APPENDIX C-2023
PROGRAM SPECIFIC REQUIREMENTS

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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.