INSURANCE PLAN OF GREATER C/O PAULETTE TAYLOR 55 WATER ST 04B10 NEW YORK NY 10041	NY HEALTH BENEFIT EXCHANGE NYS DOH, CORNING TOWER SUITE 2378 ALBANY NY 12237

POLICY NUMBER	CERTIFICATE NUMBER	PERIOD COVERED BY THIS CERTIFICATE	DATE
L1244 923-7	980313	01/01/2015 TO 01/01/2016	9/1/2015

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1244 923-7 UNTIL 01/01/2016, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY.

IF SAID POLICY IS CANCELLED, OR CHANGED PRIOR TO 01/01/2016 IN SUCH MANNER AS TO AFFECT THIS CERTIFICATE, 10 DAYS WRITTEN NOTICE OF SUCH CANCELLATION WILL BE GIVEN TO THE CERTIFICATE HOLDER ABOVE. NOTICE BY REGULAR MAIL SO ADDRESSED SHALL BE SUFFICIENT COMPLIANCE WITH THIS PROVISION. THE NEW YORK STATE INSURANCE FUND DOES NOT ASSUME ANY LIABILITY IN THE EVENT OF FAILURE TO GIVE SUCH NOTICE.

THIS POLICY AFFORDS COVERAGE TO THE SOLE PROPRIETOR, PARTNERS AND/OR MEMBERS OF A LIMITED LIABILITY COMPANY.

EMBLEMHEALTH SERVICES COMPANY LLC
ABERNETHY, DAVID
BABITACH, GEORGE
BALDUCCI, LYNN
BRANCHINI, FRANK
BRANCHINI, ROBERT
BYRD, ARTHUR
BYRNE, DANIEL
CHANSLER, JEFFREY
DELLA IACONO, MICHAEL
DIAB, MOHAMMED
DIAZ, JOSE

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

Sherwin Taylor

DIRECTOR,INSURANCE FUND UNDERWRITING

This certificate can be validated on our web site at https://www.nysif.com/cert/certval.asp or by calling (888) 875-5790
VALIDATION NUMBER: 844385264

U-26.3

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

Appendix E-2

CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name and address of Insured (Use street address only) HIP Health Insurance Plan of Greater New York 55 Water Street New York, NY 10041-8190	1b. Business Telephone Number of Insured (646) 447-5000 x 1c. NYS Unemployment Insurance Employer Registration 63-70401 1d. Federal Employer Identification Number of Insured or Social Security Number 13-1828429
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) NY HEALTH BENEFIT EXCHANGE NYS DOH, CORNING TOWER, SUITE 2378 ALBANY , NY 12237	3a. Name of Insurance Carrier **Metropolitan Life Insurance Company** 3b. Policy Number of entity listed in box "1a": 155940 3c. Policy effective period: 1/1/2015 to 9/28/2016

4. Policy covers:

a. X All of the Employer's Employees eligible under the New York Disability Benefits Law

b.___ Only the following class or classes of the employer's employees:

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability Benefits insurance coverage as described above.

Date Signed 9/29/2015 By [signature]

(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Catherine Campbell

Telephone Number 813-673-3812 Title Statutory Disability Compliance

IMPORTANT: If box "4a" is checked, and signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier this certificate is COMPLETE. Mail it directly to the certificate holder.

If box "4b" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 20 Park Street, Albany, New York 12207.

PART 2. To be completed by NYS Workers' Compensation Board (Only if box "4b" of Part 1 has been checked)

State Of New York
Workers' Compensation Board

According to information maintained by the NYS Workers' Compensation Board, the above named employer has complied with the NYS Disability Benefits Law with respect to all of his/her employees.

Date Signed________________ By________________________

(Signature of NYS Workers' Compensation Board Employee)

Telephone Number________________ Title________________________

Please Note: *Only insurance carriers licensed to write NYS disability benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue the DB-120.1 form.* **Insurance brokers are NOT authorized to issue this form.**

DB-120.1 (5-06)

Additional Instructions for the DB-120.1 Form

By signing this form, the insurance carrier identified in box "3" on this form is certifying that it is insuring the business referenced in box "1a" for disability benefits under the New York State Disability Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed as the certificate holder in box "2". T***his Certificate is valid for the earlier of one year after this form is approved by the insurance carrier or its licensed agent, or the policy expiration date listed in box "3c".***

Please Note: Upon the cancellation of the disability benefits policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of NYS Disability Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability Benefits Law.

DISABILITY BENEFITS LAW

§220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and not withstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article, and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits for all employees has been secured as provided by this article.

Appendix G

NOTICES

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

(a) via certified or registered United States mail, return receipt requested;
(b) by facsimile transmission;
(c) by personal delivery;
(d) by expedited delivery service; or
(e) 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 Department of Health
Name: PJ Weiner
Title: Assistant Director, Plan Management
Address: NYS Department of Health, 90 Church Street, New York NY 10007
Telephone Number: (212) 417-5293
Facsimile Number:
E-Mail Address: pjweiner@health.ny.gov

Health Insurance Plan of Greater New York d/b/a EmblemHealth
Name: Karen Ignagni
Title: CEO
Address: 55 Water Street, New York, NY 10041-8190
Telephone Number: 646-447-6107
Facsimile Number:
E-Mail Address: kignagni@emblemhealth.com

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.

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 representative 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.

APPENDIX I
TRADING PARTNER AGREEMENT

All trading partners who will be participating in electronic transactions with the NY State of Health, The Official Health Plan Marketplace (formerly known as the New York Health Benefit Exchange) must first have a fully executed Trading Partner Agreement (TPA) with the NY State of Health. The TPA form is available on the following pages.

TRADING PARTNER AGREEMENT

This Trading Partner Agreement ("***Agreement***") is made and entered into on this 4th day of November, 2015 (the "***Effective Date***"), by and between HIP Insurance Plan of Greater New York ("HIP") ("***Trading Partner***"), whose provider identifier is 88582, and the **New York State Department of Health** (STATE).

WITNESSETH

WHEREAS, the Trading Partner has entered into a contract with STATE to provide the Essential Plan to eligible individuals in New York, and must electronically exchange information and data with the STATE in connection with certain healthcare transactions, which may include but not be limited to benefit enrollment and maintenance for qualified individuals enrolling in coverage ("834 Transactions"), and encounter / health care claim transactions ("837 Transactions"), together with such other healthcare transactions that may be necessary pursuant to agreement by and between STATE and Trading Partner; and

WHEREAS, STATE and Trading Partner seek to address certain requirements that are applicable to the parties under regulations issued pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (as the same may be amended from time to time, "*HIPAA*") including, without limitation, the Standards for Electronic Transactions, which were issued in their final form on August 17, 2002 (as the same may be amended from time to time, the "*Transaction Regulations*"), and the Security Standards, which were issued in their final form on February 20, 2003 (as the same may be amended from time to time, the *"Security Standards"*); and

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants and agreements herein contained, Trading Partner and STATE agree to the foregoing and as follows:

1. General Obligations.

1.1 Compliance With Transaction Regulations. Each party shall, and shall cause its applicable subcontractors and agents to comply with the applicable requirements of the Transaction Regulations and any applicable Implementation Specifications issued therein. STATE shall provide, and shall update from time to time, a HIPAA compliant (i) Trading Partner Information Companion Guide (the "TPI Guide"), (ii) an 834 Companion Guide; (iii) an 837 Post Adjudicated Claims Data Reporting (PACDR) Companion Guide; (iv) an Interface Control Document for Group Set Up File, and such other guides that may be necessary to provide specific instructions, where applicable, to assist Trading Partners in appropriately filling out their transactions for STATE (collectively referred to herein as "Trading Partner Guides"). These guides shall be made available by STATE.

1.2 No Changes. With respect to each transaction, each party agrees that it will not change any definition, data condition or use of a data element or segment as proscribed in the Transaction Regulations and/or the applicable Implementation Specifications. Further, neither party will take any action to change the meaning or intent of the Implementation Specifications.

1.3 No Additions. With respect to each transaction, each party agrees that it will not add any data elements or segments to the maximum defined data set as proscribed in the Transaction Regulations and/or the applicable Implementation Specifications.

1.4 No Use. With respect to each transaction, each party agrees that it will not use any code or data elements that either are marked "not used" or are not in the Transaction Regulations and/or the applicable Implementation Specifications.

1.5 Testing Requirements. The Trading Partner Guides set forth the testing requirements that Trading Partner and/or its contractors and/or agents must implement and/or complete prior to submitting any live, production transactions to STATE or its fiscal agent. Trading Partner agrees to satisfy these requirements.

1.6 Communications. The Trading Partner Guides set forth specifications for establishing connectivity with, and transmitting transactions to, STATE or its fiscal agent. Trading Partner agrees to satisfy these requirements.

1.7 Supplementary Specifications. The Trading Partner Guides set forth the current supplementary specifications ("*Supplementary Specifications*") of STATE with respect to the Transaction Regulations and any applicable Implementation Specifications. STATE shall have the right to amend the Supplementary Specifications and/or to provide additional supplementary specifications to Trading Partner from time to time (all of which shall constitute Supplementary Specifications for purposes of this Agreement). Trading Partner will be expected to implement such amendments and additions within sixty (60) calendar days following STATE publication of same, unless a shorter period is necessary to conform to applicable laws and/or regulations or otherwise required by STATE to ensure effective transactions.

1.8 Security Requirements.
(a) Each party will take reasonable care to ensure that the information submitted in each transaction is timely, complete, accurate and secure, and will take reasonable precautions to prevent unauthorized access to: (i) its own and the other party's transmission and processing systems; (ii) the transmissions themselves; and (iii) the control structure applied to transmissions between them.

(b) Each party is solely responsible for the preservation, privacy and security of data in its possession, including data in transmissions received from the other party and other persons. If either party receives from the other data not intended for it, the receiving party will immediately notify the sender to arrange for its return, re-transmission, or destruction, as the other party directs.

(c) Under the final HIPAA Security Regulations, parties entering into a Business Associate agreement relating to the electronic exchange of data will implement additional requirements as specified in the Security Regulations including, without limitation, requirements relating to encryption, Public Key Infrastructure (PKI) and other similar technologies

(d) Each party and its Business Associates shall be prohibited from: (i) transmitting healthcare transactions covered under this Agreement directly to STATE from outside of the U.S. or its territories, and (ii) from providing IP addresses or other information to STATE that would allow for transmission of healthcare transactions covered under this Agreement directly from STATE to a location outside the U.S. or its territories.

2. Costs and Expenses. Each party shall be responsible for any and all costs and expenses related to such party's compliance with the Transaction Regulations, any applicable Implementation Specifications and the terms of this Agreement. Further, each party shall be responsible for all costs, charges and fees it may incur in connection with transmitting and receiving transactions.

3. Term and Termination.

3.1 Term; Effect of Termination. This Agreement shall remain in effect until one party provides written notice of termination to the other, which termination shall be effective thirty (30) days following the other party's receipt of the notice. Termination or expiration of this Agreement or any other contract between the

parties does not relieve either party of its obligations under this Agreement and under federal and State laws and regulations pertaining to the privacy and security of Individually Identifiable Health Information nor its obligations regarding the confidentiality of proprietary information.

4. Miscellaneous.

4.1 Defined Terms. Capitalized terms used in this Agreement but not defined herein shall have the meanings ascribed to them in the Transaction Regulations and/or in HIPAA.

4.2 Interpretation. Any ambiguity in any term or condition of this Agreement shall be resolved in favor of a meaning that permits the parties to comply with HIPAA.

4.3 ***Standard Clauses***. Appendix A, Standard Clauses for NYS Contracts, January 2014, is incorporated into this Trading Partner Agreement by reference.

IN WITNESS WHEREOF, STATE and Trading Partner have caused this Agreement to be signed and delivered by their duly authorized representatives as of the date set forth above.
On behalf of STATE and Trading Partner:

NEW YORK STATE DEPARTMENT OF HEALTH

By: Donna Frescatore

Print Name: Donna Frescatore

Title: Executive Director

TRADING PARTNER: Health Insurance Plan of Greater New York ("HIP")

By: Shawn Fitzgibbon

Print Name: Shawn Fitzgibbon

Title: SVP

EmblemHealth

Provider # 01131584

Essential Plan (EP) Premium Rate Sheets

Effective Date January 1,2016

County Name	*Essential Plan 1*	*Monthly Premium EP1*	*Dental Vision Monthly Premium EP1*	*Essential Plan 2*	*Dental Vision Monthly Premium EP2*	*Essential Plan 3*	*Essential Plan 4*
Nassau	$520.53	$20.00	$26.45	$602.60	$30.66	$467.97	$469.48
NYC	$446.89	$20.00	$26.56	$518.62	$30.77	$420.78	$422.87
Suffolk	$520.53	$20.00	$26.45	$602.60	$30.66	$467.97	$469.48
Westchester	$500.39	$20.00	$26.43	$575.70	$30.65	$447.71	$449.15

Appendix J

11/30/15

10/26/15