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

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 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