MISCELLANEOUS/CONSULTANT SERVICES

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

NYS COMPTROLLER'S #

ORIGINATING AGENCY GLBU: DOH01
DEPARTMENT ID: 3450000

CONTRACTOR (Name and Address):

TYPE OF PROGRAM(S):

CHARITIES REGISTRATION NUMBER:

CONTRACT TERM

FROM: January 1, 2021
TO: December 31, 2025

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

FUNDING AMOUNT FOR CONTRACT TERM: NOT TO EXCEED

FEDERAL TAX IDENTIFICATION NUMBER:

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

NYS VENDOR IDENTIFICATION NUMBER:

MUNICIPALITY NO. (if applicable)

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

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

( ) IF MARKED HERE, THIS CONTRACT MAY BE RENEWED FOR ___ ADDITIONAL ____ PERIOD(S) SUBJECT TO APPROVAL OF THE OFFICE OF THE STATE COMPTROLLER.

APPENDICES ATTACHED AND PART OF THIS CONTRACT
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 Contract Amendment 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- NEW YORK STATE DEPARTMENT OF HEALTH CONTRACT
-X- APPENDIX M Participation by Minority and Women-Owned Business Enterprises
-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 Insurer Certification and Recertification for Participation in 2021, 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 I Trading Partner Agreement
-X- APPENDIX J Capitation Rates

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

PLEASE RETAIN THIS DOCUMENT
FOR FUTURE REFERENCE.

June 2023

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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, if this contract exceeds $50,000 (or $75,000 for State University of New York or City University of New York contracts for goods, services, construction and printing, and $150,000 for State University Health Care Facilities) 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 $25,000, 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, either for itself or its customer agencies by the Office of General Services Business Services Center, is required when such contracts exceed $85,000. Comptroller's approval of contracts established as centralized contracts through the Office of General Services is required when such contracts exceed $125,000, and when a purchase order or other procurement transaction issued under such centralized contract exceeds $200,000.

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, nor subject any individual to harassment, because of age, race, creed, color, national origin, citizenship or immigration status, sexual orientation, gender identity or expression, military status, sex, disability, predisposing genetic characteristics, familial status, marital status, or domestic violence victim status or because the individual has opposed any practices forbidden under the Human Rights Law or has filed a complaint, testified, or assisted in any proceeding under the Human Rights Law. 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 (2 NYCRR § 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 Part 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 clause. 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 and Technology Development
625 Broadway
Albany, New York 12245
Telephone: 518-292-5100

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 33rd Floor
New York, NY 10017
646-846-7364
email: mwbebusinessdev@esd.ny.gov
https://ny.newnycontracts.com/FrontEnd/searchcertifieddirectory.asp

The Omnibus Procurement Act of 1992 (Chapter 844 of the Laws of 1992, codified in State Finance Law § 139-i and Public Authorities Law § 2879(3)(n)–(p)) 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, codified in State Finance Law § 165(6) and Public Authorities Law § 2879(5)) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 2023, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii.

22. COMPLIANCE WITH BREACH NOTIFICATION AND DATA SECURITY LAWS. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law §§ 899-aa and 899-bb and State Technology Law § 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 §§ 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law §§ 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 § 5-a, if the contractor fails to make the certification required by Tax Law § 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: https://ogs.ny.gov/iran-divestment-act-2012

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.

27. ADMISSIBILITY OF REPRODUCTION OF CONTRACT. Notwithstanding the best evidence rule or any other legal principle or rule of evidence to the contrary, the Contractor acknowledges and agrees that it waives any and all objections to the admissibility into evidence at any court proceeding or to the use at any examination before trial of an electronic reproduction of this contract, in the form approved by the State Comptroller, if such approval was required, regardless of whether the original of said contract is in existence.

Appendix Q

MODIFICATION OF STANDARD DEPARTMENT OF HEALTH CONTRACT LANGUAGE

State of New York Agreement, Subsection F, Section I, General Terms and Conditions, is replaced in its entirety with the following:

F. For the purposes of this Contract, the term "Proposal" includes all Appendix D-1 documents as marked on the face page hereof and approved by the Department. For the purposes of this Contract, Appendix D includes the Invitation and Requirements for Insurer Certification and Recertification for Participation as amended, including questions and answer documents (the body of which is attached) and Attachments, which are set forth in their entirety at: https://info.nystateofhealth.ny.gov/invitation

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 Department (New York State 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.

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.

NEW YORK STATE DEPARTMENT OF HEALTH CONTRACT

This Contract is made by and between the New York State Department of Health (DEPARTMENT) and the CONTRACTOR identified on the face page.

WITNESSETH:

☐ **WHEREAS**, the DEPARTMENT has formally requested vendors to submit bid proposals for the project described in Appendix B for which bids were opened on the date noted on the face pages of this Contract; and the DEPARTMENT has determined that the CONTRACTOR is the successful bidder, and the CONTRACTOR covenants that it is willing and able to undertake the services and provide the necesssary materials, labor and equipment;

☐ **WHEREAS**, the DEPARTMENT has determined, without a formal bid proposal, that it is in need of the services described in Appendix C; and 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 terms, promises, responsibilities, and covenants set forth below the parties agree as follows:

I. General Terms and Conditions

A. This Contract incorporates the face pages attached and all of the marked appendices identified on the face page.
B. The maximum compensation for the Contract term of this Contract shall not exceed the amount specified on the face page.
C. This Contract may be renewed for an additional period (PERIOD), as specified on the face page.
D. To amend or exercise any renewal option of this Contract, the parties shall prepare new appendices, to the extent that any require modification, and a Contract Amendment Form in the format provided by the DEPARTMENT (Appendix X). Any terms of this Contract not modified shall remain in effect for each PERIOD of the Contract. The Contract Amendment Form is subject to the approval of the Office of the State Comptroller. This Contract may not be amended orally. The CONTRACTOR shall not make any changes in the scope of work at any time without prior authorization in writing from the DEPARTMENT and without prior approval in writing of the amount of compensation for such changes.
E. Appendix A (Standard Clauses as required by the Attorney General for all State Contracts) takes precedence over all other parts of the Contract.
F. For the purposes of this Contract, the term “Proposal” includes all Appendix C documents as marked on the face page.

G. The CONTRACTOR is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the DEPARTMENT nor make any claims, demand or application to or for any right based upon any different status.
H. The CONTRACTOR agrees, throughout the term of this Contract, to maintain, at CONTRACTOR'S expense, those benefits to which its employees are entitled by law, including health benefits, any necessary insurance for its employees, including professional liability, worker's compensation, disability and unemployment insurance, and to provide the DEPARTMENT with certification of such insurance upon request. The CONTRACTOR remains responsible for all applicable federal, state, and local taxes, and all FICA contributions.
I. For the purposes of this Contract, the Appendix B includes all Request for Proposal (RFP) or Funding Availability Solicitation (FAS) documents including questions and answer documents, amendments and attachments.
J. CONTRACTOR is under an affirmative duty to be informed by personal examination of the specifications and location of the proposed work and by such other means as it may select, of character, quality and extent of work to be performed and the conditions under which the Contract is to be executed.
K. The DEPARTMENT will make no allowance or concession to a CONTRACTOR for any alleged misunderstanding or deception because of quantity, quality, character, location or other conditions.
L. 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 this Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the DEPARTMENT. A confirmation in writing of such orders or directions will be given by the DEPARTMENT when so requested from the CONTRACTOR.
M. If the DEPARTMENT is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, the 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 DEPARTMENT.
N. The DEPARTMENT shall conduct any inspection at a time during normal business hours where the activities of the work under this Contract are taking place and in a manner so as not to unreasonably disrupt the CONTRACTOR'S business. During its inspection the DEPARTMENT may view and audit any materials related to this Contract.
O. No failure by the DEPARTMENT at any time to give notice of any breach by the other party of, or to require compliance with, any condition or provision of this Contract shall be deemed a waiver of similar or dissimilar provisions or conditions at the same or at any prior or subsequent time.

II. Payment and Reporting

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

1. Preferred Method: Email a .pdf copy of your signed voucher to the BSC at: accountspayable@ogs.ny.gov with a subject field as follows:

Subject: **Unit ID:**
(Note: **Do not** send a paper copy in addition to your emailed voucher.)

2. Alternate Method: Mail vouchers to Business Service Center at the following U.S. postal address:

   NYS Department of Health
   Unit ID:
   Building 5, 5th Floor 1220 Washington Ave
   Albany, NY 12226-1900

B. Payment of such invoices and/or vouchers by the DEPARTMENT shall be made in accordance with Article XI-A of the New York State Finance Law.

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 DEPARTMENT 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.

Payment terms shall be:

III. Term and Termination

A. Upon approval of the Office of the State Comptroller this Contract shall be effective for the term as specified on the face page.

B. This Contract may be terminated by mutual written agreement of the Contracting parties.

C. This Contract may be terminated by the DEPARTMENT for cause upon the failure of the CONTRACTOR to comply with the terms and conditions of this Contract, including the attachments hereto, provided that the DEPARTMENT shall give the CONTRACTOR written notice via registered or certified mail, return receipt requested, or shall deliver same by hand-receiving CONTRACTOR'S receipt therefore, such written notice to specify the CONTRACTOR'S failure and the termination of this Contract. Termination shall be effective ten (10) business days from receipt of such notice, established by the receipt returned to the DEPARTMENT. The CONTRACTOR agrees to incur no new obligations nor to claim for any expenses made after receipt of the notification of termination.

D. This Contract may be deemed terminated immediately at the option of the DEPARTMENT upon the filing of a petition in bankruptcy or insolvency, by or against the CONTRACTOR. Such termination shall be immediate and complete, without termination costs or further obligations by the DEPARTMENT to the CONTRACTOR.

E. The DEPARTMENT reserves the right to stop the work being performed under this Contract at any time that the DEPARTMENT deems the CONTRACTOR to be unwilling or unable to perform the work to the satisfaction of the DEPARTMENT. In the event of such cessation of work, and where the CONTRACTOR has been afforded an opportunity to cure its inability to adequately perform within a reasonable time as specified by the DEPARTMENT, but not to exceed 30 days, and the CONTRACTOR has failed to remedy such defect of performance to the satisfaction of the DEPARTMENT, the DEPARTMENT shall have the right to terminate this Contract and to arrange for the completion of the work in such manner as the DEPARTMENT may deem advisable; and if the cost of having the work completed by a replacement CONTRACTOR exceeds the amount of the initially-awarded Contract, the CONTRACTOR and its surety shall be liable to the DEPARTMENT for any excess cost on account thereof.

F. This Contract may be canceled at any time by the DEPARTMENT giving to the CONTRACTOR not less than 30 days written notice that on or after a date therein specified this Contract shall be deemed terminated and canceled.

G. 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 Contract, the DEPARTMENT thereupon shall have the right to terminate this Contract by giving notice in writing of the fact and date of such termination to the CONTRACTOR.

2. If, in the judgment of the DEPARTMENT, the CONTRACTOR acts in such a way which is likely to or does impair or prejudice the interests of the DEPARTMENT, the DEPARTMENT shall thereupon have the right to terminate this Contract by giving notice in writing of the fact and date of such termination to the CONTRACTOR. The CONTRACTOR shall receive equitable compensation for such services as shall, in the judgment of the State Comptroller, have been satisfactorily performed by the CONTRACTOR prior to the effective date of termination of this Contract, such compensation shall not exceed the total cost incurred for the work which the CONTRACTOR was engaged in at the time of termination, subject to audit by the State Comptroller.

H. Upon termination of this Contract, the following shall occur:

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

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

IV. Contract Insurance Requirements

A. Prior to the start of work under this Contract, the CONTRACTOR shall procure at its sole cost and expense, and shall maintain in force at all times during the term of this Contract, insurance of the types and in the amounts as herein below set forth, written by companies authorized by the New York State Department of Financial Services to issue insurance in the State of New York ("admitted" carriers) with an A.M. Best Company rating of "A-" or better or as acceptable to the DEPARTMENT. Before commencing performance of the work, the CONTRACTOR shall deliver to the DEPARTMENT evidence of such policies in a form acceptable to the DEPARTMENT. These policies must be written in accordance with the requirements of the paragraphs below, as applicable. The DEPARTMENT may, at its sole discretion, accept policies of insurance written by a non-authorized carrier or carriers when Certificates and/or other policy documentation is accompanied by a completed Excess Lines Association of New York (ELANY) Affidavit; provided that nothing herein shall be construed to require the DEPARTMENT to accept insurance placed with a non-authorized carrier under any circumstances.

B. Conditions Applicable to Insurance. All policies of insurance required by this Contract must meet the following requirements:

1. **Coverage Types and Policy Limits.** The types of coverage and policy limits required from the CONTRACTOR are specified in subsection C Specific Coverages and Limits of this section.

2. **Policy Forms.** Except as may be otherwise specifically provided herein or agreed in writing by the DEPARTMENT, policies must be written on an occurrence basis. Under certain circumstance, the DEPARTMENT may elect to accept policies written on a claims-made basis provided that, at a minimum, the policy remains in force throughout the performance of the services and for three (3) years after completion of the Contract. If the policy is cancelled or not renewed during that time, the CONTRACTOR must purchase at its sole expense Discovery Clause coverage sufficient to complete the 3-year period after completion of the Contract. Written proof of this extended reporting period must be provided to the DEPARTMENT prior to the policy's expiration or cancellation.

3. **Certificates of Insurance/Notices.** CONTRACTOR shall provide a Certificate or Certificates of Insurance, in a form satisfactory to the DEPARTMENT, before commencing any work under this Contract. Certificates shall reference the Contract Number. Certificates shall be mailed to:

Name/Title:

Organization:

Address:

Address:

Unless otherwise agreed, policies shall be written so as to include a provision that the policy will not be canceled, materially changed, or not renewed without at least 30

days prior written notice except for non-payment as required by law to the DEPARTMENT at the address specified above in this paragraph. In addition, if required by the DEPARTMENT, the CONTRACTOR shall deliver to the DEPARTMENT within forty-five (45) days of such request a copy of any or all policies of insurance not previously provided, certified by the insurance carrier as true and complete.

Certificates of Insurance shall:

a. Be in the form approved by the DEPARTMENT.

b. Disclose any deductible, self-insured retention, aggregate limit or any exclusion to the policy that materially changes the coverage required by this Contract.

c. Specify the Additional Insureds and Named Insureds as required herein.

d. Refer to this Contract by number, the Supplemental Certificate, and any other attachments on the face of the certificate,

e. When coverage is provided by a non-admitted carrier, be accompanied by a completed ELANY Affidavit, and

f. Be signed by an authorized representative of the insurance carrier or producer.

Only original documents (Certificates of Insurance, Supplemental Insurance Certificates, and other attachments) will be accepted.

Electronic forms will be accepted as original documents, provided the subject electronic document can be directly traced back to the insurance carrier, agent, or broker via email distribution or similar means.

4. Primary Coverage. The liability and protective liability insurance policies shall provide primary and non-contributory coverage to the DEPARTMENT for any claim arising from the CONTRACTOR'S Work under this CONTRACT, or as a result of the CONTRACTOR'S activities. Insurance policies that remove or restrict blanket contractual liability located in the "insured contract" definition (as stated in Section V, Number 9, Item f in the ISO CGL policy) so as to limit coverage against claims that arise out of the work, or that remove or modify the "insured contract" exception to the employer's liability exclusion, or that do not cover the additional insured for claims involving injury or employees of the named insured or subcontractors, are not acceptable.

5. Policy Renewal/Expiration. At least two weeks prior to the expiration of any policy required by this Contract, evidence of renewal or replacement policies of insurance with terms no less favorable to the DEPARTMENT than the expiring policies shall be delivered to the DEPARTMENT in the manner required for service of notice in subsection B.3. Certificates of Insurances/Notices of this Section. If, at any time during the term of this Contract, the coverage provisions and limits of the policies required herein do not meet the provisions and limits set forth in this Contract or proof thereof is not provided to the DEPARTMENT, the CONTRACTOR shall immediately cease work under this Contract. The CONTRACTOR shall not resume work under this Contract

until authorized to do so by the DEPARTMENT. Any delay, time lost, or additional cost incurred as a result of the CONTRACTOR not having insurance required by this Contract or not providing proof of same in a form acceptable to the DEPARTMENT shall not give rise to a delay claim or any other claim against the DEPARTMENT. Should the CONTRACTOR fail to provide or maintain any insurance required by this Contract, or proof thereof is not provided to the DEPARTMENT, the DEPARTMENT may withhold further Contract payments, treat such failure as a breach or default of the Contract, and/or, after providing written notice to the CONTRACTOR, require the Surety, if any, to secure appropriate coverage and/or purchase insurance complying with this Contract and charge back such purchase to the CONTRACTOR.

6. Self-Insured Retention/Deductibles. Certificates of Insurance must indicate the applicable deductible/self-insured retentions above $100,000.00, which are subject to approval from the DEPARTMENT. Additional surety/security may be required in certain circumstances. The CONTRACTOR shall be solely responsible for all claim expenses and loss payments within the deductible or self-insured retention.

7. Subcontractors. Should the CONTRACTOR engage a subcontractor, the CONTRACTOR shall endeavor to impose the insurance requirements of this document on the subcontractor, as applicable. Required insurance limits should be determined commensurate with the work of the subcontractor. Proof thereof shall be supplied to the DEPARTMENT.

C. Specific Coverages and Limits

The types of insurance and minimum policy limits shall be as follows:

1. Workers' Compensation

   For work to be performed in New York State, 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 NYS Workers' Compensation Law. The CONTRACTOR shall provide notice to the DEPARTMENT immediately if CONTRACTOR'S Workers' Compensation coverage has lapsed or terminated during the PERIOD of this Contract.

   If the Contract involves work on or near a shoreline, a U.S. Longshore and Harbor Workers' Compensation Act and/or Jones Act policy as applicable must be provided. Any waiver of this requirement must be approved by the DEPARTMENT and will only be granted in unique or unusual circumstances.

   Unless the CONTRACTOR is a political sub-division of New York State, evidence of Workers' Compensation and Employers Liability coverage must be provided on one of the following forms specified by the Commissioner of the Workers' Compensation Board:

   a. C-105.2 (September 2007, or most current version) – Certificate of Workers' Compensation Insurance.
   b. U-26.3 – Certificate of Workers' Compensation Insurance from the State Insurance Fund.

c. GSI-105/SI-12 – Certificate of Workers' Compensation Self Insurance.
d. CE-200 – Certificate of Attestation of Exemption (If CONTRACTOR meets the requirements)

All forms are valid for one year from the date the form is signed/stamped, or until policy expiration, whichever is earlier.

2. Disability Benefits

For work to be performed in New York State, 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 NYS Disability Benefits Law. Any waiver of this requirement must be approved by the DEPARTMENT and will only be granted in unique or unusual circumstances. The CONTRACTOR shall provide notice to the DEPARTMENT immediately if CONTRACTOR'S Disability Benefits coverage has lapsed or terminated during the PERIOD of this Contract.

Evidence of Disability Benefits coverage must be provided on one of the following forms specified by the Commissioner of the Workers' Compensation Board:

a. DB-120.1 (May 2006 or most current version) – Certificate of Insurance Coverage under the NYS Disability Benefits Law
b. DB-155 – Certificate of Disability Self Insurance
c. CE-200 – Certificate of Attestation of Exemption

All forms are valid for one year from the date the form is signed/stamped, or until policy expiration, whichever is earlier.

3. Commercial General Liability

For work to be performed in New York State, the CONTRACTOR shall provide and maintain Commercial General Liability Insurance (CGL) covering the liability of the CONTRACTOR for bodily injury, property damage, and personal/advertising injury arising from all work and operations under this Contract, using form CG 00 01 12 07 or a policy providing equivalent coverage. The limits under such policy shall not be less than the following:

a. Each Occurrence limit - $1,000,000
b. General Aggregate - $2,000,000
c. Products/Completed Operations must be equivalent to the "General Aggregate" limit
d. Personal/Advertising Injury - $1,000,000
e. Damage to Rented Premises - $50,000
f. Medical Expense - $5,000

Coverage shall include, if applicable, the following:

a. premises liability;
b. independent contractors/subcontractors;
c. blanket Contractual liability, including tort liability of another assumed in a Contract;

d. defense and/or indemnification obligations, including obligations assumed under this Contract;
e. cross liability for additional insureds;
f. products/completed operations for a term of no less than 3 years, commencing upon acceptance of the work, as required by this Contract;
g. explosion, collapse, and underground hazards;
h. CONTRACTOR means and methods;
i. liability resulting from Section 240 or Section 241 of the New York State Labor Law; and
j. Cybersecurity Liability.

The following ISO forms must be endorsed to the policy:

a. CG 00 01 01 96 or an equivalent – Commercial General Liability Coverage Form

b. CG 20 10 11 85 or an equivalent – Additional Insured-Owner, Lessees or CONTRACTORS (Form B)

c. CG 25 03 11 85 or an equivalent – Designated Construction Project(s) general aggregate limit (only required for construction Contracts).

Limits may be provided through a combination of primary and umbrella/excess liability policies. The CGL aggregate shall be endorsed to apply on a per project basis for construction Contracts.

Policies shall name the State of New York as Additional Insured, and such coverage shall be extended to afford Additional Insured status to those entities during the Products/Completed Operations term.

The CGL policy, and any umbrella/excess policies used to meet the "Each Occurrence" limits specified above, must be endorsed to be primary with respects to the coverage afforded the Additional Insureds, and such policy(ies) shall be primary to, and non-contributing with, any other insurance maintained by the DEPARTMENT. Any other insurance maintained by the DEPARTMENT shall be in excess of and shall not contribute with the CONTRACTOR'S or subcontractor's insurance, regardless of the "Other Insurance" clause contained in either party's policy of insurance.

4. Commercial Automobile Liability

Commercial Auto Liability insurance covering liability arising out of the use of any motor vehicle in connection with the work, including owned, leased, hired and non-owned vehicles bearing or, under the circumstances under which they are being used, required by the Motor Vehicle Laws of the State of New York to bear, license plates. Such policy shall have a combined single limit for Bodily Injury and Property Damage of at least one million dollars and shall name the State of New York as additional insured. The limits may be provided through a combination of primary and umbrella/excess liability policies. If this Contract involves the removal of hazardous waste from the project site or otherwise transporting hazardous materials, pollution liability coverage for covered

autos shall be provided by form CA 99 48 03 06 or CA 00 12 03 06 and the Motor Carrier Act Endorsement (MCS90) shall be attached.

5. Umbrella and Excess Liability

When the limits of the CGL, Auto, and/or Employers Liability policies procured are insufficient to meet the limits specified, the CONTRACTOR shall procure and maintain Commercial Umbrella and/or Excess Liability policies with limits in excess of the primary; provided, however, that the total amount of insurance coverage is at least equal to the requirements set forth above. Such policies shall follow the same form as the primary. Any insurance maintained by the DEPARTMENT or any additional insured shall be considered excess of and shall not contribute with any other insurance procured and maintained by the CONTRACTOR including primary, umbrella and excess liability regardless of the "other insurance" clause contained in either party's policy.

V. Conflicts of Interest

A. Prior to the execution of this Contract, the CONTRACTOR shall provide to the DEPARTMENT a form (Attachment 4, Contractor Assurance of No Conflict of Interest or Detrimental Effect), signed by an authorized executive or legal representative, attesting that the CONTRACTOR'S performance of the services does not and will not create a conflict of interest with, nor position the CONTRACTOR to breach any other Contract currently in force with the State of New York, and that the CONTRACTOR will not act in any manner that is detrimental to any State of New York project in which the CONTRACTOR is rendering services.

B. The CONTRACTOR hereby reaffirms the attestations made in Attachment 4 and further covenants and represents that there is and shall be no actual or potential conflict of interest that could prevent the CONTRACTOR'S satisfactory or ethical performance of duties required to be performed pursuant to the terms of this Contract. The CONTRACTOR shall have a duty to notify the DEPARTMENT immediately of any actual or potential conflicts of interest.

C. In conjunction with any subcontract under this Contract, the CONTRACTOR shall obtain and deliver to the DEPARTMENT, prior to entering into a subcontract, Attachment 4 Contractor Assurance of No Conflict of Interest or Detrimental Effect form, signed by an authorized executive or legal representative of the subcontractor. The CONTRACTOR shall also require in any subcontracting contract that the subcontractor, in conjunction with any further subcontracting contract, obtain and deliver to the DEPARTMENT a signed and completed Contractor Assurance of No Conflict of Interest or Detrimental Effect form for each of its subcontractors prior to

D. entering into a subcontract.

The CONTRACTOR shall disclose any existing or contemplated relationship with any other person or entity, including relationships with any member, shareholders of 5% or more, parent, subsidiary, or affiliated entity which would constitute an actual or potential conflict of interest or appearance of impropriety, relating to other clients/customers of the CONTRACTOR or former officers and employees of the DEPARTMENT and its affiliates, in connection with rendering services enumerated in this Contract. If a conflict does

or might exist, please describe how you will eliminate or prevent it. Indicate what procedures will be followed to detect, notify the DEPARTMENT of, and resolve any such conflicts. The DEPARTMENT will review the nature of any relationships and reserves the right to terminate this Contract for any reason, or for cause, if, in the judgment of the DEPARTMENT, a real or potential conflict of interest cannot be cured.

E. The CONTRACTOR shall disclose whether it or any of its members, shareholders of 5% or more, parents, affiliates, or subsidiaries have been the subject of any investigation or disciplinary action by the New York State Joint Commission on Public Ethics, or its predecessors or its predecessor entities (collectively, "Commission"), and if so, shall include a brief description indicating how any matter before the Commission was resolved or whether it remains unresolved. The DEPARTMENT will review the nature of any relationships and reserves the right to terminate this Contract for any reason, or for cause, if, in the judgment of the DEPARTMENT, a real or potential conflict of interest cannot be cured.

F. The DEPARTMENT and the CONTRACTOR recognize that conflicts may occur in the future because the CONTRACTOR may have existing, or establish new, relationships. The DEPARTMENT will review the nature of any relationships and reserves the right to terminate this Contract for any reason, or for cause, if, in the judgment of the DEPARTMENT, a real or potential conflict of interest cannot be cured.

VI. Public Officers Law

Contractors, consultants, vendors, and subcontractors may hire former employees of the DEPARTMENT. However, for informational purposes, in accordance with New York Public Officers Law, former employees of the State Agency or Authority may neither appear nor practice before the State Agency or Authority, nor receive compensation for services rendered on a matter before the State Agency or Authority, for a period of two years following their separation from State Agency or Authority service. In addition, former State Agency or Authority employees are subject to a "lifetime bar" from appearing before the State Agency or Authority or receiving compensation for services regarding any transaction in which they personally participated or which was under their active consideration during their tenure with the State Agency or Authority.

VII. Ethics Requirements

The CONTRACTOR and its subcontractors shall not engage any person who is, or has been at any time, in the employ of the DEPARTMENT to perform services in violation of the provisions of the New York Public Officers Law, other laws applicable to the service of DEPARTMENT employees, and the rules, regulations, opinions, guidelines or policies promulgated or issued by the New York State Joint Commission on Public Ethics, or its predecessors (collectively, the "Ethics Requirements"). The CONTRACTOR certifies that all of its employees and those of its subcontractors who are former employees of the DEPARTMENT and who are assigned to perform services under this Contract shall be assigned in accordance with all Ethics Requirements. During the Term, no person who is employed by the CONTRACTOR or its subcontractors and who is disqualified from providing services under this Contract pursuant to any Ethics Requirements may share in any net revenues of the CONTRACTOR or its subcontractors derived from this Contract. The

CONTRACTOR shall identify and provide the DEPARTMENT with notice of those employees of the CONTRACTOR and its subcontractors who are former employees of the DEPARTMENT that will be assigned to perform services under this Contract, and ensure that such employees comply with all applicable laws and prohibitions. The DEPARTMENT may request that the CONTRACTOR provide whatever information the DEPARTMENT deems appropriate about each such person's engagement, work cooperatively with the DEPARTMENT to solicit advice from the New York State Joint Commission on Public Ethics, and, if deemed appropriate by the DEPARTMENT, instruct any such person to seek the opinion of the New York State Joint Commission on Public Ethics. The DEPARTMENT shall have the right to withdraw or withhold approval of any subcontractor if utilizing such subcontractor for any work performed hereunder would be in conflict with any of the Ethics Requirements. The DEPARTMENT shall have the right to terminate this Contract at any time if any work performed hereunder is in conflict with any of the Ethics Requirements.

VIII. Subcontracting

A. The CONTRACTOR agrees not to subcontract any of its services, as indicated in its Scope of Work, without the prior written approval of the DEPARTMENT. Approval shall not be unreasonably withheld upon receipt of written request to subcontract.

B. The CONTRACTOR may arrange for a portion/s of its responsibilities under this Contract to be subcontracted to qualified, responsible subcontractors, subject to approval of the DEPARTMENT. If the CONTRACTOR determines to subcontract a portion of the services, once known, the subcontractors must be clearly identified and the nature and extent of their involvement in and/or proposed performance under this Contract must be fully explained by the CONTRACTOR to the DEPARTMENT. As part of this explanation, the CONTRACTOR must submit to the DEPARTMENT a completed Contractor Assurance of No Conflict of Interest or Detrimental Effect form (Attachment 4), from each known subcontractor as required under this section.

C. The CONTRACTOR retains ultimate responsibility for all services performed under the Contract.

D. All subcontracts shall be in writing and shall contain provisions which are functionally identical to and consistent with the provisions of this Contract, including, but not limited to, the body of this Contract, Appendix A – Standard Clauses for New York State Contracts and, if applicable, Appendix B. Unless waived in writing by the DEPARTMENT, all subcontracts between the CONTRACTOR and subcontractors shall expressly name the DEPARTMENT as the sole intended third party beneficiary of such subcontract. The DEPARTMENT reserves the right to review and approve or reject any subcontract, as well as any amendment to said subcontract(s), and this right shall not make the DEPARTMENT a party to any subcontract or create any right, claim, or interest in the subcontractor or proposed subcontractor against the DEPARTMENT.

E. The DEPARTMENT reserves the right, at any time during the term of the Contract, to verify that the written subcontract between the CONTRACTOR and subcontractors is in compliance with all of the provisions of this Section and any other subcontract provisions contained in this Contract.

F. The CONTRACTOR shall give the DEPARTMENT immediate notice in writing of the initiation of any legal action or suit which relates in any way to a subcontract with a subcontractor or which may affect the performance of the CONTRACTOR'S duties under the Contract. Any subcontract shall not relieve the CONTRACTOR in any way of any responsibility, duty and/or obligation of this Contract.

G. If at any time during performance under this Contract total compensation to a subcontractor exceeds or is expected to exceed $100,000, that subcontractor shall be required to submit and certify a Vendor Responsibility Questionnaire.

IX. General Specifications

A. The work shall be commenced and shall be actually undertaken within such time as the DEPARTMENT may direct by notice, whether by mail, e-mail, or other writing, whereupon the undersigned 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 CONTRACTOR will be required to complete the entire work or any part thereof as the case may be, to the satisfaction of the DEPARTMENT in strict accordance with the specifications and pursuant to this Contract.

C. CONTRACTOR will possess, and maintain, at no cost to the DEPARTMENT and for the term of the Contract, 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. Certification Regarding Debarment and Suspension

Regulations of the Department of Health and Human Services, located at Part 376 of Title 2 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs 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 DEPARTMENT (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 any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the DEPARTMENT must require its prospective CONTRACTORS, as prospective lower tier participants, to provide the certification as set forth below:

By signing this Contract or submitting a proposal pursuant to a solicitation issued by the Department, the prospective lower tier participant is providing the certification set out below:

a. 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 an erroneous certification, in addition to the other remedies available, the Federal Government, New York State or the DEPARTMENT may pursue available remedies, including suspension and/or debarment.

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

c. 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 Section, are defined in 2 CFR Part 180, as supplemented by 2 CFR Part 376.

d. The prospective lower tier participant agrees by signing this Contract or submitting a proposal pursuant to a solicitation issued by the DEPARTMENT 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 2 CFR Part 180, as supplemented by 2 CFR Part 376, or 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.

e. The prospective lower tier participant further agrees by signing this Contract or 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.

f. 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 2 CFR Part 180, as supplemented by 2 CFR Part 376, or 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. The DEPARTMENT strongly encourages each participant to check the List of parties Excluded from Federal Procurement and Non-procurement Programs in the System for Award Management.

g. 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 Section.

h. Except for transactions authorized under paragraph (d) of this certification, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 2 CFR Part 180 or 48 CFR Part 9, Subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available, the Federal Government, the New York State or the DEPARTMENT may pursue available remedies, including suspension and/or debarment.

i. Certification regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions

i. The prospective lower tier participant certifies, by signing this Contract or submitting a proposal to the Department, 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 agency.

ii. 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.

E. Ownership Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this Contract 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 DEPARTMENT for conformity with the policies and guidelines of the DEPARTMENT 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 Contract, dealing with any aspect of performance under this Contract, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the DEPARTMENT, and shall not be published or otherwise disseminated by the CONTRACTOR to any other party unless prior written approval is secured from the DEPARTMENT or under circumstances as indicated in paragraph 1 of this subsection. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the DEPARTMENT. The DEPARTMENT 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 Contract 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 Contract, without express written permission of the DEPARTMENT.

4. All reports, data sheets, documents, etc. generated under this Contract shall be the sole and exclusive property of the DEPARTMENT. 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 or its authorized agents.

5. This is 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 any application software provided to the DEPARTMENT as a part of this Contract.

F. Confidentiality Clause

The CONTRACTOR, its officers, agents and employees and subcontractors shall treat all information which is obtained by it through its performance under this CONTRACT, 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.

G. 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 Contract 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: (a) consulting, integration, code or data conversion, b) maintenance or support services, c) data entry or processing, or d) 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 or 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.

H. Lead Guidelines

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

I. On-Going Responsibility

1. General Responsibility Language: The CONTRACTOR shall at all times during this 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 this Contract.

3. Termination (for Non-Responsibility): Upon written notice to the CONTRATOR, and a reasonable opportunity to be heard with appropriate DEPARTMENT officials or staff, this 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.

J. Indemnification

CONTRACTOR shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and save harmless the DEPARTMENT from suits, actions, damages and costs of every name and description relating to personal injury and damage to real or personal tangible property and intellectual property, caused by any intentional act or negligence of CONTRACTOR, its agents, employees, partners or subcontractors, without limitation; provided, however, that the CONTRACTOR shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the DEPARTMENT.

K. Indemnification Relating to the Third Party Rights

1. The CONTRACTOR will also indemnify and hold the DEPARTMENT harmless from and against any and all damages, expenses (including reasonable attorneys' fees), claims, judgments, liabilities and costs that may be finally assessed against the DEPARTMENT in any action for infringement of a United States Letter Patent, or of any copyright, trademark, trade secret or other third party proprietary right except to the extent such claims arise from the DEPARTMENT'S gross negligence or willful misconduct, provided that the DEPARTMENT shall give CONTRACTOR: (a) prompt written notice of any action, claim or threat of infringement suit, or other suit, (b) the opportunity to take over, settle or defend such action, claim or suit at CONTRACTOR'S sole expense, and (c) assistance in the defense of any such action at the expense of CONTRACTOR.

2. If usage shall be enjoined for any reason or if CONTRACTOR believes that it may be enjoined, CONTRACTOR shall have the right, at its own expense and sole discretion to take action in the following order of precedence: (a) to procure for the DEPARTMENT the right to continue Usage; (b) to modify the service or Product so that Usage becomes non-infringing, and is of at least equal quality and performance; or (c) to replace said service or Product or part(s) thereof, as applicable, with non-infringing service or Product of at least equal quality and performance. If the above remedies are not available, the parties shall terminate this Contract, in whole or in part as necessary and applicable, provided the DEPARTMENT is given a refund for any amounts paid for the period during which Usage was not feasible.

L. Force Majeure

1. A force majeure occurrence is an event or effect that cannot be reasonably anticipated or controlled by the DEPARTMENT or the CONTRACTOR, its subcontractors, or others under the CONTRACTOR'S or its subcontractor's control. Force majeure includes, but is not limited to, acts of God, acts of war, acts of public enemies, strikes, fires, explosions, actions of the elements, floods, or other similar causes beyond the control of the CONTRACTOR or the DEPARTMENT in the performance of this Contract where non-performance, by exercise of reasonable diligence, cannot be

prevented. The CONTRACTOR shall provide the DEPARTMENT with written notice of any force majeure occurrence as soon as the force majeure occurrence giving rise to a delay in CONTRACTOR'S performance under this Contract is known.

2. Neither the CONTRACTOR nor the DEPARTMENT shall be liable to the other for any delay in or failure of performance under this Contract due to a force majeure occurrence. Any such delay in or failure of performance shall not constitute default or give rise to any liability for damages. The existence of such causes of such delay or failure shall extend the period for performance to such extent as determined by the CONTRACTOR and the DEPARTMENT to be necessary to enable complete performance by the CONTRACTOR if reasonable diligence is exercised after the case of delay or failure has been removed.

3. Notwithstanding the above, at the discretion of the DEPARTMENT where the delay or failure will significantly impair the value of this Contract to the DEPARTMENT, the DEPARTMENT may:

    a. Accept allocated performance or deliveries from the CONTRACTOR. The CONTRACTOR, however, hereby agrees to grant preferential treatment to the DEPARTMENT with respect to product, materials, or services; or

    b. Purchase from other sources (without recourse to and by the CONTRACTOR for the costs and expenses thereof) to replace all or part of the product, materials, or services which are the subject of the delay, which purchases may be deducted from the Contract quantities without penalty or liability to the DEPARTMENT; or

    c. Terminate the Contract, or the portion thereof which is subject to delays, and thereby discharge any unexecuted portion of this Contract or the relevant part thereof.

4. In addition, the DEPARTMENT reserves the right, at its sole discretion, to make an equitable adjustment in the Contract terms and/or pricing should extreme and unforeseen volatility in the marketplace affect pricing or the availability of supply. “Extreme and unforeseen volatility in the marketplace” is defined as market circumstances which meet the following criteria: (a) the volatility is due to causes outside the control of the CONTRACTOR; (b) the volatility affects the marketplace or industry, not just the particular source of supply utilized for performance of this Contract; (c) the effect on pricing or availability of supply is substantial; and (d) the volatility so affects the CONTRACTOR’S performance that continued performance of this Contract would result in a substantial loss.

M. 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:

Contact at State of New York Department of Health

Name/Title

Address

Email

Phone/Fax

Contact at Contractor

Name/Title

Address

Email

Phone/Fax

Any such notices 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 Contract 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 Contract. 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.

N. Provision Related to Consultant Disclosure Legislation

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 DEPARTMENT fiscal year included in this Contract term. This report must be submitted to:

1. The NYS Department of Health, at the following address New York State Department of Health, Bureau of Contracts Room 2827, Corning Tower, Albany, NY 12237; and

2. 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

3. The NYS Department of Civil Service, Albany NY 12239, ATTN: Consultant Reporting.

O. Provisions Related to 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). 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.

P. Technology Purchases Notification

The following provisions apply if this Request for Proposal (RFP) seeks proposals for "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 RFP results in procurement of software over $20,000, or of other technology over $50,000, or where the DEPARTMENT determines that the potential exists for coordinating purchases among New York State agencies and/or the purchase may be of interest to one or more other New York State agencies, prior to award selection, this RFP and all responses thereto are subject to review by the New York State Office for Information Technology Services.

3. Accessibility of State Agency Web-based Intranet and Internet Information and Applications. 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, as determined by quality assurance testing. Such quality assurance testing will be conducted by the DEPARTMENT and awarded CONTRACTOR and the results of such testing must be satisfactory to the DEPARTMENT before web content will be considered a qualified deliverable under the Contract or procurement.

APPENDIX M

PARTICIPATION BY MINORITY AND WOMEN-OWNED BUSINESS ENTERPRISES

I. General Provisions

A. The New York State Department of Health is required to implement the provisions of New York State Executive Law Article 15-A (Article 15-A) and 5 NYCRR Parts 140-145 ("MWBE Regulations") for all state Contracts as defined therein, with a value (1) in excess of $25,000 for labor, services, equipment, materials, or any combination of the foregoing or (2) in excess of $100,000 for real property renovations and construction.

B. The CONTRACTOR to this Contract agrees, in addition to any other nondiscrimination provision of this Contract and at no additional cost to the DEPARTMENT to fully comply and cooperate with the DEPARTMENT in the implementation of New York State Executive Law Article 15-A. These requirements include equal employment opportunities for minority group members and women ("EEO") and contracting opportunities for certified minority and women-owned business enterprises ("MWBEs"). CONTRACTOR's demonstration of "good faith efforts" pursuant to 5 NYCRR §142.8 shall be a part of these requirements. These provisions shall be deemed supplementary to, and not in lieu of, the nondiscrimination provisions required by New York State Executive Law Article 15 (the "Human Rights Law") or other applicable federal, state or local laws.

C. Failure to comply with all of the requirements herein may result in a finding of non-responsiveness, non-responsibility and/or a breach of this Contract, leading to the withholding of funds or such other actions, liquidated damages pursuant to Section VII of this Appendix or enforcement proceedings as allowed by this Contract.

II. Contract Goals

A. For purposes of this procurement, the DEPARTMENT hereby establishes an overall goal of__% for MWBEs participation,___% for Minority-Owned Business Enterprises ("MBE") participation and__% for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs).

B. For purposes of providing meaningful participation by MWBEs on this Contract and achieving the Contract Goals established in Section II-A hereof, CONTRACTOR should reference the directory of New York State Certified MBWEs found at the following internet address: http://www.esd.ny.gov/mwbe.html.

C. Additionally, CONTRACTOR is encouraged to contact the Division of Minority and Women's Business Development ((518) 292-5250; (212) 803-2414; or (716) 846-8200) to discuss additional methods of maximizing participation by MWBEs on the Contract.

Where MWBE goals have been established herein, pursuant to 5 NYCRR §142.8, CONTRACTOR must document "good faith efforts" to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of this Contract. In

accordance with Section 316-a of Article 15-A and 5 NYCRR §142.13, the CONTRACTOR acknowledges that if CONTRACTOR is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in this Contract, such a finding constitutes a breach of this Contract and the CONTRACTOR shall be liable to the DEPARTMENT for liquidated or other appropriate damages, as set forth herein.

III. Equal Employment Opportunity (EEO)

A. CONTRACTOR agrees to be bound by the provisions of Article 15-A and the MWBE Regulations promulgated by the Division of Minority and Women's Business Development of the Department of Economic Development. If any of these terms or provisions conflict with applicable law or regulations, such laws and regulations shall supersede these requirements.

B. CONTRACTOR shall comply with the following provisions of Article 15-A:

1. CONTRACTOR and subcontractors shall undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, EEO shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.

2. The CONTRACTOR shall submit an EEO policy statement to the DEPARTMENT within seventy-two (72) hours after the date of the notice by the DEPARTMENT to award this Contract to the CONTRACTOR.

3. If CONTRACTOR or subcontractor does not have an existing EEO policy statement, the DEPARTMENT may provide the CONTRACTOR or subcontractor a model statement (see Form #5 - Minority and Women-Owned Business Enterprises Equal Employment Opportunity Policy Statement).

4. The CONTRACTOR'S EEO policy statement shall include the following language:

   a. The CONTRACTOR will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force.

   b. The CONTRACTOR shall state in all solicitations or advertisements for employees that, in the performance of this 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.

   c. 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.

C. Form #4 - Staffing Plan

To ensure compliance with this Section, the CONTRACTOR shall submit a staffing plan to document the composition of the proposed workforce to be utilized in the performance of this Contract by the specified categories listed, including ethnic background, gender, and Federal occupational categories. CONTRACTOR shall complete the Staffing plan form and submit it as part of their bid or proposal or within a reasonable time, but no later than the time of award of this Contract.

D. Workforce Utilization Report

1. The CONTRACTOR shall submit a Workforce Utilization Report, and shall require each of its subcontractors to submit a Workforce Utilization Report, in such form as shall be required by the DEPARTMENT on a QUARTERLY basis during the term of the Contract.
2. Separate forms shall be completed by the CONTRACTOR and any subcontractors.
3. Pursuant to Executive Order #162, CONTRACTORS and subcontractors are also required to report the gross wages paid to each of their employees for the work performed by such employees on the contract on a quarterly basis.

E. CONTRACTOR shall comply with the provisions of the Human Rights Law, all other state and federal statutory and constitutional non-discrimination provisions. CONTRACTOR and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

The CONTRACTOR shall include the provisions of subparagraphs (a) through (c) of paragraph 4 of subsection B and subsection D of this Section which provides for relevant provisions of the Human Rights Law, in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with this Contract.

IV. MWBE Utilization Plan

A. The CONTRACTOR represents and warrants that CONTRACTOR has submitted an MWBE Utilization Plan (Form #1) either prior to, or at the time of, the execution of this Contract.

B. CONTRACTOR agrees to use such MWBE Utilization Plan for the performance of MWBEs on this Contract pursuant to the prescribed MWBE goals set forth in Section II.A of this Appendix.

C. CONTRACTOR further agrees that a failure to submit and/or use such MWBE Utilization Plan shall constitute a material breach of the terms of this Contract. Upon the occurrence of such a material breach, the DEPARTMENT shall be entitled to any remedy provided herein, including but not limited to, a finding of CONTRACTOR non-responsiveness.

V. Waivers

A. For Waiver Requests CONTRACTOR should use Form #2 – Waiver Request.

B. If the CONTRACTOR, after making good faith efforts, is unable to comply with MWBE goals, the CONTRACTOR may submit a Request for Waiver form documenting good faith efforts by the CONTRACTOR to meet such goals. If the documentation included with the waiver request is complete, the DEPARTMENT shall evaluate the request and issue a written notice of acceptance or denial within twenty (20) days of receipt.

C. If the DEPARTMENT, upon review of the MWBE Utilization Plan and updated Quarterly MWBE CONTRACTOR Compliance Reports determines that CONTRACTOR is failing or refusing to comply with the Contract goals and no waiver has been issued in regards to such non-compliance, the DEPARTMENT may issue a notice of deficiency to the CONTRACTOR. The CONTRACTOR must respond to the notice of deficiency within seven (7) business days of receipt. Such response may include a request for partial or total waiver of MWBE Contract Goals.

VI. Quarterly MWBE CONTRACTOR Compliance Report

CONTRACTOR is required to submit a Quarterly MWBE CONTRACTOR Compliance Report to the DEPARTMENT by the 10th day following each end of quarter over the term of this Contract documenting the progress made towards achievement of the MWBE goals of this Contract. Data should be submitted via the online compliance system at https://ny.newnyContracts.com. Additionally, Contractor and each of its Subcontractors shall be required to submit a Workforce Utilization Report, in such format as shall be required by the DEPARTMENT on a Quarterly basis during the term of the Contract.

VII. Liquidated Damages - MWBE Participation

A. Where the DEPARTMENT determines that CONTRACTOR is not in compliance with the requirements of this Contract and CONTRACTOR refuses to comply with such requirements, or if CONTRACTOR is found to have willfully and intentionally failed to comply with the MWBE participation goals, CONTRACTOR shall be obligated to pay to the DEPARTMENT liquidated damages.

B. Such liquidated damages shall be calculated as an amount equaling the difference between:

   1. All sums identified for payment to MWBEs had the CONTRACTOR achieved the Contractual MWBE goals; and

   2. All sums actually paid to MWBEs for work performed or materials supplied under this Contract.

C. In the event a determination has been made which requires the payment of liquidated damages and such identified sums have not been withheld by the DEPARTMENT, CONTRACTOR shall pay such liquidated damages to the DEPARTMENT within sixty (60) days after they are assessed by the DEPARTMENT unless prior to the expiration of such sixtieth day, the CONTRACTOR has filed a complaint with the Director of the Division of Minority and Women's Business Development pursuant to Subdivision 8 of Section 313 of the Executive Law in which event the liquidated damages shall be payable if Director renders a decision in favor of the DEPARTMENT.

APPENDIX C-2023
PROGRAM SPECIFIC REQUIREMENTS

Table of Contents

I. DEFINITIONS

"1332 State Innovation Waiver Specific Terms and Conditions" or **"1332 STC"** means the agreement and incorporated documents between the United States Departments of Health and Human Services (HHS) and the Treasury and the STATE, which governs the operation of the 1332 Waiver.

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

"Agreement" means 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"** means the comprehensive operational plan 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 ("BHP") in accordance with applicable law.

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

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

"Certification" or **"Essential Plan Certification"** means 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 plan complies with the requirements of the Invitation, as modified by the Marketplace, as well as provisions of applicable law.

"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.

"Coverage Effective Date" is the date when Essential Plan coverage~~, or Essential Plan Plus Adult Vision and Dental,~~ 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 or the 1332 STC and applicable law.

"Enrollee" means an Eligible Individual enrolled in an Essential Plan ~~or Essential Plan Plus Adult Vision/Dental~~ offered through the Marketplace.

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

"Essential Plan" means 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) or, in the alternative, pursuant to a State Innovation Waiver under section 1332 of the ACA, to be offered through the Marketplace in accordance with applicable law~~NY Social Services Law section 369-gg~~.

~~**"Essential Plan Plus Adult Vision/Dental"** means 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.~~

"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).

"Health Care Services" means the provision of medical, dental, and vision 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)" means 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)" means 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) 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.

(6) A State Innovation Program authorized under section 1332 of the Affordable Care Act (the "1332 State Innovation Waiver" or "1332 Waiver").

"Invitation" means the Invitation and Requirements for Insurer Certification and Recertification and the attachments thereto, issued by the Marketplace to health plan issuers to participate in the Marketplace, as modified by the Questions and Answers regarding the Invitation posted on the Marketplace website. "Marketplace" means 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 NY Public Health Law sections 268 – 268-h and Executive Order Number 42 on April 12, 2012.

"Marketplace Facilitated Enroller" means employees and representatives of the CONTRACTOR who have (i) completed Marketplace approved training regarding QHP eligibility for Insurance Affordability Programs and benefit rules and regulations, (ii) passed an examination to assure successful completion of the training, and (iii) received Marketplace authorization to provide application assistance to individuals enrolling in Insurance Affordability Programs through the Marketplace.

"Medical Record" means 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" means 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" means a provider of Health Care Services with which the CONTRACTOR has no Provider Agreement.

"Participating Provider" means a provider of Health Care Services that has a Provider Agreement with the CONTRACTOR.

"Personally Identifiable Information (PII)" means 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" means the dollar amount payable by the Enrollee to the CONTRACTOR to effectuate and maintain coverage.

"Provider Agreement" means any written contract between the CONTRACTOR and Participating Providers to provide Health Care Services to CONTRACTOR's Enrollees in Essential Plan ~~and/or Essential Plan Plus Adult Vision and Dental~~.

"Recertification" refers 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.

"Service Area" means the geographic area(s) designated by the STATE or DFS in which a Contractor's Essential Plan(s) shall be offered.

"Subscriber" means the Enrollee to whom the CONTRACTOR issues a Subscriber Contract to obtain health care coverage on behalf of him or herself.

"Subscriber Contract" means 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.

"**Unwind**" refers to the period of approximately 14 months following the end of the continuous enrollment condition authorized during the federal COVID-19 Public Health Emergency and any extension of time granted by CMS to allow STATE to complete renewals for Enrollees.

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 ~~and Essential Plans Plus Adult Vision/Dental~~ 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 will at all times act as independent contractors and nothing in this Agreement will 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 ~~and Essential Plans Plus Adult Vision/Dental~~, the BHP Blueprint, the 1332 STC, and related issues addressed in this Agreement continue to develop on an ongoing basis. If laws and regulations pertaining to Essential Plans, ~~and/or~~ the BHP Blueprint, and/or the 1332 STC change the requirements or processes set forth in this Agreement, the requirements of federal and state laws and regulations will govern. The STATE will 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 will support each other in their marketing, enrollment, and Enrollee transition efforts in accordance with applicable law. The Parties will 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), or pursuant to a 1332 State Innovation Waiver and applicable State law related to 1332 Waivers, CONTRACTOR must 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 September 1st of the year in which they respond to the Invitation~~November 1, 2020~~ and (b) demonstrate to the satisfaction of the STATE that they have the capacity to be fully operational by September 1st of the year in which they respond to the Invitation~~November 1, 2020~~.

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, including Essential Health Benefits, Cost Sharing and Individual Premium Contributions;

    b. the Quality and Enrollee Satisfaction requirements;

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

    d. the Premium Rate and Policy Form and Filing requirements

~~4. Certification of CONTRACTOR's health insurance plan(s) as Essential Plan(s) Plus Adult Vision / Dental by the STATE confirms that the plan(s) also comply with the following provisions of the Invitation:~~

~~a. the Applicant-Specific Requirements, including Cost-Sharing and Individual Premium Contributions;~~

~~b. the Quality and Enrollee Satisfaction requirements;~~

~~c. the Network Adequacy Requirements;~~

~~d. the Premium Rate and Policy Form and Filing requirements.~~

~~5.~~4. STATE will notify the CONTRACTOR of Essential Plan certification ~~and Essential Plan Plus Adult Vision / Dental certification~~ by e-mail and/or regular mail.

B. Contractor's Essential Plans

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

2. CONTRACTOR must 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 must 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 must cover established geographic areas 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 must 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 must 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 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.

8. CONTRACTOR must submit to the STATE a URL link that provides access to the CONTRACTOR's formulary. 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 must 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 will review CONTRACTOR's formulary to assure compliance with State law.

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

11. CONTRACTOR must 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 must 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.

C. Essential Plan Maintenance

1. CONTRACTOR acknowledges and agrees that the certification of Essential Plan(s) ~~and Essential Plans Plus Adult Vision / Dental~~ 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~~iv) 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 or her designee. Decertification must 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 must 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 if 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 must 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 satisfies the access standards in 45 C.F.R. 156.230 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 must 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.

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 Enrollees have access to all services without undue delay. This includes geographic accessibility (i.e. meeting time / distance standards) and accessibility 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).

B. Network Composition

1. CONTRACTOR's network must contain all 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, the network must include at least three (3) hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, New York, 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.

    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:

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 will undertake its best efforts to meet the 30-minute / 30-mile standard.

2. In its behavioral health network, CONTRACTOR must 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 must 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 must 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 must 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 must 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 must 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 must review its provider network on a monthly basis to identify providers that require exclusion.

E. Network Adequacy Review / Process

1. STATE:

a. Will 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. Will review the adequacy of CONTRACTOR's network upon submission and on a quarterly basis thereafter.

c. Will, in the event STATE identifies an insufficiency in CONTRACTOR's network, provide CONTRACTOR with written notice of such insufficiency and an opportunity to cure within the specific time period required by the STATE., The time period will be at least 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 STATE finds the CONTRACTOR's network deficient. If 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:

   a. will make available to the STATE a URL link that provides an up-to-date online directory of providers. The STATE will make such link publicly available on the Marketplace website.

   b. Must 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. Will submit its network through the Provider Network Data System (PNDS) in accordance with the 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 if the system is not able to capture or accurately identify particular providers;

   d. Must ensure it has secured a Provider Agreement for each provider included in the network CONTRACTOR has submitted for review and approval;

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

   f. Must ensure that the consumer network protections set forth in applicable law are available to Enrollees, including those related to emergency medical services and surprise bills as outlined in Chapter 60 of the Laws of 2014, as amended.

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 will 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 must 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 must 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

A. Monitoring by State

1. CONTRACTOR must develop and maintain a quality strategy that encompasses all the requirements set forth in section 1311(g) of the ACA (42 USC § 18031(g)). 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 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;

   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 must 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.

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

4. CONTRACTOR must 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 must 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 must 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 will determine an individual applicant's eligibility to enroll in an Essential Plan as well as other Insurance Affordability Programs. The STATE will not permit an applicant to request an eligibility determination for less than all Insurance Affordability Programs.

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

3. STATE will make eligibility determinations in accordance with the requirements of the BHP Blueprint, the 1332 STC, state and federal law, and state policies and procedures.

4. The STATE will redetermine Essential Plan eligibility every 12 months and ~~When individual Enrollees report a change in circumstances, the STATE will re-determine eligibility and~~ allow for transition to another Insurance Affordability Program in accordance with the BHP Blueprint, the 1332 STC, the requirements of state and federal law and state policies and procedures.

5. Enrollees will have twelve (12) months of continuous coverage regardless of changes in circumstances, as long as the enrollees are under age 65, are not otherwise enrolled in minimum essential coverage and remain New York State residents ~~STATE will 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.

6. STATE will provide Enrollees with an annual notice of redetermination of eligibility. If an Enrollee remains eligible for coverage in an Essential Plan, the STATE will provide Enrollee with notice of a reasonable opportunity at least annually to change plans. Enrollee will 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.

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

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 that the STATE issues in accordance with the BHP Blueprint or the 1332 STC will include a notice of the right to appeal the determination and instructions regarding how to file an appeal.

10. STATE will provide applicants with the opportunity to appeal Essential Plan eligibility determinations through the Marketplace.

11. STATE will 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 must initiate termination of the enrollment of individual Enrollees and permit CONTRACTOR to terminate such coverage 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 ; and non-payment of premiums for coverage of the Enrollee and the exhaustion of the 30-day grace period to pay any premium prior to disenrollment.

B. Obligations of CONTRACTOR

1. CONTRACTOR must 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.

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 must comply with the provisions of Appendix C-1 of this Agreement regarding the Marketplace Facilitated Enrollment (FE) Program.

3. CONTRACTOR must 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. Applicants who meet the eligibility standards qualify for an Essential Plan as follows:

    a. Individuals with income greater than 200 percent and less than or equal to 250 percent of FPL (“Essential Plan 200-250”), subject to an approved 1332 Waiver, or

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

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

~~c.~~d. 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

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

5. For individuals who are determined eligible to enroll in an Essential Plan offered through the Marketplace, effective dates for enrollment are 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, 2021 will have coverage in the Essential Plan starting February 1, 2021.

   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. For example, an individual who selects an Essential Plan on February 12, 2021 will have coverage that begins on March 1, 2021. An individual who selects an Essential Plan on February 18, 2021 will have coverage in the Essential Plan starting April 1, 2021.

6. Enrollees who renew coverage in an Essential Plan after the fifteenth of the month in their last month of coverage will have no gap in coverage. Coverage will begin on the first day of the following month and they will be enrolled in the same plan. Enrollees who renew coverage in an Essential Plan after the fifteenth of the month in their last month of coverage who opt to select a new plan will be enrolled in their current plan the first of the following month and will transition into their new plan the first of the next month. For example, an Enrollee whose coverage ends on December 31, 2023 who returns to their Marketplace account on December 25, 2023 and completes necessary updates and remains eligible for the Essential Plan will be enrolled in their same plan beginning January 1, 2024. If the Enrollee selects a new Essential Plan, they will be enrolled in their same plan

beginning January 1, 2024 and the coverage in their new plan will begin February 1, 2024.

~~b.~~ 7. Beginning with coverage ending June 30, 2023, and for the duration of the Unwind, Enrollees who fail to renew before their eligibility end date, but who renew within thirty (30) days of the end date and remain eligible for Essential Plan and for the same health plan will have retroactive enrollment to the first of the month so there is no gap in coverage. For example, an Enrollee with an end date of June 30, 2024 who fails to renew timely, but who completes a renewal on July 12, 2024 and elects to remain enrolled with the same health plan will have a July 1, 2024 start date.

~~6.~~ 8. Starting November 1, 2023, individuals who are determined eligible to enroll in the Essential Plan offered through the Marketplace shall have a coverage effective date of the first of the month in which an Essential Plan is selected. For example, an individual who selects an Essential Plan on February 20, 2024 will have coverage in the Essential Plan starting February 1, 2024.

~~7.~~ 9. 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 must 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 will be considered timely.

~~8.~~ 10. 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.~~ 11. After enrollment is effectuated, CONTRACTOR must provide Enrollee with a thirty (30) day grace period to pay Premiums prior to disenrollment.

~~10.~~ 12. CONTRACTOR must provide Enrollees with reasonable notice of past due Premiums and an opportunity to pay prior to disenrollment.

~~11.~~ 13. 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.

~~12.~~ 14. CONTRACTOR must 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.

~~13.~~ 15. CONTRACTOR must accept retroactive enrollments from the STATE in special circumstances as determined by the STATE. Such circumstances 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 must 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. CONTRACTOR must enter into a Trading Partner Agreement with STATE to address the secure exchange of HIPAA compliant health care transactions.

2. The STATE must 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 will transmit 834 transactions to CONTRACTOR on a daily basis and CONTRACTOR must process these transactions regularly, 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 up the files;

    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 must adhere to the Trading Partner Agreement attached hereto as an Appendix and the individual Trading Partner Guides referenced therein.

5. CONTRACTOR must 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. CONTRACTOR may fulfill the Notification of the Coverage Effective Date through a "Welcome Letter" or similar notification. To the extent practicable, such notification must precede the Coverage Effective Date.

a. As of the Coverage Effective Date, and until the Effective Date of Disenrollment, the CONTRACTOR is, pursuant to the terms and conditions of the Essential Plan, 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.

3. CONTRACTOR will 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 must 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, gender identity or type of illness or condition.

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

3. In accordance with federal regulation, CONTRACTOR must 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 must 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 must 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. Assure that documents and website content that are considered critical for obtaining health insurance coverage or access to health care services for qualified individuals, applicants, or enrollees include taglines in the top 15 non-English languages spoken in the state, stating the availability of written translation or oral interpretation services to understand the information provided and the toll-free and TTY/TDY telephone number of the customer service unit. Documents that are considered critical include provider directories, enrollee handbooks, appeal and grievance notices and denial and termination notices. The Department will provide CONTRACTOR with a list of the top 15 non-English languages spoken in the state or will identify the recognized data source for the top 15 non-English languages spoken in the state.

d. 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.

e. 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.

f. To the extent that HHS establishes standards on written materials and/or verbal information for the Marketplace that provid es 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.

B. Provider Directories

1. The CONTRACTOR must maintain and update, and make publicly available, a listing by specialty of all Participating Providers, including facilities (the "Provider Directory"). 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 must 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 must 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 must 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 must 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 must, 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.

D. Member Identification Cards

1. CONTRACTOR must 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 must 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 must 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 must 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. 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;

    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; 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.

    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.

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

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;

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 must 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 must make reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before termination of coverage for such individuals.

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 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.

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 two weeks prior to the beginning of the open enrollment date of the applicable calendar 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

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

2. 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 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 must 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 must 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 must 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 must 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 must initiate an advertising campaign designed to publicize the access to quality, affordable health insurance.

B. Obligations of CONTRACTOR

1. CONTRACTOR must 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 must 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 must use the NY State of Health 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. Such materials must be developed in accordance with the Marketplace co-branding guidelines and receive co-branding approval prior to distribution or publication. STATE will provide co-branding guidelines to CONTRACTOR upon CONTRACTOR's request.

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

7. CONTRACTOR must 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 must 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 must 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.

3. CONTRACTOR must 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 and HITECH. This includes individual Medical Records and any other health and enrollment information that identifies a particular Enrollee.

4. CONTRACTOR must:

    a. Disclose PII and PHI only in accordance with applicable law, including 42 C.F.R. Part 431, subpart F. ;

    b. Maintain information in a timely and accurate manner;

    c. 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, ensure that each Enrollee may (i) request a copy of his or her records and information in a designated records set, (ii) receive such records and information in a timely manner, and (iii) request that his or her records be supplemented or corrected.

5. CONTRACTOR's privacy and security standards must be consistent with the principles outlined in 45 C.F.R. 155.260(a)(3), specifically: (i) individual access, (ii) correction, (iii) openness and transparency, (iv) individual choice, (v) collection, use and disclosure limitations, (vi) data quality and integrity, (vii) safeguards, and (viii) accountability.

6. CONTRACTOR must safeguard PII and PHI with reasonable operational, administrative, technical and physical controls to ensure its confidentiality, integrity and availability and to prevent unauthorized or inappropriate access,

use or disclosure. CONTRACTOR must monitor, periodically assess and update these controls to ensure their continued effectiveness.

7. CONTRACTOR must require any subcontractors or agents with access to PII and/or PHI to comply with the CONTRACTOR's privacy and security obligations pursuant to this Agreement.

8. CONTRACTOR must, following the discovery of any "Breach" in the security of a system used to exchange data in accordance with this Agreement, including PII and/or PHI, immediately notify the STATE and commence an investigation in accordance with applicable law to determine the scope of any actual or suspected Breach and restore the security of the system to prevent any further Breach. "Breach" shall mean the compromise, unauthorized access, loss of control or similar occurrence where persons other than authorized users and for other than authorized purposes have access or potential access to PII and/or PHI, whether physical or electronic.

9. CONTRACTOR must 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 must promptly report to the STATE any security incident of which it becomes aware. "Security incident" means the attempted or successful (i) unauthorized access, use, disclosure, modification or destruction of Enrollee information, including PII or PHI, (ii) interference with system operations affecting the exchange of data set forth in this Agreement, and/or (iii) loss of Enrollee information, including PII or PHI, due to the loss or misplacement of hardware, storage devices or paper documents.

XIV. REPORTING / DATA COLLECTION

A. General Requirements

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

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

3. CONTRACTOR must 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 must 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 must 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 must 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 a Medical Loss Ratio no less than eighty-six percent (86%)~~an eighty-five percent (85%) Medical Loss Ratio~~ beginning January 1, 2023~~2016~~.

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

5. CONTRACTOR must 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:

a. Claims payment policies and practices;
b. Periodic financial disclosures;
c. Data on enrollment;
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 must ensure that the above listed information is provided in plain language as defined in 45 C.F.R. 155.20.

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.

XV. INDIANS AND ALASKA NATIVES

1. CONTRACTOR must 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.

   b. No Cost Sharing shall be imposed on Indians.

   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).

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.

3. CONTRACTOR must 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).

XVI. INDEMNIFICATION

A. Indemnification by Contractor

1. CONTRACTOR must 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.

XIX. RECORDS MAINTENANCE / EXAMINATION AND AUDIT

A. Maintenance of Contractor Records

1. The CONTRACTOR must 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 must 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 must 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 must, 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 must 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 must 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 must 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.

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 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. The STATE will determine Capitation Rates prospectively and will not retroactively adjust Capitation Rates to reflect actual Essential Plan data or CONTRACTOR experience for the time period covered by the rates. The STATE may adjust Capitation Rates retroactively to satisfy program requirements.

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 or applicable law related to Section 1332 State Innovation Waivers.

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.

4. The CONTRACTOR is subject to the Medical Loss Ratio of at least eighty-six ~~eighty five~~ percent (86~~85~~%) and to rebating provisions. For purposes of the rebate, the STATE is considered the enrollee. (See, Patient Protection and Affordable Care Act §1331(b)(3), 42 CFR 600.415(b)(3); 45 CFR 158.240).

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 insurance affordability programs (IAPs). The NY State of Health, The Official Health Plan Marketplace (Marketplace) of the New York State Department of Health ("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 the Essential Plan (Basic Health Program)] and QHPs 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 the Essential Plan.

2. CONTRACTOR's employees and representatives may provide application assistance to individuals applying for coverage 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 must 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 must ensure its employees and representatives complete any subsequent training required by the Marketplace, which includes successfully completing annual re-authorization training.

3. CONTRACTOR must establish procedures to ensure that 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.

4. CONTRACTOR must 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.

5. CONTRACTOR must comply with the Privacy and Security provisions of this Agreement consistent with 45 C.F.R. §155.260 and applicable law, as well as Marketplace authentication and data security standards and procedures. CONTRACTOR shall ensure that its Marketplace FEs are appropriately supervised to assure ongoing compliance with Privacy and Security requirements to safeguard PII.

6. CONTRACTOR must either directly or through an appropriate referral to an Navigator or non-Navigator assistance personnel or to NY State of Health Customer 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.

7. 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. initiating 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.

8. CONTRACTOR must obtain a written attestation from each Marketplace FE regarding his or her commitment to comply with the standards specified in paragraphs "1" through "7" of Section "II" of this appendix, related to required training, authorization, availability of information, privacy and security of PII, accessibility, and prohibition regarding fees. CONTRACTOR must provide these attestations to STATE upon request.

9. 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. All computers used by Marketplace FEs must have supported Operating Systems and the latest security patches installed.

iii. Generally, Marketplace FEs should provide in person assistance if possible. However, under some circumstances, in accordance with guidelines issued by STATE, Marketplace FEs may provide certain assistance by telephone or other methods approved by the STATE. This includes but is not limited to using the telephone or other methods to collect follow-up information, or to assist in the renewal process.

iv. 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.

v. Register and monitor performance of their individual Marketplace FEs.

10. CONTRACTOR shall implement plans of correction for Marketplace FEs who are not adequately performing their duties under the Marketplace FE program, and shall 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.

11. CONTRACTOR must inform STATE within two (2) business days if a Marketplace FE has left his or her position or is on extended leave and must inform the STATE to whom their clients should be re-assigned. This information must be reported to: Assistor.Admin@health.state.ny.us.

12. 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 on-line training programs.

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.

NY State of Health 2021 Plan Invitation:

Supplemental Information

May 7, 2020

Updated Standard Bronze Product

The New York State Department of Financial Services and NY State of Health have updated the Standard Bronze (non-HSA) Product Design for 2021. The updated product design is included in **Attachment B** and is posted online here: https://info.nystateofhealth.ny.gov/invitation

The standard Bronze (non-HSA) product includes 3 pre-deductible visits to a primary care provider (PCP) or specialist that are subject to a co-payment. There is a modest increase to the deductible (from $4,425 in 2020 to $4,700 in 2021) and cost sharing for PCP and specialist visits will be subject to co-payment instead of co-insurance.

Questions and Answers

Invitation

Question: Given that we are all working remote, can our letters of interest and participation proposals be signed electronically?
Answer: Yes. NY State of Health requests that all plan letters of interest and participation proposals are submitted electronically, including electronic signatures.

Dental

Question: Are we being asked to add "NSD" to the plan name? Or is that for QHPs with dental?
Answer: For QHP products only: Include "NSD" to indicate that the embedded dental benefits are not subject to the QHP deductible. Please note this where applicable for both pediatric and adult/family coverage.

Question: Which entities will be required to complete and submit a Qualified Dental Plan (QDP) Benefit and Cost Sharing Template? Only stand-alone dental plans? Will medical QHPs that include adult dental benefits also be required to submit this template?

Answer: Medical QHP issuers that offer products with adult/family embedded dental benefits must complete the template and only need to provide us with details relating to products that

have adult/family embedded dental coverage. Medical issuers that offer QHPs without embedded dental benefits or who offer products with only pediatric dental coverage embedded, do not need to complete the template.

Stand-Alone Dental Plans must complete the template for both pediatric standard products and non-standard adult-family products.

The template will be sent to the issuers in the next few weeks by the plan managers. The data submission due date to NY State of Health is August 31, 2020.

New subsection added to (v) to E.1., Page 60 2021 Plan Invitation – Submission of QDP Benefit Cost Sharing Template to DOH.

Invitation and Requirements for Insurer Certification and Recertification for Participation in 2021

QUALIFIED HEALTH PLANS, STAND-ALONE DENTAL PLANS & ESSENTIAL PLANS

Revised May 7, 2020

Table of Contents

APPENDIX D

2021 Schedule of Key Events

EVENT	DUE DATE	QHP	SADP	EP
Invitation Released	April 30, 2020	x	x	x
Letters of Interest Due to NYSoH	May 7, 2020	x	x	x
Written Questions Accepted by NYSoH	April 28 – May 29, 2020	x	x	x
Dental Forms and Rate Filings Due to DFS in SERFF	May 4, 2020		x	
Medical Policy Forms and Rates Due to DFS in SERFF	May 18, 2020	x		
Dental on Exchange Binders Due in SERFF	May 18, 2020		x	
Participation Proposals Due to NYSoH	May 29, 2020	x	x	x
Medical On Exchange Binders are Due in SERFF	June 5, 2020	x		
Provider Network Submission Due to NYSoH	July 27, 2020	x	x	x
Essential Plan Templates Due to NYSoH	July 31, 2020			x
DFS Rate Decision Due Date	August 6, 2020	x	x	
Essential Plan Subscriber Agreements Due to NYSoH	August 31, 2020			x
Plans Must Complete Approval of Information in Issuer Portal	September 4, 2020	x	x	x
Certification of Plans by NYSoH	September 25, 2020	x	x	x

QHP – Qualified Health Plan • SADP – Stand-Alone Dental Plan • EP – Essential Plan

Section I: Introduction and Overview

A. 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"), Stand-Alone Dental Plans ("SADPs") and Essential Plans ("EPs"), through NY State of Health, the Official Health Plan Marketplace ("Marketplace"), in 2020, to apply for recertification for 2021; 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, SADPs, and EPs to be offered on the Marketplace in calendar year of 2021.

Following the submission and review of the information required by this Invitation, the DOH will review whether Applicants and their proposed products meet all federal minimum participation standards and other requirements necessary for certification as a QHP, SADP or an EP. Applicants and individual plans found by DOH to satisfy all minimum standards and requirements, and in the case of Applicants applying for the first time, Applicants who sign a new Agreement with the DOH, will have products certified as QHPs, SADPs, or EPs available through the Marketplace. This will be the only opportunity for insurers to apply for certification or recertification of products to be offered on the Marketplace in 2021.

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.

B. Background

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

NY State of Health, the official health plan Marketplace of New York State, authorized by the Federal Patient Protection and Affordable Care Act of 2010, was established in April 2012 by Governor Cuomo's Executive Order 42, and codified in the NY Public Health Law in 2019. The NY State of Health Marketplace has successfully increased the affordability and accessibility of health insurance coverage in New York. By February 7, 2020, more than 4.9 million New Yorkers were enrolled in coverage, an increase of more than 150,000 people from 2019. Marketplace enrollment growth is consistent with New York's declining uninsured rate, which reached a historic low of 4.7 percent in 2018.

As of February 7, 2020, over 3.4 million New Yorkers were enrolled in Medicaid through NY State of Health and more than 1.5 million people enrolled in a non-Medicaid program through the Marketplace. This includes 272,948 people enrolled in a Qualified Health Plan and 796,998 enrolled in the Essential Plan. The 2020 Open Enrollment Period finished with more than 1 million people (1,069,946) enrolled in a Qualified Health Plan or the Essential Plan.

Applicants can enroll in coverage through NY State of Health online, by telephone, or with the help of an in-person assistor. During the 2020 Open Enrollment Period, nearly 2 million New Yorkers visited the NY State of Health website, Customer Service answered nearly 1.6 million telephone calls, and there were more than 7,500 certified enrollment experts, including navigators, certified application counselors, health plan facilitated enrollers and health insurance brokers who worked with consumers. In-person assistors helped more than three- quarters (80 percent) of enrollees complete their Marketplace applications in 2020. Through its website, NY State of Health makes available to consumers an easy to use plan preview, or anonymous shopping tool, which allows individuals to shop for a health plan and to also receive a personalized premium estimate before starting an application.

In 2020, NY State of Health increased efforts to reach new consumers, renew existing enrollees, and dispel consumer confusion around changes to the Affordable Care Act. NY State of Health got its message out to consumers through its "You Deserve Affordable Health Care" advertising campaign, at more than 250 community outreach events, and by sending nearly 2.4 million emails to consumers reminding them of important steps needed to complete their enrollment. Marketplace statewide advertising was in English, Spanish, and Mandarin, on tv, radio, digital platforms, ethnic print publications and digital and billboards in the metro-NYC region.

Section II: Qualified Health Plan and Stand-Alone Dental Plans – Individual and Small Business Marketplaces

A. Participation Requirements

1. Licensure and Solvency

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

- Be licensed as an insurer under Articles 42 or 43 of NY Insurance Law or certified under Article 44 of NY 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, 2020 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 1,2020.

2. Choice of Participation

Applicants may apply to participate in the individual market and small business marketplace. They are not required to participate in both.

3. 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 and consumers. 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.

Applicants seeking to expand their QHP service area in addition to notifying DFS and DOH must file a service area expansion application with the Division of Health Plan Contracting and Oversight or DHPCO. This application should be sent to bmccsmail@health.ny.gov.

4. QHP Applicant Product Offerings

a. Essential Health Benefits

Applicants must agree to provide the Essential Health Benefits ("EHBs") specified by the DOH for calendar year 2021, delineated in Attachment "A." The EHBs must be included in the calculation of the actuarial values of the products.

b. Metal Levels

All products 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 U.S. Department of Health and Human Services ("HHS") AV calculator.

Bronze: 60% AV
Silver: 70% AV
Silver CSR 73% AV (200-250% Federal Poverty Level)
Silver CSR 87% AV (150-200% Federal Poverty Level)
Silver CSR 94% AV (100-150% Federal Poverty Level)
Gold: 80% AV
Platinum: 90% AV

Consistent with current federal rules, reflected in 2019 final federal regulation, a *de minimus* variation of -4/+2% AV is permissible, except with respect to the Silver Level CSR (cost-share reduction) variations, which only permits a variation of +/- 1% AV and the Bronze Level, which permits a *de minimus* variation of -4/+5% AV . Further, the minimum permissible differential between the Silver (70% AV) and Silver CSR (73% AV) is two (2) percentage points. For purposes of this invitation, standard silver, and non-standard silver level products if offered by the issuer, must have an actuarial value of at least 70%, with a permissible *de minimus* variation of +2% AV. This limit on silver level product variation applies to the Individual Market only and does not apply to the small business marketplace (SHOP).

c. Standard Products

QHP 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 QHP 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 market; there is no requirement to offer standard products for the small business marketplace. The standard products for 2020 are provided in Attachment "B."

d. Standard Products With 3 Pre-Deductible Visits

The 2021 standard bronze product includes 3 visits to a primary care provider (PCP) or specialist that are not subject to the deductible. ~~copayments, or coinsurance~~. QHP Applicants may also continue to offer a standard gold level and silver level product

with 3 visits to a PCP that are not subject to the deductible. At these metal levels, copayments will apply. This additional gold or silver product(s) will not count towards the number of non-standard products offered by the QHP Applicant in the individual marketplace. If the QHP Applicant opts to offer this product, it must:

i. Be offered at the Gold, Silver, Silver CSR 73% AV, and, Silver CSR 87% AV metal levels, in every county of its QHP service area.

ii. Include the benefits and visit limits as delineated in Attachment "A" and the cost-sharing limitation delineated in Attachment "C," with the exception that the wellness benefit may be substituted for a different wellness benefit in accordance with federal and state regulation and guidance, as well as DFS review and approval.

e. Child-Only Offerings

In accordance with federal regulation, QHP Applicants must agree to offer a child-only product at each metal level described in Section II(A)(4)(b), above, in the individual market. 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 II (A)(4)(b), above, offered at the child-only rate outlined in Section II(B)(4)(b). Only one child- only product is required per metal level. Please note that a QHP Applicant's participation in the State's Child Health Plus program does not satisfy this requirement.

f. Catastrophic Products

QHP Applicants must agree to offer at least one standard catastrophic product in each county of the Applicant's service area in the individual market. The standard catastrophic product can be found in Attachment "B." As part of the Participation Proposal, which is Attachment "G," the DOH will require QHP Applicant's affirmative intent to offer, or continue to offer, a catastrophic product.

If the DOH determines there is adequate catastrophic coverage in a particular county, the DOH may, in its sole discretion, allow other QHP Applicants, in the same county, the option of not offering the catastrophic product.

An Applicant's decision not to offer catastrophic coverage will be for the entire plan year of 2021.

The DOH will inform the QHP Applicant of this option during the certification process and the decision regarding inclusion/exclusion of the catastrophic product will be made by the DOH prior to certification.

In the event there is not adequate coverage in a particular county, all QHP Applicants in that county will be obligated to offer the catastrophic product.

g. Out-of-Network Products

An "out-of-network" product is a product that provides coverage for services rendered by health care providers that are not in the health plan issuer's network. QHP 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 the individual market only.

QHP 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.

h. Non-Standard Products

QHP Applicants may opt to offer up to three (3) "non-standard" products, as described below, in all or part of its service area, if the partial service area is approved by DOH and DFS in accordance with the requirements listed in Section II(A)(3), those stated below, and any applicable DFS instruction or guidance. This non-standard product limit only applies to the individual market, there will be no limit on the number of products offered by an insurer on the small business marketplace.

Non-standard products offered on the Marketplace must have "meaningful differences" from each other and from the standard QHPs. Non-standard QHPs are considered meaningfully different when additional benefits, not included in the Essential Health Benefits, are covered (e.g., adult dental, adult vision, acupuncture). Non-standard products must allow consumers to easily identify the differences between non-standard products and standard products, so that consumers can determine which plan provides the highest value at the lowest cost to address their needs. All non-standard products must comply with federal and state laws, regulations and guidance and shall be subject to DFS and Marketplace review and approval. Non-standard silver level products, if offered by the issuers, must have an actuarial value of at least 70%, with a permissible *de minimus* variation of +2% AV.

Non-standard products do not have to be offered at all four metal levels. They must, however, be offered at a minimum of two metal levels of the issuer's choosing (for example, silver and bronze). If the QHP Applicant elects to offer (a) non-standard product(s) at the bronze level, the Applicant must also offer at least the same number of non-standard products at one of the other metal levels.

Examples of permissible and non-permissible combinations:

	Platinum	Gold	Silver	Bronze
Permissible:	0	0	2	2
Permissible:	1	2	0	2
Permissible:	0	1	0	1
	Platinum	**Gold**	**Silver**	**Bronze**
Non-Permissible:	0	0	1	2
Non-Permissible:	2	0	0	3
Non-Permissible:	0	0	0	1

QHP Applicants that offered a Bronze QHP that was HSA eligible in 2020, will be permitted to offer the HSA Compliant Bronze set forth in Attachment "B" in 2021, to ensure the HSA can carry over for their respective enrollees.

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

We encourage Applicants to review enrollment in non-standard products offered in prior years, to determine whether they should continue to be offered.

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 review. This requirement is not intended to limit the number of drugs that the QHP Applicant may cover in a drug category or class. QHP 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. QHP 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 QHP Applicants in that county will be obligated to offer a QHP with embedded pediatric dental coverage.

QHP Applicants will also have the option of offering adult/family dental, and/or supplemental pediatric dental benefits, as an additional benefit per Section II(A)(4)(h), above. If the QHP Applicant offers a family dental benefit, the pediatric component must include at least the same pediatric dental benefits as outlined in Attachment "A." These requirements apply to the individual and small group marketplace.

QHP Applicant's product descriptions must include a plain language description of what services are included within "Basic" and "Major" dental services and must include information about any waiting periods, benefit maximums and whether a deductible is applicable for adult dental care benefits.

To assist the DOH in providing meaningful, detailed benefit and cost sharing dental information to consumers we will be requesting Applicants to complete a Qualified Dental Plan (QDP) Benefit and Cost Sharing Template which will be used to populate the NY State of Health Dental Comparison Tool. The instructions and template will be sent separately from the invitation, no later than May 15, 2020 and will include the due date for the data submission.

The Dental Comparison Tool was added to the NY State of Health website in December 2019. https://info.nystateofhealth.ny.gov/resource/dental-plan-comparison-tool

The Dental Comparison Tool assists consumers in review and comparison of dental plans offered on the marketplace. The purpose of the new data collection template is to ensure consistency in dental benefit information across insurers and to facilitate consumer comparisons across insurers.

k. QHP and SADP Naming Conventions

To assist consumers in identifying products and differences between products, QHP and SADP Applicants must use the following naming conventions to identify all QHPs and SADPs offered on the Marketplace, in the order as presented below. Please 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	This should be the same product name the Applicant uses to market the product.
Metal Tier	Bronze, Silver, Gold, Platinum, Child-Only, Catastrophic	Indicate metal tier using entire the word for metal level.
Standard/ Non-Standard	ST, ST3PCP or NS	Indicate standard, standard with 3 PCP visits or non- standard by using "ST" for standard, "ST3PCP" for the standard with 3 PCP visits before the deductible, 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.
Network Name	To be assigned by Applicant	Indicate the network name associated with each product
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 benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Specify the type of dental coverage embedded in the QHP. If none, leave blank
Dental Coverage, ~~Adult/Family,~~ Deductible.	NSD	For QHP Products Only Include "NSD" to indicate that ~~adult/family~~ the embedded dental benefits are not subject to the QHP deductible. Please note this where applicable for both pediatric and adult/family coverage.
Dental Coverage, ~~Adult/Family~~, Waiting Period	WP	Include "WP" to indicate any waiting periods for adult dental services.

Examples of permissible QHP Individual Market names are shown below:

ABC Product, Platinum, ST, INN, 123 Network, Dep25
ABC Product, Gold, ST, INN, Dep29
ABC Product, Silver, NS, OON, Dep29, Family Vision Family Dental NSD, WP

Small Business Marketplace

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	This should be the same product name the Applicant uses to market the product.
Metal Tier	Bronze, Silver, Gold, Platinum,	Indicate metal tier using the entire word for metal level.
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Network Name	To be assigned by Applicant	Indicate the network name associated with each Product.
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 benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Specify the type of dental coverage embedded in the QHP. If none, leave blank.
Dental Coverage, ~~Adult/Family~~, Deductible	NSD	For QHP Products Only Include "NSD" to indicate that ~~adult/family~~ the embedded dental benefits are not subject to the QHP deductible. Please note this where applicable for both pediatric and adult/family coverage.
Dental Coverage, ~~Adult/Family~~, Waiting Period	WP	Include "WP" to indicate any waiting periods for adult dental services.
Domestic Partner	DP	Include only if domestic partners are eligible for coverage.
Family Planning	FP	Include only if the family planning benefit is covered.
Healthy NY	HNY	Include if the product is a Healthy NY product.

Examples of permissible QHP Small Business Market names are shown below:

ABC product, Platinum, ST, INN, Dep25

ABC product, Gold, NS, OON, Adult Dental, Dep29, DP, FP

ABC product, Silver, ST3PCP, ONN, Dep25

ABC product, Gold, ST, INN, Dep 25, HNY

l. Effective Dates

All certified and recertified products offered through the Marketplace will have effective dates of January 1, 2021, in the individual market and the small business marketplace.

Qualified employers will be able to purchase Marketplace certified products directly from the plan issuer at any point during the year.

QHP 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 2021, must be established and submitted to DOH and DFS through this Invitation.

5. Stand-Alone Dental Applicant Product Offerings

SADP Applicants shall offer products through the Marketplace in accordance with federal and state laws and regulations, and in accordance with the participation requirements set forth below.

SADP Applicant's product descriptions must include a plain language description of what services are included within "Basic" and "Major" dental services and must include information about any waiting periods, benefit maximums and whether a deductible is applicable for adult dental care benefits.

a. Essential Health Benefits

The SADP Applicant must agree to provide the pediatric dental benefits outlined Attachment "A." The pediatric dental benefits are minimum benefits and the SADP Applicant may add additional benefits.

b. The Standard Product

The SADP Applicant must offer one standard pediatric stand-alone dental product in every county of its service area. The standard product offered by the SADP 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 the individual market.

c. Non-Standard Products

The SADP Applicant may opt to offer up to three (3) non-standard products for the individual market. The SADP Applicant may opt to offer unlimited non-standard products for the small business marketplace.

The non-standard product(s) may be a(n) adult/family dental product or additional pediatric dental product offering(s). These requirements apply to both the individual market and the small business marketplace.

d. Other Applicable Provisions

SADP Applicants must meet the requirements set forth in Section II(A)(4)(l) above and Section II(B)(5), below.

6. 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

Small group is a group that meets the definition of "small group" in the NY Insurance Law and regulations, which is currently defined as a group of one hundred (100) or fewer full time equivalent employees ("FTEs") over the prior calendar year with at least one common law employee enrolled as defined by 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: https://www.dfs.ny.gov/consumers/small_businesses/small_group_expansion_faqs

b. Employer Choice

Qualified employers will have the flexibility to offer their employees any SHOP certified product(s) offered by health plan issuer(s).

c. Product Offerings

Issuers proposing to no longer offer products in 2021 that were certified in 2020 on the small business marketplace, must inform the NY State of Health by the date Medical Policy Forms and Rates are due to DFS as indicated in the 2021 Schedule of Key Events, explaining the reason for the removal.

There will be no designation of "standard" and "non-standard" products in the small business marketplace. That is, Applicants applying for the small business marketplace in 2021 are not required to offer the standard benefits shown in

Attachment "B." Applicants must, however, adhere to metal level actuarial value requirements and must agree to offer at least one product at each metal level on the small business marketplace.

There will be no limit on the number of plans offered by an insurer on the small business marketplace. Insurers are encouraged to offer all small group market products approved for offer in the outside market to increase the availability of tax credits to small employers.

For Plan Year 2021, Healthy NY issuers will continue to have the option of seeking SHOP- certification. This will allow existing HNY employers to access the Federal small business health care tax credit, if otherwise eligible. SHOP-certified Healthy NY products will only be displayed on the NYSOH website to employer groups that attest that they are a current Healthy NY employer group.

d. Minimum Participation and Employer Contribution Standards

While insurers in the small business marketplace and the off-marketplace small group insurance market are discouraged from imposing minimum participation requirements, non-HMO insurers are permitted to impose minimum participation requirements. However, if a small group cannot meet the insurer's minimum participation requirements, an insurer must still permit the group to enroll during an annual small group market open enrollment period that begins November 15 and extends through December 15 of each year. The annual open enrollment period applies to coverage issued or renewed between November 15 and December 15 and coverage applied for between November 15 and December 15 with an effective date of January 1. Insurers may impose minimum participation requirements on renewal outside of the open enrollment period but only to the extent the same requirements were imposed upon the group's initial application for coverage.

For coverage issued by the small business marketplace prior to April 1, 2018, insurers were not permitted to impose minimum participation requirements. Therefore, insurers may not impose minimum participation requirements upon renewal for small business marketplace employer groups who were issued small business marketplace coverage prior to April 1, 2018.

e. 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,

please visit https://www.irs.gov/forms-pubs/about-publication-969.

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.

f. Non-Discrimination

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

B. Premium Rates and Policy Form Filings

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

Pursuant to Sections 3201, 3231, 4235, and 4308 of the NY 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 NY 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 to issuing or delivering such contracts and prior to QHP certification or recertification.

2. Policy Form Filings

All policy forms for QHP products and SADPs shall be submitted to DFS by the date shown in the 2021 Schedule of Key Events, for approval through the System for Electronic Rate and Form Filing ("SERFF") in accordance with instructions established by DFS and HHS.

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.

DFS will develop updated model language for the Subscriber Agreements to all QHP products and SADPs, which will be available on the DFS website. All QHP Applicants and SADP Applicants must use the model language.

3. Rate Filings

All premium rate applications for Marketplace products must be received by DFS on or before the due date shown in the 2021 Schedule of Key Events for SADP Applicants and QHP Applicants.

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

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.

QHP 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 must rerun their products through the updated AV calculator to ensure that all proposed products meet the required 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 https://www.cms.gov/cciio/resources/regulations-and-guidance/index#plan-management.

4. Provisions Applicable to QHP Applicants

a. Rating Tiers

Individual and small group products in New York State are community rated in accordance with state law, regulations and guidance. QHP Applicants cannot consider 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
Single + spouse	2.00

Single + child(ren)	1.70
Single + spouse + child(ren)	2.85

These relativities shall apply to 2021 rates in the individual market and the 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, QHP 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

QHP Applicant's premium rates should reflect the risk adjustment and federal reinsurance programs as directed by DFS.

d. Single Risk Pool Inside and Outside of the Marketplace

Under the ACA and applicable regulations, QHP 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 business marketplace, respectively. This requirement applies to products offered both inside and outside of the Marketplace, for each market. Consequently, if the QHP Applicant offers a small group or individual product on the Marketplace, it should submit one rate adjustment filing per market containing the non-grandfathered products offered inside and outside the Marketplace. DFS will issue instructions as to how to submit the rate adjustment filings. Catastrophic products will have their own risk pool.

e. Premium Rate Periods

(i.) Small Group Products: Applicants may use quarterly rolling rates for Marketplace products offered through the small business marketplace, with a 12-month guarantee for the employer.

For example, if the employer's plan year begins April 1, 2020, the rate provided to that employer will be guaranteed for all employees through March 31, 2021, as well as new employees or special enrollments that occur during the plan year, through March 31, 2021.

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

f. Rating Regions

When submitting products for rate review, Applicants must adhere to the rating regions set forth in Attachments "D" and "E".

5. 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 groups and individuals in purchasing coverage through the Marketplace.

a. Producer Certification

Producers who have successfully completed the training certification program for each applicable market 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.

b. Producer Compliance

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

c. Producer Compensation

All QHP and Essential Plan Applicants' must comply with all applicable provisions of New York State insurance law. In addition, all QHP Applicants' compensation arrangements with Producers must be the same for products sold inside and outside of the Marketplace. For example, compensation for a policy sold on the Marketplace must be the same as the compensation for a policy sold outside of the Marketplace. In addition, if compensation is provided, QHP Applicants must provide the same compensation at all metal levels.

Essential Plan compensation arrangements must follow the same requirements as in

the individual market. Essential Plan producer compensation schedules will be requested during the Essential Plan rate setting process.

Section III: Essential Plans

A. Essential Plan Participation Requirements

New York elected to establish a Basic Health Program, an option provided to states in the ACA, in April 2015. The Essential Plan is authorized by Section 369-gg of the NY State Social Services Law and was approved by the Centers for Medicare and Medicaid Services on March 27, 2015.

To be eligible for the Essential Plan, 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 income between 138%-200% of the Federal Poverty Level ("FPL") or less than 138% of the FPL and be ineligible for Medicaid due to immigration status.

Insurers must provide health care services as detailed in the attachments to this Invitation. Monthly premium contribution is set in NY State Social Services Law and cost-sharing cannot exceed the amount the individual would have paid for QHP coverage in the Marketplace.

1. Licensure and Solvency

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

Be licensed as an insurer under Articles 32 or 42 or 43 of NY State Insurance Law, or certified under Article 44 of NY 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, 2020 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 1, 2020.

2. Choice of Participation

Applicants that apply to participate in the Essential Plan may also apply to participate in both the QHP individual market and the QHP small business marketplace but are not required to participate in either. EP Applicants may participate with the Medicaid or Child Health Plus programs but are not required to participate in either program.

3. Service Area

EP 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. EP 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. EP 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.

Applicants seeking to expand their EP service area in addition to notifying DFS and DOH must file a service area expansion application with the Division of Health Plan Contracting and Oversight or DHPCO. This application should be sent to bmccsmail@health.ny.gov

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

4. Benefits, Cost-Sharing and Individual Premium Contributions

a. Standard Essential Plans

EP Applicants must agree to offer four variations of EP products based on enrollee income as a percentage of FPL and other factors as described below and delineated in Attachment "H" (hereinafter referred to as the "Standard EP").

All Standard EPs below are based on the essential health benefits benchmark plan specified by DOH for calendar year 2021, with the following exceptions: pediatric services, including oral and vision care, will not be included in the benefit, the wellness benefit may be substituted for a different wellness benefit or benefits in accordance with federal and state regulations, guidance and DOH review and approval.

All EPs offered shall include only in-network options and at no time shall an EP Applicant impose cost-sharing with respect to preventive health services, or items, as defined in 45 CFR § 147.130.

(i) For individuals with incomes greater than 150% and less than or equal to 200% of FPL ("Essential Plan 1" in Attachment "H"), EP Applicants must provide the Standard EP. Individual enrollees will pay $20 per individual, per month, for Essential Plan 1 coverage. EP Applicants must also offer a version of this product for the American Indian/Alaska Native ("AI/AN") population with no cost-sharing for any services.

(ii) For individuals with incomes greater than 138% and less than or equal to 150% of FPL ("Essential Plan 2" in Attachment "H"), EP Applicants must provide the Standard EP. Enrollees will have no monthly premium for Essential Plan 2 coverage. EP Applicants must also offer a version of this product for the AI/AN population with no cost-sharing for any services.

(iii) For individuals with incomes greater than 100% and less than or equal to 138% of FPL, who are not eligible for Federal Medicaid due to immigration status ("Essential Plan 3" in Attachment "H"), EP Applicants must provide the Standard EP. Pursuant to Section 369-gg and 366(1)(g)(ii) of the NY Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 138% of the federal poverty level, and who previously would have qualified for NY Medicaid benefits, EP Applicants must include benefits equivalent to those provided under NY Medicaid, as may be modified from time to time, which 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. Enrollees will have no monthly premium for Essential Plan 3 coverage.

(iv) For individuals with incomes at or below 100% of FPL, who are not eligible for Federal Medicaid due to immigration status ("Essential Plan 4", in Attachment "H"), EP Applicants must provide the Standard EP. Pursuant to Section 369-gg and 366(1)(g)(ii) of the NY Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 100% of the federal poverty level, and who would have previously qualified for NY Medicaid benefits, EP Applicants must include benefits equivalent to those provided under NY Medicaid, as may be modified from time to time, which 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. Enrollees will have no monthly premium for Essential Plan 4 coverage and will have no cost-sharing on benefits.

b. Standard Essential Plan Plus Adult Vision/Dental Benefits

For individuals who qualify for Essential Plan 1 and Essential Plan 2, above, EP Applicants may also elect to offer **one** additional EP product that offers the same benefits and cost-sharing as the Standard EP, but that also includes coverage for adult dental and vision benefits as defined in Attachment "H" ("Standard EP 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 EP premium per individual, per month, plus any additional costs for the dental and vision coverage.

All EP Applicants must complete Attachment "K" confirming their commitment to offer the Standard EP and indicating whether they will offer the Standard EP Plus Adult Vision/Dental. Applicants that elect to offer the Standard EP Plus Adult Vision/Dental must make the option available to enrollees at both income levels for Essential Plan 1 and Essential Plan 2.

c. Standard Essential Plan and Stand-Alone Dental Products

Stand-alone dental products can be offered to individuals who qualify for Essential Plan 1 and Essential Plan 2. Individual enrollees will pay the applicable Standard EP premium per individual per month, plus any additional costs for the stand-alone dental plan.

d. Additional Features of Essential Plans

EP Applicants must include in the Standard EP and the Standard EP Plus Adult Vision/Dental, the following features per 42 CFR § 600.410(d):

(i) Care coordination and care management for enrollees, with a 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.

e. Essential Plan Naming Conventions

To assist consumers in easily identifying the EP Plans, all EP 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 insurer. The EPs must be labeled as follows (*see* Attachment "H"):

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

Optional EP 1 and 2 Product Variations:

- Essential Plan 1 Plus Vision and Dental
- Essential Plan 2 Plus Vision and Dental

f. Effective Dates

Individuals who enroll in the Essential Plan in 2021 will have the following effective dates:

(i) For individuals who have incomes at or below 138% of the FPL, and do not qualify for Federal Medicaid due to immigration status, and are newly enrolling in coverage, the effective date of Essential Plan coverage will be the first of the month in which they selected an EP plan. For example, an individual who enrolls in an Essential Plan on February 15, 2021, will have coverage starting February 1, 2021.

(ii) For individuals who have incomes above 138% of the FPL, and are newly enrolling in coverage, the effective date shall follow the "fifteenth of the month" rule, which means individuals who enroll in an Essential Plan between the first and the fifteenth of the month will have coverage that begins the first day of the next month; and individuals who enroll in an Essential Plan between the sixteenth and the last day of the month, will have coverage on the first day of the second month following the month in which they enrolled.

(iii) For individuals who have incomes at or below 138% of the FPL, and do not qualify for Federal Medicaid due to immigration status, and are renewing coverage, the effective date will be the first of the following month.

(iv) For individuals who have incomes above 138% of the FPL, and are renewing coverage, the effective date shall be the first of the following month.

Note that EP enrollees who renew coverage after the fifteenth of the month in their last month of coverage will have no gap in coverage. Coverage will begin the first of the following month and they will be enrolled into their same plan. Consumers who change plans at renewal and renew after the fifteenth of the month will be enrolled into their same plan the first of the following month and then transitioned to their new plan the first of the next month. For example, an enrollee whose coverage ends December 31, 2020 returns on December 25, 2020 and completes necessary updates and remains eligible for the Essential Plan will be enrolled in their same plan beginning January 1, 2021. If the enrollee is changing plans, coverage in their new plan will begin February 1, 2021.

g. Compensation

EP Applicants who contract with the DOH to offer the Essential Plan on the NY State of Health Marketplace will receive from DOH, a monthly capitation payment for each member that has enrolled in its EP 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. EP Applicants will be informed of their monthly capitation payment amount around August 31, 2020.

Essential Plans are subject to the MLR provisions at 85% (*See* Patient Protection and Affordable Care Act § 1331(b)(3); 45 CFR § 158.210(c), 45 CFR § 158.240(b)). The EP 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 Essential Plan in 2021.

h. Premium Payment

EP Applicants must accept premium and cost-sharing payments made from third party entities on behalf of a 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.

i. Rating Regions and Risk Adjustment

Capitation payments will be made to EP Applicant on a county basis and in accordance with the nine rating regions set forth in Attachments "I" and "J" to this Invitation. The DOH currently risk adjusts for certain rating groups within the Essential Plan rating structure. The DOH will expand risk adjustment to all rating groups once complete encounter data is available.

j. Subscriber Agreements and Template Submissions

EP Applicants must use the subscriber agreements that will be provided to them shortly after the release of this Invitation. Revisions to the model language contained in the subscriber agreements will be limited to the bracketed sections of the subscriber agreements. EP Applicants can include their logos and numerical contract-identifying information on agreements. The subscriber agreements must be submitted to the DOH by the due date shown in the 2021 Schedule of Key Events.

EP Applicants must submit the required EP 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 the due date shown in the 2021 Schedule of Key Events.

k. Non-Discrimination

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

Section IV: Requirements Applicable to Qualified Health Plans, Stand-Alone Dental Plans, Essential Plans and Small Business Marketplace

A. Administrative Requirements

a. Enrollment and Member Services

a. Enrollment Periods for QHPs and Stand-Alone Dental Plans

QHP Applicants and SADP Applicants must adhere to the open enrollment periods and special enrollment periods established under applicable law and guidance. 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 advanced premium tax credit assistance. For enrollees in the individual market that do not receive advanced 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.

b. Enrollment Period for the Essential Plan

Enrollment in the Essential Plan will be open all year. Eligibility for the Essential Plan will be recertified every twelve (12) months. If an EP enrollee updates his/her information within a 12-month enrollment period, eligibility will be re-determined. If the enrollee is determined to remain eligible for EP, a new, 12-month enrollment period will begin. Effective dates of dental coverage for Essential Plan 1 and Essential Plan 2 enrollees, who elect to purchase vision and dental, shall follow the same eligibility periods as medical coverage.

The EP Applicant must provide a ten (10) day initial grace period and a thirty (30) day grace period thereafter 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. The EP Applicant will continue to receive a capitation payment for the grace period month and EP Applicant will be obligated to cover claims for services incurred during the grace period.

Essential Plan 2 enrollees who elect to purchase vision and dental coverage will only have a premium for the vision and dental portion of their coverage. If an enrollee is disenrolled from Essential Plan 2 coverage on the basis of non-payment of premium, they will be re-enrolled into the equivalent Essential Plan medical-only product.

c. Enrollment/Disenrollment Transactions

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:

(i) Transaction files, including maintenance and termination transactions, must be picked

up daily;

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

(iii) Effectuation transactions, which are the basis of Federal Advance Premium Tax Credit (APTC) payments to issuers, must be sent within five (5) business days of receipt of payment, and must include the insurer-assigned member identification number;

(iv) Terminations and cancellations must be sent within five (5) business days of the grace period end date;

(v) Error files are sent to insurers daily; error files must be reviewed and corrected on a regular basis, but no less frequently than once per week.

d. 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.

e. Subscriber Contracts

All Applicants must post all approved subscriber contracts on their website so that they are available to prospective members when open enrollment begins.

f. 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 limited English proficiency (“LEP”) and

individuals with disabilities, including accessible websites 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.

The Applicant and its contractors must:

(i) 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 fonttype;

(ii) 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, in any county of the service area where the applicants and/or enrollees of the issuer speak a common non-English language, the issuer must provide taglines in those languages indicating the availability of written translation of materials in any language the prospective or current enrollee speaks;

(iii) Pursuant to 45 CFR § 155.205(c)(2)(iii), before the beginning of the 2021 open enrollment period, documents and website content that are considered critical (see HHS Technical Guidance, March 30, 2016 at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Language-access-guidance.pdf) for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees or enrollees must include taglines in the top 15 language spoken by the LEP population as determined by the Secretary of HHS (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf);

(iv) Make verbal interpretation services available 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;

(v) 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; and

(vi) 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.

g. 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 twenty-four (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

a. New York State of Health Marketing and Outreach

The DOH intends to continue its multi-faceted advertising, marketing and outreach campaign focused on connecting New Yorkers with quality, affordable health insurance. The DOH will engage in targeted outreach to consumers through navigators, certified application counselors, facilitated enrollers, consumer advocates, small businesses, brokers, and other stakeholders to promote enrollment through the Marketplace.

b. QHP and EP Applicant Responsibilities

Applicant may conduct advertising campaigns, including but not limited to television, radio, digital, 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.

The Applicant shall use the NY State of Health 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.

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.

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 a 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.

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.

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

C. 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, Applicants must adhere to the following:

a. General Standards

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.

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.

b. Specific Standards for QHP Applicants and EP Applicants

a. Network Composition

The QHP Applicant's and EP 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 use providers, allied health professionals, ancillary providers, durable medical equipment ("DME") providers, home health providers, and pharmacies. Specifically, the Applicant's network must meet the following minimum standards:

(i) Each county network must include at least one (1) 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 and Queens;

(ii) Each county network must include the core provider and service types established in the Data Dictionary through the Provider Network Data System ("PNDS") website;

(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:

Primary Care Providers

- In metropolitan areas – 30 minutes by public transportation or by car;
- In nonmetropolitan areas – 30 minutes or 30 miles by public transportation or car; and
- In rural areas, transportation requirements may exceed these standards if justified.

Dental Providers

- In metropolitan areas – 30 minutes by public transportation or by car;
- In nonmetropolitan areas – 30 minutes or 30 miles by public transportation or car; and
- A time and distance standard of 45 minutes/45 miles may be used in the following rural counties and provider types, where a lack of providers has been demonstrated to DFS:
    - o Pedodontists: Allegany, Cayuga, Chemung, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence, Steuben and Tompkins.
    - o Oral Surgeons: Essex, Franklin, Lewis, Schoharie and Steuben.
    - o Orthodontics: Broome, Cayuga, Chemung, Clinton, Essex, Franklin, Jefferson, Lewis, Madison, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence and Tompkins.

Other Provider Types

- It is preferred, that the Applicant meet the 30-minute or 30-mile standard, unless justified.

(vi) QHP Applicants and EP Applicants that contract with a hospital with greater than 50 beds must meet the patient safety standards and documentation collection requirements set forth in such regulation;

(vii) QHP Applicants and EP 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 QHP Applicants' and EP Applicants' service area;

(viii) The QHP Applicant and EP 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 clinic, to the extent such providers are available;

(ix) QHP Applicants and EP Applicants are 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.

Pursuant to applicable law, QHP Applicants and EP Applicants are required to notify enrollees of significant changes in their networks which will be effective in the 2021 plan year. Applicants are required to submit disruption analysis reports to the NY State of Health, when a network is scheduled to have a hospital disenroll, an IPA or major medical group, or is scheduled to lose or change their pharmacy carrier.

(x) DOH requests Applicants to conduct additional outreach to their enrollees in advance of significant network changes as indicated above, to ensure their awareness. Applicants are required to inform DOH of such outreach plans.

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b. Specific Standards for 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 two (2) orthodontists, 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).

In addition to these requirements, the Applicant's dental network must meet the time and distance standards set forth above in Section IV(C)(2)(a)(v).

c. Sanctioned Providers Applicable to All Applicants

The Applicant shall **not** include in its network any provider who has:

(i) Been sanctioned or prohibited from participation in Federal Health Care Programs under either Section 1128 or Section 1128A of the SSA; or

(ii) Had his/her license suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

d. 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 the DOH 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, Applicants may contract with providers in adjacent counties to fulfill the network adequacy requirements, as determined by the DOH.

e. 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. Pursuant to NY Insurance Law § 3217-1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), Applicants must update their online directory, as well as their PNDS submission(s) within fifteen (15) days of becoming aware of the addition or termination of a provider from its network, or a change in a physician's hospital affiliation.

f. Submission of the Network

The Applicant shall submit its network through the Provider Network Data System, https://pnds.health.ny.gov, in accordance with instructions issued by the DOH and the Provider Network Submission Instructions set forth in Attachment "Q". Submissions 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.

g Identification and Use of Existing Essential Plan Network for Current and New Issuers

To the extent the EP Applicant intends to use an existing network to satisfy the network adequacy requirements of the Essential Plan, the Applicant shall identify such intent and the corresponding network. The existing network being used to support the EPs must be the same network that is approved by the Marketplace or DOH.

D. Enhancements to Network Information.

In addition to the Network Adequacy requirements set forth in Section IV(C), 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 products 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 NY Insurance Law § 3217-1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), 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, SADPs or EPs.

If multiple network configurations are offered by the Applicant, the directories must clearly identify the network(s) for the particular Marketplace 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 individual network(s) offered by the Applicant so a consumer using the directory can clearly and easily access the correct network via the URL link provided to the Marketplace. For tiered networks, the directory must clearly identify the tier in which the provider participates

In order to ensure that the most accurate and timely information is displayed to consumers, the Applicant must indicate within its online provider directory when an individual provider, group, or facility will be leaving the network. The Applicant must provide reasonable notice and indicate the date on which the provider, group or facility will no longer be in the Applicant's network.

b. Verification of Networks and Appointment AvailabilityStandards/Monitoring

1. The Applicant shall provide their process to periodically verify the accuracy of its reported Marketplace provider network(s). Such process 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 processes are to validate participation by providers and to make sure providers are aware of their participation in Marketplace networks.

2. Applicants and their contractors must submit for review appointment availability standards established for office hours and after office hours. Access standards should include but not be limited to routine care, follow up visit for emergency/hospital discharge, urgent care and emergency care for medical, behavioral health and substance use appointments. Applicants and their contractors must explain the health plan process to ensure compliance with these standards including frequency of review and advise where appointment availability standards may be found by consumers, such as, member handbook or Applicant's website.

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 QHP Applicant and EP Applicant must have in place a treatment cost calculator available through an internet website and such other means for individuals without access to the internet. Such treatment cost calculators must be able to demonstrate enrollee cost-sharing using current price data 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.

E. Consumer Network Protections

a. Access to Out-of-Network Providers and Information

Consistent with Financial Services Law Article 6, QHP Applicant and EP Applicants must adhere to the following:

(i) QHP Applicants and EP Applicants must hold its members harmless from liability for all out-of-network emergency ("ER") bills. In addition, QHP Applicants and EP Applicants must hold their member harmless from liability for non-emergency ("non-ER") surprise out-of-network bills: (a) 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 (b) whenever a participating physician refers a member to an out-of-network provider without the member's written consent.

(i) QHP Applicants and EP Applicants shall allow their 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.

(ii) QHP Applicants and EP 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.

(iv) QHP Applicants and EP Applicants 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.

(v) QHP Applicants and EP Applicants 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 Part H of Chapter 60 of the Laws of 2014 (the "Out-of-Network Law").

QHP Applicant and EP 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 by the Out-of-Network Law. Upon request, QHP Applicant and EP Applicant will provide a URL link to its out-of-network treatment cost calculator.

F. Prescription Drug Benefits

a. Formulary Requirements

QHP and EP Applicants must make available to DOH, (a) URL link(s) that will easily allow consumers to access the Applicant's prescription drug formulary or formularies. At a minimum, the following must be met:

(i) The link(s) must provide an up-to-date listing of all covered drugs;

(ii) Separate links must be provided for each product offered on the Marketplace and the formulary or formularies must clearly identify the product(s); and

(iii) The link must allow consumers to identify the cost-sharing amount for each drug or indicate that the drug is not subject to cost-sharing.

QHP Applicants and EP Applicants must comply with NY Public Health Law § 4406-c, and NY Insurance Law § 3216(i)(27), § 3221(a)(16) and § 4303(jj). Formularies will be reviewed to ensure the intent of the state law is being followed. QHP Applicants and EP 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.

G. Pharmacy and Therapeutics Committee

The QHP Applicant and EP Applicant must use a pharmacy and therapeutics committee that meets the standards set forth in 45 C.F.R. § 156.122(a)(3).

H. Pharmacy Rules

Pursuant to 45 C.F.R. § 156.122 (e)(1), QHP Applicants and EP Applicants must allow enrollees to access prescription drug benefits at in-network retail pharmacies, unless: (1) the drug is subject to restricted distribution by the U.S. Food and Drug Administration; or (2) the drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

Prescription Drug Co-payments

QHP and EP Applicants must comply with: (i) NY Insurance Law § 4325(h) and NY Public Health Law § 4406-c(6) to assure that enrollee co-payments do not exceed the usual and customary cost of a prescribed drug, and (ii) NY Insurance Law § 3217-b(a)(2) and 4325(a)(2), and NY Public Health Law § 4406-c(2) to ensure that contracts with pharmacies, whether negotiated directly or through a pharmacy benefit manager, do not contain "gag clauses" or other provisions in violation of (i) NY Insurance Law § 4325(h) and NY Public Health Law § 280-a, NY Public Health Law § 4406-c(6) or NY Education Law § 6826-a.

I. Quality and Enrollee Satisfaction

a. QHP Applicant Requirements

1 Quality Rating System

New York will use U.S. Centers for Medicare and Medicaid Services ("CMS") generated quality ratings in 2019, which is based upon data provided to CMS by health insurers in 2018. Each rated health plan has an "overall" quality rating, ranging from 1 to 5 stars, which accounts for member experience, medical care and health plan administration.

More information about these ratings is available at https://www.healthcare.gov/quality-ratings/

2 Quality Improvement Strategy ("QIS") or Quality Strategy ("QS")

QHP Applicants must submit either a **Quality Improvement Strategy ("QIS")** or a **Quality Strategy ("QS")**, as determined below. Quality Improvement Strategy ("QIS")

QHP Applicants that offered QHP coverage through the Marketplace in 2018 and 2019 and had more than 500 QHP enrollees in a "product" (defined by CMS for this purpose as insurer model, including HMO, EPO, PPO, POS, etc.) as of July 1, 2019, must submit at least one initial QIS **Implementation Plan** and **Progress Report Form for the 2021 Plan Year.**

Applicants must**:**

(i) Implement a QIS, described as a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.

(ii) Implement a QIS that includes at least one of the following:

- Activities for improving health outcomes;
- Activities to prevent hospital readmissions;
- Activities to improve patient safety and reduce medical errors;
- Activities for wellness and health promotion; and/or
- Activities to reduce health and health care disparities.

(iii) Adhere to guidelines, including the QIS Technical Guidance and User Guide for the 2020 coverage year, established by Health and Human Services ("HHS"), in consultation with experts in health care quality and stakeholders.

(iv) Report on progress implementing the QIS to the DOH on a periodic basis.

QHP Applicants must submit the required QIS information as part of their participation proposal for the 2021 coverage year by completing the required parts of the 2020 Plan Year QIS Implementation Plan and Progress Report forms.

The submitted QIS Implementation Plan and Progress Report form for the 2021 plan year will be evaluated by the New York State Department of Health "(NYS DOH") Office of Quality and Patient Safety, in consultation with the NY State of Health. Based upon the results of the QIS evaluation, an overall outcome of "meets" or "does not meet" will be assigned to the QIS submission. QHP Applicants will be notified in writing regarding any corrective actions required.

3 Quality Strategy ("QS")

QHP Applicants that did not offer QHP coverage through the Marketplace in 2018 and 2019 or did not have more than 500 enrollees enrolled in a product as of July 1, 2019, must develop a **Quality Strategy ("QS")** that encompasses all the requirements set forth in 1311 (g) of the Affordable Care Act ("ACA"). This strategy must be implemented and updated annually with progress reported to the designated office of the DOH. The quality strategy should describe how the Applicant will address the following:

(i) 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;

(ii) 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;

(iii) 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;

(iv) The implementation of wellness and health promotion activities;

(v) The implementation of activities to reduce health and health care disparities, including the use of language services, community outreach, and cultural competency trainings; and

(vi) 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.

4 Quality Reporting System ("QRS")

QHP Applicants must submit quality data collected as part of the Quality Reporting System ("QRS") and QHP enrollee survey requirements to NYS DOH. QHP Applicants should follow the 2019 Quality Rating System Measure Set Technical Specifications. These quality indicators 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 Date and Information Set ("HEDIS").

Applicants must report quality measures such as satisfaction data, birth files and optional enhancement files. All Applicants will be using one tool, the National Committee for Quality Assurance ("NCQA") Interactive Data Submission System ("IDSS") to submit to both NYS DOH and

NCQA. All quality measures will be reported via the NCQA IDSS tool. CMS-QRS reporting will require Applicants to have:

- HEDIS Volume 2;
- NCQA IDSS tool;
- Programming for all required measures (either in house capability or via a vendor);
- A HEDIS audit conducted by a licensed audit organization of their QARR data prior to submission to NCQA; and
- A certified and HHS approved survey vendor to administer enrollee experience surveys.

5 Enrollee Satisfaction Survey

QHP Applicants must annually survey a sample of their Marketplace eligible members to allow the DOH to assess members' experience of care, including their access to care as well as their interactions with their providers and health plan. This information will be collected through the enrollee satisfaction survey under CMS guidelines. The NYS DOH will use the experience of care information to identify any opportunities for improvement and the analyses of this data may require some plans to develop and implement quality improvement strategies.

a. EP Applicant Requirements

1 Quality Strategy ("QS")

EP Applicants must comply with the **Quality Strategy ("QS"),** as outlined above.

2 Quality Reporting ("QR")

EP Applicants will be required to participate in the NYS 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 ("NCQA") and the 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 plan issuer 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 the plan issuer will also be posted on the DOH website in eQARR and related publications.

The QARR technical specifications are released annually during the Fall of the measurement year, with reporting of QARR data due on or about the following June 15th.

Applicants must report quality measures such as satisfaction data, birth files and optional

enhancement files. All Applicants will be using one tool, the National Committee for Quality Assurance ("NCQA") Interactive Data Submission System ("IDSS") to submit to both NYS DOH and NCQA. All quality measures will be reported via the NCQA IDSS tool. CMS-QRS reporting will require Applicants to have:

- HEDIS Volume 2;
- NCQA IDSS tool;
- Programming for all required measures (either in house capability or via a vendor);
- A HEDIS audit conducted by a licensed audit organization of their QARR data prior to submission to NCQA; and
- A certified and federally approved CAHPS vendor to administer satisfaction surveys.

3 Satisfaction Survey ("CAHPS")

EP Applicants will be required to annually survey a sample of their eligible members to allow the DOH to assess many aspects of the member's experience of care, including their access to care and services, their interaction with their providers and health plan.

For EP, this information will be collected using a national satisfaction survey methodology called Consumer Assessment of Healthcare Providers and Systems ("CAHPS").

The DOH will use the experience of care information to identify any opportunities for improvement and the analyses of this data may require some plans to develop and implement quality improvement strategies

4 Accreditation

The DOH will not require Applicants to be accredited as a condition of participation in 2021.

J Reporting

a. 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, the number of claims that are denied, customer service information, rating of provider practices, information on cost-sharing and payments with respect to any 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.

b. 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.

c. 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 the site of service and may also include diagnosis information. Each encounter must be recorded in an information system as each unique occurrence between recipient and provider. Encounters must 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.

d. 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 also 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.

K Certification, Recertification and Decertification Processes

e. 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.

f. Decertification

A plan issuer certified by the Marketplace 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 applicable law. Decertification of individual products shall occur in accordance with all applicable laws and regulations governing the removal of a product from the market, including notification to enrollees.

g. Non-Renewal

Plan issuers may opt not to renew participation or products in the Marketplace. The issuer must

notify DOH of its decision not to renew, no later than thirty (30) days prior to the start of Open Enrollment. The Issuer shall cooperate with DOH in the development of a plan to facilitate the orderly transition of its members, including, but not limited to, notification to consumers and providing DOH with member specific information to the extent permitted by law.

h. Suspension

The DOH may suspend enrollment in a health plan in the event a 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.

L 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, as amended. The two laws are collectively referred to as the Affordable Care Act ("ACA");
- 45 C.F.R. Parts 155 and 156 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; and
- 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:

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 § 4308 (Supervision of Superintendent);

- N.Y. Insurance Law § 4235, 11 N.Y.C.R.R. 52.2 (Group Accident and Health Insurance);

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 Pursuantto Chapter 41 of the Laws of 2014;
- Updated FAQs Regarding 18 Approved Forms of Contraception Issued by CMS May 11, 2015 (found here: http://www.dol.gov/ebsa/faqs/faq-aca26.html);
- Discrimination Based on Sexual Orientation, Gender Identity and/or Gender Dysphoria, DFS Insurance Circular Letter No. 9 (2018), June 25, 2018

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); and
- 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 V: Application Process

A. Issuing Agency

As stated in Section I (A), 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 2021 Schedule of Key Events, 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.

A form Letter of Interest is attached to this Invitation as Attachment "F" for QHP Applicants, EP Applicants, SADP Applicants and Small Business Market (SHOP) Applicants. Please indicate which offerings you are interested in participating in for 2021.

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 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. 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 demonstrates 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:

- Withdraw the Invitation at any time, at the DOH's sole discretion;
- Disqualify any Applicant whose conduct and/or Application fails to conform to the requirements of this Invitation;
- 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; and
- At any time during the Invitation process, amend the Invitation to correct errors or omissions, 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 the PNDS website 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 Contents

As part of the certification process, Applicants are required to submit the following, which collectively constitutes the Application:

For QHP Applicants and Stand-Alone Dental Plan Applicants:

(i) Participation Proposal;
(ii) Submission of Policy Form, Rates, and Binders to DFS for QHP and SADP Applicants;
(iii) Submission of Provider Network Information; and
(iv) QIS Implementation Plan and Progress Report Form or Quality Strategy (QHP Applicants Only).
(v) Submission of QDP Benefit Cost Sharing Template to DOH

For EP Applicants:

(i) Participation Proposal;
(ii) Submission of Subscriber Agreements to DOH for EP Applicants;
(iii) Submission of EP Information Templates to DOH;
(iv) Submission of Provider Network Information; and
(v) Quality Strategy**.**

Each of the component parts must be received by the due dates set forth in the 2021 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 V (C). Electronic submissions are also required and can be sent to the email address noted in Section V (C). Participation Proposals will not be accepted by fax. The Participation Proposal must be signed and executed by an individual with 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 "G" (QHP Applicants and SADP Applicants) and Attachment "K1" (EP Applicants). Applicants applying to offer both QHPs and EPs must complete **both** Attachments**.**

b. Submission of Policy Forms and Rates to DFS for QHP Applicants

As set forth in Section II(B), 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 Subscriber Agreements and Templates to DOH for EP Applicants

As set forth in Section II (B), EP Applicants will be required to submit EP Subscriber Agreements to DOH. EP Applicants will also be required to submit plan information via DOH required templates. Policy forms and templates must be sent directly to the Applicant's assigned Plan Manager by the due

date indicated in the 2021 Schedule of Key Events.

d. Submission of Provider Network Information

As set forth in Section IV (C)(6), Applicants shall submit their network through the Provider Network Data System ("PNDS") in accordance with the Provider Network Submission Instructions contained in Attachment "Q" to this Invitation.

e. Submission of Quality Improvement Strategy or Quality Strategy

As set forth in Section IV (G), QHP Applicants and EP Applicants shall submit their QIS or QS as part of the Participation Proposal.

f. Vendor Responsibility

On or around the same time that Applicants submit forms and rates, Applicants 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 questions about the VendRep System contact 866-370-4672 or 518-408-4672 or ITServiceDesk@osc.state.ny.us

g. Submission of HHS Form 690, Assurance of Compliance

Applicants shall, as a condition of certification pursuant to 45 C.F.R. Part 92.5, submit an original, signed copy of HHS Form 690, Assurance of Compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act.

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 NY 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.

G. 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 provide Applicants with an Agreement. The Agreement resulting from this Invitation will be effective only upon approval by 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 for their products to be certified and offered through the Marketplace.

Section VI: Attachments

Attachment Designation	Attachment Name
Attachment "A"	2021 QHP Essential Health Benefits
Attachment "B"	2021 Standard Products Cost-Sharing Chart
Attachment "C"	2021 QHP Standard Product With 3 PCP Visits Cost-Sharing Chart
Attachment "D"	QHP and SADP Rating Regions by County
Attachment "E"	QHP and SADP Rating Regions Map
Attachment "F"	2021 Letter of Interest
Attachment "G (1)"	2021 QHP and SADP Participation Proposal
Attachment "G (2)"	2021 QHP Non-Standard Product Offering Details
Attachment "G (3)"	2021 QHP Products Offered by County and Market
Attachment "G (4)"	2021 SADP Products Offered by County and Market
Attachment "H"	EP Benefits and Cost-Sharing Chart
Attachment "I"	EP Rating Regions
Attachment "J"	EP Rating Regions Map
Attachment "K (1)"	2021 EP Participation Proposal
Attachment "K (2)"	2021 EP Products Offered by County
Attachment "L"	2021 EP Template Instructions
Attachment "M"	2021 EP Admin Template
Attachment "N"	2021 EP Plans Template
Attachment "O"	2021 EP Rates Template
Attachment "P"	2021 EP Service Area Template
Attachment "Q"	2021 Provider Network Submission Instructions
Attachment "R"	2021 URL Template Instructions
Attachment "S"	2021 URL Template

Section VII: Definitions

For purposes of this Invitation:

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

"Applicant" and "**Applicants"** shall mean health plan issuers applying to offer medical or dental coverage and applying for certification or recertification.

"Certification" shall mean the Marketplace's authorization of a Qualified Health Plan, Stand-Alone Dental Plan or an Essential Plan to be offered on the Marketplace based on verification that a Plan complies with the requirements of the Invitation, as modified by the Marketplace.

"Cost-Sharing Reduction (CSR)" shall mean the Federal Program pursuant to 45 C.F.R. § 155.305(g), which provides federal reductions to cost-sharing on Essential Health Benefits for an Enrollee with a household income at or below a specified percent of the federal poverty level.

"Essential Plan" or "EP" shall mean a health benefit plan that has been certified by the state as an Essential Plan pursuant to NY Social Services Law § 369-gg(1)(e), to be offered through the Marketplace in accordance with NY State Social Services Law § 369-gg(1)(a).

"Essential Plan Applicant" or "EP Applicant" shall mean an insurer that is applying to offer the Essential Plan.

"Enrollee" shall mean an Eligible Individual enrolled in a Qualified Health Plan, Stand-Alone Dental Plan or an Essential Plan offered through the Marketplace.

"Invitation" shall mean the Invitation and Requirements for Insurer Certification and Recertification for Participation and the attachments thereto, issued by the Marketplace to health plan issuers to participate in Qualified Health Plans, Essential Plans and Stand-Alone Dental Plans, as modified by the Questions and Answers regarding the Invitation posted on the Marketplace website.

"Marketplace shall mean 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 and codified in the NY Public Health Law in 2019.

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

"Participating Provider" shall mean a provider of health care services or dental services that has a provider agreement with the Applicant.

"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") shall refer to individually identifiable health information as defined in 45 CFR 164.402.

"Qualified Employee" shall mean an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the small business marketplace, in accordance with 45 C.F.R. § 155.20 and Marketplace policies and procedures.

"Qualified Employer" shall mean an employer that (i) has 100 or fewer employees; (ii) small business marketplace(a) has its principal business address in the Marketplace service area small business marketplace or (b) offers coverage to each eligible employee through the small business marketplace serving that employee's primary worksite.' An employer that meets these criteria and which has at least one employee that is not the owner's spouse enrolled in coverage shall be authorized to offer Qualified Employees the ability to purchase Qualified Health Plans through the small business marketplace.

"Qualified Health Plan" or **"QHP"** shall mean a health benefit plan that has received the Marketplace's certification to be offered through the Marketplace, including a Stand-Alone Dental Plan except where otherwise noted.

"QHP Applicant" shall mean a health insurer that is applying for QHP certification or recertification that offers medical coverage.

"Qualified Individual" shall mean an individual that is eligible, pursuant to the ACA and federal regulation, to enroll in a QHP through the Marketplace.

"Recertification" shall refer to the Marketplace's annual review and verification of a Qualified Health Plan's compliance with the requirements for certification and the provisions of applicable law regarding Qualified Health Plans.

"Service Area" shall mean the geographic area(s) designated by the NY State Department of Health or NY State Department of Financial Services ("DFS") in which an Applicant's Qualified Health Plan(s) shall be offered.

"Small Business Marketplace" (a/k/a the "Small Business Health Options Program, or SHOP") shall mean the Small Business Health Options Program, as defined at ACA § 1311 (b)(1)(B) and 45 C.F.R. Part 155.

"Small Employer" shall mean an employer with 1-100 FTE employees.

"Special Enrollment Periods" shall, as described in 45 C.F.R. § 155.420, and applicable law and guidance, mean the periods during which a qualified individual or enrollee who experiences

certain qualifying events as set forth in federal regulation, may enroll in, or change enrollment in, a QHP through the Marketplace outside of the annual open enrollment periods.

"Stand-Alone Dental Plan" or **"SADP Applicants"** shall mean a dental services plan that has received the Marketplace's certification to be offered through the Marketplace.

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 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 ____day of _____, 2020 (the "***Effective Date***"), by and between _____ ("***Trading Partner***"), and the **State of New York Department of Health** (STATE).

W I T N E S S E T H

WHEREAS, the Trading Partner has entered into a contract with the STATE to provide the Essential Plan to eligible individuals in New York, and must electronically exchange information and data with the NYSOH in connection with certain healthcare transactions; including:

(i) benefit enrollment and maintenance for qualified individuals enrolling in coverage ("834 Transactions"), and

(ii) encounter / health care claim transactions ("837 Transactions"), and

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 as applicable, a HIPAA compliant (i) Trading Partner Information Companion Guide (the "TPI Guide"), (ii) an 834 Companion Guide; (iii) an 820 Companion Guide; (iv) an 837 Post Adjudicated Claims Data Reporting (PACDR) Companion Guide; (v) 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 Trading Partner Guides will be distributed by the NYSOH's Plan Management department.

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, October, 2019, 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:

STATE OF NEW YORK DEPARTMENT OF HEALTH

By: _____

Print Name:

Title:

TRADING PARTNER: _____

By: _____

Print Name:

Title: