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**ATTACHMENT F (1)**

**2025 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 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 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 w ped dental

Individual w/o ped dental

Stand-Alone Dental Applicant 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 1, 2024, 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**

**a)** 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 proposing to offer in the Marketplace:

|  |  |  |  |
| --- | --- | --- | --- |
| **INDIVIDUAL EXCHANGE** | | **SHOP EXCHANGE** | |
| **Metal Tier** | **Number** | **Metal Tier** | **Number** |
| **Bronze** |  | **Bronze** |  |
| **Silver** |  | **Silver** |  |
| **Gold** |  | **Gold** |  |
| **Platinum** |  | **Platinum** |  |

**b)** Identify whether Health Insurer Applicant will be offering an additional Bronze product in 2025 with HSA eligibility that was offered in 2024:

Yes No

**c)** Stand-Alone Dental Carrier Applicants, provide the anticipated number of products that you are proposing to offer in the Marketplace:

|  |  |  |  |
| --- | --- | --- | --- |
| **INDIVIDUAL EXCHANGE** | | **SHOP EXCHANGE** | |
| **Category** | **Number** | **Category** | **Number** |
| **Pediatric (ST)** |  | **Pediatric (ST)** |  |
| **Pediatric (NS)** |  | **Pediatric (NS)** |  |
| **Adult/Family (NS)** |  | **Adult/Family (NS)** |  |

**4. Proposal Attachment Submissions**

**a. Health Insurer Applicants:**

1. Provide the following information:

***Attachment F (2)*** - 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 2025, highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2025 (i.e. a new non-standard product), highlight the column(s) containing the new product(s) in yellow. If you are proposing to leave a county in 2025, highlight the corresponding cells for each product and county in red.

* 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.

**ii)** 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.

**iii)** Indicate below your intent to offer a catastrophic product in each county of Applicant’s service area:

Yes, Health Insurer Applicant intends to offer the catastrophic product.

No, Health Insurer Applicant prefers not to offer the catastrophic product.

**d)** **Stand-Alone Dental Applicants**

**(i)** Provide the following information:

* ***Attachment F (3)*** - Provide the name of Applicant and place an x in each box indicating which product(s) you will offer in each county. If you are proposing to enter a new county in 2025, highlight the cell in yellow indicating the new county. If you are proposing to offer (a) new product(s) for 2025 (i.e. offering EP for the first time, or offering a new non-standard product), highlight the column(s) with the new product(s) in yellow. If you are proposing to leave a county in 2025, highlight the cell in red, indicating a product removal.
* 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/Claims 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”) 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, always, strictly adhere to all applicable federal and state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted.

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Print Title

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Signature

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Date