

ATTACHMENT E

PARTICIPATION PROPOSAL

All Applicants must submit the following information to the e-mail address set forth in Section V.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 Exchange, SHOP Exchange or both, and the type of Applicant.

<u>PARTICIPANT TYPE</u>	<u>EXCHANGE</u>
<input type="checkbox"/> Health Insurer Applicant	<input type="checkbox"/> Individual
<input type="checkbox"/> Stand-Alone Dental Applicant	<input type="checkbox"/> SHOP
<input type="checkbox"/> 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 October 1, 2013, 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 Exchange products 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. Service Area

List Applicant’s current service area by county. If the service area is all counties within New York State, state “All Counties.” Entities in the process of applying for licensure with the State, provide a list of anticipated counties or state “All Counties” if applicable.

4. 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 it is applying to offer in the Exchange(s):

INDIVIDUAL EXCHANGE		SHOP EXCHANGE	
Metal Level	Number	Metal Level	Number
Bronze (60% AV)		Bronze (60% AV)	
Silver (70% AV)		Silver (70% AV)	
Gold (80% AV)		Gold (80% AV)	
Platinum (90% AV)		Platinum (90% AV)	

Stand-Alone Dental Carrier Applicants, provide the anticipated number of products that it is applying to offer in the Exchange(s):

INDIVIDUAL EXCHANGE		SHOP EXCHANGE	
Category	Number	Category	Number
Pediatric (High 85%)		Pediatric (High 85%)	
Pediatric (Low 75%)		Pediatric (Low 75%)	
Adult		Adult	
Family		Family	

5. Addendum Submissions

A. Health Insurer Applicants: Individual Exchange

a) For each Standard and Non-Standard Product offered through the Individual Exchange, provide the following information in *Addendum 1*:

- Name of Applicant
- Type of Licensure
- Product name for each standard, child only, catastrophic, out-of-network, and non-standard product being offered. Note the following
 - child only products must be offered in conjunction with standard products offered in each metal level,
 - a catastrophic plan must be offered in each county of the Applicant’s service area, and
 - if an out-of-network product is offered by the Applicant outside of the exchange, an out-of-network product must be offered inside the exchange at the silver and platinum metal levels.
- If the Applicant is using an existing Provider Network, indicate the Network Name and ID number. If the Applicant is using a new Provider Network, input the word “New”.
- For each Non-standard product, complete *Addendum 2*, the Essential Health Benefit Alteration Form, to describe how the benefit is being modified. Per Section II.D.1.f. of the Invitation, the following can be modified for non-standard products:
 - (1) cost-sharing in any category
 - (2) substitution of benefit services within the Preventive/Wellness/Chronic Disease Management category and

the Rehabilitative/Habilitative categories

(3) the addition of any benefits, including visit limits, services within an essential health benefit category and services that are not considered essential health benefits.

All state mandated services cannot be reduced or omitted, even if they fall within one of the substitution categories identified above.

- Indicate the counties and New York City boroughs for each product the Applicant proposes to offer. Each county should be marked with an “x”.

b) Once Applicant has obtained a Standard Component ID number from the Health Insurance Oversight System (HIOS), resubmit all Addendums with the applicable number included.

c) Submit to the DOH a copy of all final documents submitted through SERFF and approved by DFS as part of the Rate and Form Filings. Copies are 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 Exchange web portal.

d) Indicate below your intent to offer a Catastrophic Plan in each county of Applicant’s service area:

Yes, Applicant intends to offer a catastrophic plan

No, Applicant prefers not to offer a catastrophic plan

B. Health Insurer Applicants: SHOP Exchange

a) For each Standard and Non-standard Product offered through the SHOP Exchange, provide the following information in *Addendum 3*:

- Name of Applicant
- Product name for each standard, out-of-network, and non-standard product being offered. Note the following:
 - If an out-of-network product is offered by the Applicant outside of the exchange, an out-of-network product must be offered inside the exchange at the silver and platinum metal levels.
- If the Applicant is using an existing Provider Network, indicate the Network Name and ID number. If the Applicant is using a new Provider Network, input the word “New”.

- For each Non-standard product, complete *Addendum 2*, the Essential Health Benefit Alteration Form, to describe how the benefit is being modified. Per Section II.D.1.f. of the Invitation, the following can be modified for non-standard products:

(1) cost-sharing in any category

(2) substitution of benefit services within the Preventive/Wellness/Chronic Disease Management category and the Rehabilitative/Habilitative categories

(3) the addition of any benefits, including visit limits, services within an essential health benefit category and services that are not considered essential health benefits.

All state mandated services cannot be reduced or omitted, even if they fall within one of the substitution categories identified above.

- Indicate the counties and New York City boroughs for each product the Applicant proposes to offer. Each county should be marked with an “x”.

b) Once Applicant has obtained a Standard Component ID number from the Health Insurance Oversight System (HIOS), resubmit all Addendums with the applicable number included.

c) Submit to the DOH a copy of all final documents submitted through SERFF and approved by DFS as part of the Rate and Form Filings. Copies are 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 Exchange web portal.

C. Health Insurer Applicants: Out-of-Network Products Outside of Exchange

List all Out-of Network Products offered outside of the Individual and Shop Exchanges beginning in 2014. Indicate each of the counties where the Out-of-Network Products will be offered.

D. Stand-alone Dental Products

a) Pediatric Dental Products: For each Stand-alone Pediatric Dental Product offered, provide the following information in *Addendum 4* (please note that each Applicant must provide a Pediatric Dental Product in each county of the Applicant’s service area) :

- Applicant name
- Type of Licensure
- Indicate if the mandated Pediatric Stand-alone product offered is a high coverage product or low coverage product by using the words “high” or “low”

- Indicate the name of the Pediatric Stand-alone product
- If the Applicant is using an existing Provider Network, indicate the Network Name and ID number. If the Applicant is using a new Provider Network, input the word “New”.
- Indicate the counties and New York City boroughs for each product the Applicant proposes to offer. Each county should be marked with an “x”.

b) For each Stand-alone Optional Dental Product offered, provide the following information in Addendum 4

- Indicate Product Name under each type of Product (i.e., Pediatric, Adult or Family). Please note that Applicants can offer up to two additional Dental products.
- If the Applicant is using an existing Provider Network, indicate the Network Name and ID number. If the Applicant is using a new Provider Network, input the word “New”.
- Indicate the counties and New York City boroughs for each product the Applicant proposes to offer. Each county should be marked with an “x”.

c) Repeat the above for each Stand-alone Pediatric Dental Product and Additional Dental Product offered through SHOP Exchange, but use *Addendum 5* instead.

d) Once Applicant has obtained a Standard Component ID number from the Health Insurance Oversight System (HIOS), resubmit all Addendums with the applicable number included.

4. Quality

Per Section II.E of the Invitation, provide a complete description of the Applicant’s quality strategy for each area below:

- Improving Health Outcomes
- Preventing Hospital Readmissions
- Improving Patient Safety
- Wellness and Health Promotion Activities
- Reducing Health and Health Care Disparities
- Behavioral Health Services

5. URL links

Provide URL links for the following areas:

- Product Descriptions (if applicable)
- Summary(ies) of Benefits
- Provider Directory
- Pharmacy Formulary
- Treatment Cost Calculator

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 to Participate in the New York Health Benefit Exchange (the "Invitation") is accurate, true, and complete. I understand that the New York Health Benefit Exchange 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