

**APPENDIX C
PROGRAM SPECIFIC REQUIREMENTS
TABLE OF CONTENTS**

I.	DEFINITIONS	3
II.	AGREEMENT / RELATIONSHIP OF PARTIES	7
	A. Qualified Health Plans (“QHPs”).....	7
	B. Independent Contractors.....	7
	C. Application of Law.....	7
	D. Coordination.....	8
	E. Participation in Individual Exchange or SHOP.....	8
III.	QUALIFIED HEALTH PLANS	
	A. Terms and Conditions of QHP Certification	8
	B. Contractor’s QHPs.....	9
	C. QHP Maintenance.....	10
IV.	PROVIDER NETWORKS	
	A. Network Adequacy Requirements.....	10
	B. General Standards	11
	C. Network Adequacy Review / Process	11
V.	POLICY FORM AND PREMIUM RATE FILING	
	A. Review of Rates and Forms.....	12
	B. QHP Plan Management Templates.....	13
VI.	QUALITY AND ENROLLEE SATISFACTION	13
	A. Monitoring by State.....	13
	B. Accreditation.....	13
VII.	ELIGIBILITY AND ENROLLMENT	13
	A. Individual Exchange	13
	1. Obligations of State.....	13
	2. Obligations of Contractor Participating in Individual Exchange.....	14
	B. SHOP.....	15
	1. Obligations of State.....	15
	2. Obligations of Contractor Participating in the SHOP.....	16
	C. Special Enrollment Periods in Individual Exchange / SHOP.....	17
	D. Coverage Effective Date in Individual Exchange / SHOP.....	19
	E. Process in Individual Exchange / SHOP.....	19
VIII.	ENROLLEE RIGHTS AND NOTIFICATION	20
	A. Information Requirements.....	20
	B. Provider Directories.....	21
	C. Treatment Cost Calculator for Participating Providers.....	22
	D. Treatment Cost Calculator for Out-of-Network Providers.....	22
	E. Member Identification Cards.....	22
	F. Member Handbooks / Subscriber Contracts.....	22

IX.	TERMINATION OF COVERAGE	23
	A. Individual Exchange.....	23
	1. Obligations of State.....	23
	2. Obligations of Contractor Participating in the Individual Exchange.....	24
	B. SHOP.....	25
	1. Obligation of State.....	25
	2. Obligation of Contractor Participating in the SHOP.....	26
	C. Transition of Enrollees in the Individual Exchange / SHOP.....	27
X.	RECERTIFICATION / TERMINATION OF QHP AGREEMENT	
	A. Recertification.....	27
	B. Nonrenewal.....	27
	C. Contractor Discontinuance of Counties in Service Area.....	27
	D. Contractor Failure, Delay or Inability to Complete the Agreement.....	28
	E. Process for Termination of Coverage.....	28
	F. Contractor Initiated Termination of Agreement.....	28
	G. State Initiated Termination of Agreement	29
XI.	MEMBER SERVICES	29
XII.	MARKETING	29
	A. Obligations of State.....	29
	B. Obligations of Contractor.....	29
	C. Corrective and Remedial Actions	30
XIII.	HIPAA COMPLIANCE / SECURITY	31
XIV.	REPORTING / DATA COLLECTION	32
	A. General Requirements.....	32
	B. Encounter Data.....	32
	C. Financial Reporting	33
	D. Prescription Drug Cost.....	33
	E. Transparency Requirements.....	34
XV.	AMERICAN INDIANS AND ALASKA NATIVES	34
XVI.	INDEMNIFICATION	
	A. Indemnification by Contractor.....	35
	B. Indemnification by State.....	35
XVII.	CONSEQUENTIAL DAMAGES	36
XVIII.	OWNERSHIP OF DATA	
	A. Ownership of State Exchange Data.....	36
	B. Ownership of Contractor Data.....	36
IXX.	RECORDS MAINTENANCE / EXAMINATION AND AUDIT	
	A. Maintenance of Contractor Records.....	37
	B. Access to Contractor Records.....	37
	C. Contractor Audits or Reviews.....	38

I. DEFINITIONS

“**Actuarial Value (AV)**” shall mean the percentage paid by a Contractor of the total allowed costs of benefits. “Percentage of the total allowed costs of benefits” is the anticipated covered medical spending for Essential Health Benefit coverage (as defined in 45 C.F.R. 156.110) paid by a Contractor for a standard population, computed in accordance with the Contractor’s cost-sharing, divided by the total anticipated allowed charges for Essential Health Benefit coverage provided to the standard population, and expressed as a percentage. The Actuarial Values of Qualified Health Plans offered through the Exchange in 2014 are determined based on the federal Actuarial Value calculator as described in 45 C.F.R. 156.135.

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

“**Agreement**” shall mean 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 Qualified Health Plans through the New York Health Benefit Exchange.

“**American Indian**” shall mean (i) a member of a federally recognized Indian tribe, band, or group, or a descendant in the first or second degree of any such member; (ii) an Eskimo or Aleut or other Alaska Native; (iii) a person who is considered by the Secretary of the Interior to be an Indian for any purpose; (iv) a person who is determined to be an Indian under regulations promulgated by the Secretary of the Department of Health and Human Services.

“**Annual Open Enrollment Period**” shall mean for benefit years beginning on or after January 1, 2015, the annual period beginning October 15th and extending through December 7th of the preceding year.

“**Advance Premium Tax Credit (APTC)**” shall mean the federal health insurance premium tax credit enacted by the ACA, as described in 45 C.F.R. 155.305(f).

“**APTC Grace Period**” shall mean, in accordance with 45 C.F.R. 156.270(d), a grace period of three (3) consecutive months if an Enrollee receiving advance payments of the premium tax credit has previously paid at least one (1) full month’s premium during the benefit year; during which CONTRACTOR shall continue to provide coverage for Health Care Services for the first month of the grace period and may pend claims for services rendered to Enrollee in the second and third months of the grace period.

“**Catastrophic Plan**” as defined in section 1302(e) of the ACA, a high-deductible plan that provides a restricted group of eligible individuals with health coverage for preventative care, and Essential Health Benefits after Enrollee has exceeded the plan’s deductible.

“**Certification**” or “**QHP Certification**” shall mean the Exchange’s verification that a health plan complies with the requirements of the Invitation, as modified by the Exchange, including: (i) the Applicant-Specific Requirements set forth in Section (II)(D)(1), including the provision of Essential Health Benefits; (ii) the Quality and Enrollee Satisfaction requirements in Section (II)(E); (iii) the Network Adequacy Requirements in Section (II)(F), including sufficient geographic distribution of

Essential Community Providers; (iv) the Premium Rate and Policy Form and Filing requirements in Section (III), as well as provisions of applicable law with respect to Qualified Health Plans.

“Certificate of Coverage” shall mean the contract between CONTRACTOR and a Small Employer approved by the New York State Department of Financial Services and issued to each Small Employer by the CONTRACTOR at the time of enrollment which details the provision of health care coverage.

“Child Only Plan” shall mean a plan offering coverage only to children that conforms to the requirements set forth in the Invitation.

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

“Coverage Effective Date” is the date when medical or dental coverage becomes effective for a particular Enrollee.

“Dental Services” refers to dental services provided by a Stand-Alone Dental Plan.

“Department of Financial Services (DFS)” is the New York State Department of Financial Services.

“Essential Health Benefits (EHB)” shall mean the minimum health benefits specified by the STATE. The Essential Health Benefits for 2014 and 2015 are delineated in Attachment A of the Invitation.

“Enrollee” shall mean a Qualified Individual or a Qualified Employee enrolled in a Qualified Health Plan offered through the Exchange.

“Exchange” shall mean the New York Health Benefit Exchange established within the New York State Department of Health pursuant to Executive Order Number 42 on April 12, 2012.

“Health Care Services” shall mean the provision of medical 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)” shall mean the Health Information Technology for Economic and Clinical Health Act, which was 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)” shall mean the Health Insurance Portability and Accountability Act of 1996 and the regulations issued pursuant thereto or as thereafter amended.

“Individual Exchange” shall refer to the QHPs and Stand Alone Dental Plans available to Qualified Individuals through the New York Health Benefit Exchange.

“Individual Market” shall refer to health care and stand alone dental products available to individuals and sole proprietors both inside and outside of the Exchange.

“Initial Open Enrollment Period” shall mean the period beginning October 1, 2013 and extending through March 31, 2014.

“Invitation” shall mean the Invitation for Participation in the New York Health Benefit Exchange and the attachments thereto, issued by the Exchange on January 31, 2013 to health insurers and dental plans to participate in the New York Health Benefit Exchange, as modified by the Questions and Answers regarding the Invitation posted on the Exchange website.

“Medical Record” shall mean 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” shall mean 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-APTC Grace Period” shall refer to the thirty (30) day period after Enrollee has not paid Premiums owed to CONTRACTOR during which period CONTRACTOR must accept payment for outstanding premiums in accordance with the New York State Insurance Law, and during which CONTRACTOR may continue to provide coverage for Health Care Services provided to Enrollees not in receipt of Advance Premium Tax Credits.

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

“Open Enrollment or Open Enrollment Period” shall mean the fixed time period as set forth in 45 C.F.R. 155.410 for individual applicants and Enrollees to initiate enrollment or to change enrollment from one Qualified Health Plan or Stand-Alone Dental Plan to another.

“Participating Provider” shall mean a provider of Health Care Services or Dental Services that has a Provider Agreement with the CONTRACTOR.

“Protected Health Information” refers to individually identifiable health information known as Protected Health Information as defined in HIPAA, HITECH and Parts 160 and 164 of Title 45 of the Code of Federal Regulations.

“Premium” shall mean the dollar amount payable by the Enrollee, Employer, or Employee to the Contractor to effectuate and maintain coverage. For individuals who are eligible for and elect to receive an Advanced Premium Tax Credit, a portion of Enrollee’s premium will be payable by the federal government.

“Provider Agreement” shall mean any written contract between the CONTRACTOR and Participating Providers to provide Health Care Services or Dental Services to CONTRACTOR’s Enrollees.

“Qualified Employee” shall mean an individual employed by a Qualified Employer who has been offered health insurance coverage by such Qualified Employer through the SHOP, in accordance with 45 C.F.R. 155.20 and Exchange policies and procedures.

“Qualified Employer” shall mean an employer that (i) has 50 or fewer employees; (ii) elects to offer, at a minimum, all full-time employees coverage in a Qualified Health Plan through the SHOP; and (iii) either: (a) has its principal business address in the Exchange service area and offers coverage to all its full-time employees through that SHOP; or (b) offers coverage to each eligible employee through the SHOP serving that employee's primary worksite.¹ An employer that meets this criteria may be authorized to offer Qualified Employees the ability to purchase Qualified Health Plans through the SHOP. [Pursuant to federal regulation, sole proprietors who employ only themselves and/or their spouse are not permitted to participate in the SHOP.]

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

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

“Recertification” shall refer to the Exchange’s annual review and verification of a Qualified Health Plan’s compliance with the requirements for Certification and the provisions of applicable law regarding Qualified Health Plans.

“Service Area” shall mean the geographic area(s) designated by the STATE or DFS in which a Contractor’s Qualified Health Plan(s) shall be offered.

“SHOP Special Enrollment Periods” shall mean, in accordance with 45 C.F.R. 155.725(a)(3), such periods outside of the Initial or Annual Open Enrollment Period during which a Qualified Employee of a Qualified Employer participating in the SHOP or his or her dependents may enroll into coverage through the SHOP.

“Small Business Health Options Program (SHOP)” shall mean the Small Business Health Options Program, as defined at ACA § 1311(b)(1)(B) and 45 C.F.R. Part 155, Subpart H.

“Small Employer” shall mean an employer with 50 or fewer employees.

“Small Group Market” shall refer to health care and stand alone dental products available to Small Employers both inside and outside of the Exchange.

“Special Enrollment Periods” shall, as described in 45 C.F.R. 155.420, mean the periods during which a Qualified Individual or Enrollee who experiences certain qualifying events as set forth in federal regulation, may enroll in, or change enrollment in, a QHP through the Exchange outside of the Initial and Annual Open Enrollment Periods.

“Stand-Alone Dental Plan” shall mean a dental services plan that has received the Exchange’s certification to be offered through the Exchange.

¹ 45 C.F.R. 155.710

“Subscriber” shall mean the parent, legally responsible adult, individual, head of household or Enrollee to whom the CONTRACTOR issues a subscriber contract to obtain health care coverage on behalf of his or her spouse, his or her child or children or him or herself.

“Subscriber Contract” shall mean the contract between Contractor and a subscriber approved by the DFS 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 either directly or through their Employer, describing simple and consistent information about plan benefits and coverage. The SBC helps Enrollees to better understand their coverage and compare coverage options.

“System for Electronic Rate and Form Filing (SERFF)” shall mean the centralized system for premium rate and policy form filing operated by the National Association of Insurance Commissioners.

II. AGREEMENT / RELATIONSHIP OF PARTIES

A. Qualified Health Plans (“QHPs”)

The terms and conditions and obligations of the Parties set forth in this Agreement pertain to Qualified Health Plans (“QHPs”) offered through the New York Health Benefit Exchange.

B. Independent Contractors

1. The parties acknowledge and agree that, as required by 45 C.F.R. 155.200(e), 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 shall at all times be acting as independent contractors, and nothing in this Agreement shall 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

1. This Agreement is not intended to limit the obligations imposed on CONTRACTOR pursuant to applicable laws, rules and regulations, including without limitation the ACA, the New York State Insurance Law and the New York State Public Health Law. The absence of a reference to a particular statutory or regulatory requirement in this Agreement does not affect the applicability of such requirement to CONTRACTOR and STATE.
2. The Parties acknowledge and agree that federal and State laws and regulation with respect to QHPs and related issues addressed in this Agreement continue to develop on an ongoing basis. In the event that laws and regulations pertaining to QHPs change the requirements or processes set forth in this Agreement, the requirements of federal and State laws and regulations shall govern. The

STATE shall 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 shall support each other in their marketing, enrollment, and Enrollee transition efforts in accordance with applicable law. The Parties shall communicate and cooperate with each other on an ongoing basis in accordance with the terms of this Agreement.

E. Participation in Individual Exchange or SHOP

CONTRACTOR shall offer QHPs in the Individual Exchange, SHOP, or both, in accordance with the requirements set forth in the Invitation.

III. QUALIFIED HEALTH PLANS

A. Terms and Conditions for QHP Certification

1. At all times during the Contract Term, pursuant to 45 C.F.R. 156.200(b)(4), CONTRACTOR shall be duly licensed or certified to provide health insurance in New York, in good standing and in compliance with State solvency requirements as determined by the New York State Department of Financial Services (“DFS”) and/or STATE.
2. To offer health insurance plan(s) or Stand-Alone Dental Plan(s) for purchase through the Exchange, such plans must be certified as QHP(s) by the STATE.²
3. Certification of CONTRACTOR’s health insurance plan(s) as QHP(s) by the STATE, if applicable, confirms that the plan(s) also comply with the following provisions of the Invitation:
 - (i) the Applicant-Specific Requirements set forth in Section (II)(D)(1), including the provision of Essential Health Benefits;
 - (ii) the Quality and Enrollee Satisfaction requirements in Section (II)(E);
 - (iii) the Network Adequacy Requirements in Section (II)(F), including sufficient geographic distribution of Essential Community Providers; and
 - (iv) the Premium Rate and Policy Form and Filing requirements in Section (III).
4. Certification of CONTRACTOR’s Stand-Alone Dental Plan(s) as QHPs by the STATE, if applicable, confirms that the Stand-Alone Dental Plans comply with the following provisions of the Invitation:

² 45 C.F.R. 156.200(a)

- (i) the Applicant-Specific Requirements set forth in Section (II)(D)(2);
 - (ii) the Quality and Enrollee Satisfaction requirements in Section (II)(E);
 - (iii) the Network Adequacy Requirements in Section (II)(F); and
 - (iv) the Premium Rate and Policy Form and Filing requirements in Section (III).
5. The STATE will notify CONTRACTOR of QHP certification through the System for Electronic Rate and Form Filing (“SERFF”) and/or such other form of communication as the STATE determines appropriate.
- B. CONTRACTOR’S QHPs
- 1. CONTRACTOR shall make available for purchase in the Individual Exchange and/or the SHOP, the QHP(s) that have been certified by the Exchange.
 - 2. CONTRACTOR shall make standard, and to the extent offered by the CONTRACTOR, non-standard QHPs 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.
 - 3. Any exception to the requirement that a QHP be offered in the 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.
 - 4. Pursuant to 45 C.F.R. 155.1055, CONTRACTOR’s QHPs shall cover geographic areas that are established without regard to racial, ethnic, language or health status-related factors, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.
 - 5. CONTRACTOR’s QHPs shall comply with the following documentation submitted by CONTRACTOR and approved by STATE or DFS, which is incorporated by reference and made a part of this Agreement:
 - (i) Participation Proposal, attached to this Agreement as Appendix D;
 - (ii) Network information submitted and approved by the STATE; and
 - (iii) Quality information submitted and approved by the STATE.
 - 6. CONTRACTOR shall comply with STATE processes, procedures, and requirements established in accordance with 45 C.F.R. Part 155, subpart K and 45 C.F.R. 155.705, and this Agreement.³
 - 7. CONTRACTOR shall have a process in place to comply with the standards related to the Risk Adjustment, Reinsurance and Risk Corridors program pursuant to 45 C.F.R. Part 153.⁴

³ 45 C.F.R. 156.200(b)(2)

⁴ 45 C.F.R.156.200(b)(7)

8. CONTRACTOR shall 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. QHP Maintenance

1. CONTRACTOR acknowledges and agrees that the certification of QHP(s) is conditioned upon ongoing compliance with applicable federal and State law and regulation governing QHP 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 QHPs may be decertified if CONTRACTOR (i) fails to adhere to material certification standards and applicable law, resolve State agency sanctions, or comply with any applicable corrective action plan following reasonable notice and opportunity to cure, or (ii) fails to recertify.
2. In the event that the STATE determines decertification of QHP(s) is required pursuant to 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 designee. Decertification shall occur in accordance with all applicable laws and regulations governing the removal of a QHP from the Exchange, including notification to Enrollees.
3. During the Contract Term, other than during recertification, CONTRACTOR shall not change QHP standardized benefits or cost-sharing features, including Essential Health Benefits and Actuarial Value, unless required pursuant to federal or State law.
4. CONTRACTOR may change or discontinue QHPs only in accordance with this Agreement.
5. The STATE may suspend enrollment in a QHP in the event that the DFS requires suspension, or in the event that the STATE determines, for cause, that it is in the best interest of the public. Notification of such suspension shall occur in accordance with applicable laws and regulations.

IV. PROVIDER NETWORKS IN INDIVIDUAL EXCHANGE AND SHOP

A. Network Adequacy Requirements

For QHPs offered in the Individual Exchange or SHOP, CONTRACTOR will establish and maintain a network of Participating Providers that complies with 45 C.F.R. 156.230,⁵ the Invitation, STATE network adequacy standards, the requirements of this Agreement, together with instructions and guidance issued by the STATE. The network adequacy requirements and standards for QHPs shall

⁵ Section 45 C.F.R. 156.230 requires a provider network to meet the following standards:

- a. Includes essential community providers in accordance with 45 C.F.R. 156.235;
- b. Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and
- c. Is consistent with the network adequacy standards of section 2702 of the PHS Act.

be consistent with the network adequacy requirements and standards that exist outside of the Exchange pursuant to the New York State Public Health Law and regulation.

B. General Standards

1. 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 needs of the Enrollee population and to assure that all services will be accessible without unreasonable delay. This includes being geographically accessible (i.e. meeting time / distance standards) and being accessible for people with disabilities.
2. The 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.
3. Sanctioned Providers
 - a. CONTRACTOR shall not include in its network any provider who:
 - i. 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; or
 - ii. Has had his or her license suspended by the New York State Education Department or the State Office of Professional Medical Conduct.
 - b. CONTRACTOR shall review its provider network on a monthly basis to identify providers that require exclusion.

C. Network Adequacy Review / Process

1. The STATE:
 - a. Shall 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 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. Shall review the adequacy of CONTRACTOR's network upon submission and on a quarterly basis thereafter. The frequency of submission and review shall be gradually increased to monthly. Until monthly submission has commenced, CONTRACTOR shall

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

- c. Shall, in the event an insufficiency in CONTRACTOR's network is identified, provide CONTRACTOR with written notice of such insufficiency and an opportunity to cure within the specific time period required by the STATE, which time period shall be not less than thirty (30) days or such other time period dictated by the STATE. 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 QHP's authority to enroll new applicants in the county in which the CONTRACTOR's network is found deficient. In the event that the STATE determines in its sole discretion that CONTRACTOR'S network fails to provide appropriate access to services covered by a QHP, after the QHP has had an opportunity to cure such deficiency and has failed to do so, the STATE may terminate this Agreement in accordance with Section IX (Termination of Coverage).
- 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 shall:

- a. Submit its network through the Health Commerce System ("HCS") in accordance with the PNDS Instructions included in the Invitation, or as otherwise directed by the STATE. The STATE reserves the right to request further explanation and/or details in the event that the system is not able to capture or accurately identify particular providers;
- b. Ensure that for each provider included in the network that is submitted for review and approval, it has secured a Provider Agreement;
- c. Ensure that the network data submitted to the STATE is accurate and complies with applicable law and the requirements of this Agreement, and any guidance issued by the STATE.

V. POLICY FORM AND PREMIUM RATE FILING

A. Review of Rates and Forms

1. CONTRACTOR must file with DFS its proposed policy forms and premium rates before such forms and rates may be issued or delivered and prior to QHP Certification, in accordance with the Invitation.
2. In submitting its premium rates and forms, CONTRACTOR will adhere to federal laws and regulations with respect to Risk Adjustment, Rating Regions, Reinsurance and Risk Corridors, as well as DFS instruction. Submission of rate and form changes to QHPs shall occur on an annual basis in accordance with DFS instruction and time frames. Annual approval of rates and forms will be incorporated into the STATE's QHP recertification process.

B. QHP Plan Management Templates

1. CONTRACTOR shall submit the QHP plan management templates through SERFF or in such other format as directed by the STATE and DFS.
2. CONTRACTOR acknowledges that the data contained within the QHP plan management templates supply information necessary to populate the Exchange web portal, calculate Advance Premium Tax Credits (“APTC”), calculate cost-share subsidy payments, and populate the QHP information for other data transactions. As a result, CONTRACTOR shall 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

The STATE shall monitor the quality of care delivered by CONTRACTOR pursuant to this Agreement on an ongoing basis through the use of a several quality, utilization and satisfaction metrics that have been validated, have clinical relevance to the populations served, and are widely in use by health plans serving other populations in New York State as set forth in the Invitation. Public reporting of CONTRACTOR performance will be a central feature of the STATE plan for quality oversight. The STATE shall provide the CONTRACTOR with ninety (90) days advance notice of the annual performance metrics, including data and other requirements used for reporting quality of and access to care.

B. Accreditation

CONTRACTOR shall secure accreditation in accordance with the requirements of 45 C.F.R. 156.275 and the STATE, and within the time frames established by the STATE in accordance with 45 C.F.R. 155.1045. CONTRACTOR must maintain accreditation so long as the CONTRACTOR offers QHPs.

VII. ELIGIBILITY AND ENROLLMENT

A. Individual Exchange

1. Obligations of STATE

- a. The STATE shall be responsible for determining eligibility for QHPs, as well as eligibility for Insurance Affordability Programs (“IAPs”) including Medical Assistance (“Medicaid”), Child Health Plus, Advance Premium Tax Credits and Cost-Sharing Reductions.
- b. The STATE shall use a single streamlined application to collect necessary information and determine eligibility for enrollment in a QHP and for IAPs.⁶

⁶ 45 C.F.R.155.405(a)

- c. The STATE shall permit an applicant for coverage through the Exchange to request only an eligibility determination for enrollment in a QHP. The STATE shall not permit an applicant to request an eligibility determination for less than all IAPs.⁷
- d. The STATE shall provide an Initial Open Enrollment Period and Annual Open Enrollment Periods during which Qualified Individuals may enroll in a QHP and Enrollees may change QHPs in accordance with the requirements of 45 C.F.R. 155.410.⁸
- e. To ensure coverage is effective on the first day of the following benefit year for a Qualified Individual who has made a QHP selection during the Initial Open Enrollment Period and/or an Annual Open Enrollment Period, the STATE will provide to 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.⁹
- f. The STATE will make eligibility determinations in accordance with the requirements of State and federal law and STATE policies and procedures.
- g. The STATE shall communicate and coordinate with CONTRACTOR with respect to the processes, file formats and technology required for the transmission of enrollment data by and between the STATE and CONTRACTOR.

2. Obligations of CONTRACTOR Participating in the Individual Exchange

- a. During the Initial Open Enrollment Period and Annual Open Enrollment Periods as well as Special Enrollment Periods for Enrollees throughout the Contract Term, CONTRACTOR shall make available for purchase in the Individual Exchange the QHPs that have been certified by the Exchange. Eligible individuals will be able to purchase coverage directly through the Exchange website, or may use an authorized agent or broker or Navigator / In-Person Assistor; and, to the extent permitted by federal and State law and regulation, other third-party assistors or CONTRACTOR customer service representatives.
- b. Enrollment is not effectuated until CONTRACTOR receives initial payment of premium from the prospective enrollee and sends a confirmation 834 transaction to the STATE (the "Coverage Effective Date"). Unless required otherwise by federal law, CONTRACTOR shall 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 shall be considered timely.
- c. After enrollment is effectuated, CONTRACTOR shall adhere to the APTC Grace Period for those Enrollees receiving Advance Premium Tax Credit assistance. For Enrollees in the Individual Exchange that do not receive Advance Premium Tax Credit assistance at the time that the initial premium is paid, CONTRACTOR shall provide a thirty (30) day grace period to pay premiums in accordance with the requirements of the New York State Insurance Law. CONTRACTOR will not be financially responsible for any claims incurred by Enrollee

⁷ 45 C.F.R. 155.310(b)

⁸ 45 C.F.R.155.410(a)(1)

⁹ 45 C.F.R.155.410(f)

during the ten (10) day grace period prior to paying the initial premium. CONTRACTOR will be financially responsible for any claims incurred by Enrollee during the ten (10) day grace period provided that the Enrollee pays the initial premium prior to or during such ten (10) day grace period.

- d. CONTRACTOR shall enroll Qualified Individuals who experience a qualified change in status as determined by the STATE in accordance with State and federal regulations, including the regulations governing Special Enrollment Periods in 45 C.F.R. 155.420(d), as set forth above. The Coverage Effective Date for individuals who qualify for Special Enrollment Periods will be in accordance with the dates specified in 45 C.F.R. 155.420.
- e. If CONTRACTOR receives an application from a potential enrollee for enrollment in a QHP, the CONTRACTOR must either (i) direct the applicant to the Exchange for a determination of eligibility and enrollment in a QHP if eligible, or (ii) ensure the applicant received an eligibility determination from the Exchange through the Exchange website, whether through coordination with a Navigator / In Person Assistor, broker, or by enrolling the individual directly if and when permitted by federal regulation.¹⁰
- f. CONTRACTOR shall not, with respect to its QHP(s), discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.¹¹
- g. CONTRACTOR shall, for a period not to exceed one (1) year as determined by the STATE and HHS, accept retroactive enrollments from the STATE in special circumstances as determined by the STATE. Such circumstances shall include, without limitation, retroactive enrollments required to comply with eligibility appeals processes, or retroactive enrollments required to correct an error of the STATE or the CONTRACTOR. In such cases, the Enrollee shall be required to pay in full his or her share of premiums for all months of coverage received.
- h. An individual Enrollee shall be permitted to automatically continue his or her coverage in a QHP during the next Open Enrollment Period, unless the Enrollee is terminated for reasons permitted under the subscriber agreement or has selected another plan.

B. SHOP

1. Obligations of the STATE

- a. The STATE shall determine the eligibility of Small Employers to purchase coverage for Qualified Employees through the SHOP.¹² Provided however, nothing herein shall prevent a CONTRACTOR from independently verifying small employer eligibility and providing such information to the STATE.
- b. The STATE shall treat a Qualified Employer which ceases to be a Small Employer solely by reason of an increase in the number of employees of such Employer as a Qualified Employer until the Qualified Employer otherwise fails to meet the eligibility criteria set forth in this

¹⁰ 45 C.F.R. 156.265 (b)

¹¹ 45 C.F.R. 156.200 (e)

¹² 45 C.F.R. 155.710

Agreement and applicable law and regulation, or elects to no longer purchase coverage for Qualified Employees through the SHOP.¹³

- c. An employee is a Qualified Employee eligible to enroll in coverage through the SHOP if such employee receives an offer of coverage from a Qualified Employer.¹⁴

2. Obligations of CONTRACTOR Participating in the SHOP

- a. Starting October 1, 2013, a CONTRACTOR that has elected to participate in the SHOP, and has obtained certification of QHPs to be offered through the SHOP, shall make such QHPs available for purchase in the SHOP. Qualified Employers will be able to purchase coverage for their employees directly through the SHOP Portal on the Exchange website, or may use an authorized agent or broker, Navigator/In Person Assistor or other assistor to the extent permitted by federal or State law or regulation.
- b. CONTRACTOR shall accept every employer deemed a Qualified Employer by the STATE, subject to the exceptions permitted by federal regulation. Qualified Employers shall not be subject to a minimum participation requirement, meaning no minimum percentage of a Qualified Employer's employees shall be required to have health insurance. CONTRACTOR shall comply with federal regulation regarding guaranteed issue.
- c. Throughout the Contract Term, CONTRACTOR shall accept initial enrollment from a Qualified Employer's new employees, or newly eligible employees as determined by the STATE in accordance with 45 C.F.R. Part 155, Subpart H and any policies and procedures established by the STATE in accordance with State law. Enrollments from new and newly eligible employees must be accepted at any point during the year, subject to the provisions of subparagraphs (f), (g), (h) and (i) below.
- d. Qualified Employers must be renewed in the same QHP or QHPs on the twelve (12) month anniversary date of the Coverage Effective Date, unless the Qualified Employer has been determined by the STATE to no longer be eligible for Small Group coverage and/or the employer has chosen not to renew or has selected another QHP or QHPs.
- e. Qualified Employees and their dependents who are enrolled and eligible to renew their coverage may enroll only during the Employer's annual open enrollment period, which shall be a period of at least 30 days prior to the QHP's anniversary date, unless they are determined eligible by the STATE to enroll during the plan year because of a qualified change in status as defined by applicable federal and state regulations, including 45 C.F.R. 155.420.
- f. For QHP enrollments received between the first (1st) and fifteenth (15th) day of the month, CONTRACTOR shall effectuate coverage on the first day of the following month, provided that complete enrollment information has been received in accordance with STATE policy and procedure.

¹³ 45 C.F.R. 155.710

¹⁴ 45 C.F.R. 155.710

- g. For QHP enrollments transmitted from the STATE to the CONTRACTOR from the sixteenth (16th) to the end of the month, CONTRACTOR shall effectuate coverage on the first (1st) of the month AFTER the next following month. For example, an enrollment transmitted on May 17, 2014 would require a Coverage Effective Date of July 1, 2014.
- h. CONTRACTOR shall provide newly eligible employees and their dependents with the opportunity to enroll in a QHP on the first day of being determined qualified. Coverage for such employees and dependents will be effective in accordance with the provisions of subsections “f” and “g” above.
- i. CONTRACTOR shall accept eligible employees and their dependents for QHP enrollment based on an attestation by the Qualified Employer that the prospective enrollees are full-time employees or such employees’ dependents.
- j. CONTRACTOR shall process small group premiums in accordance with the policies and procedures established by the STATE, which may include a HIPAA Compliant 820 file, group eligibility and ACH.
- k. The STATE shall review and respond to concerns from CONTRACTOR with respect to the eligibility of an employer group and its employees, but the STATE shall have the sole authority to determine whether an applicant is eligible to enroll in a QHP. Notwithstanding the foregoing, in accordance with Part 86 of Title 11 of the New York Code of Rules and Regulations, CONTRACTOR must alert the STATE and DFS in the event it suspects or appears that a Qualified Employer and/or employees have committed fraud.

C. Special Enrollment Periods in Individual Exchange / SHOP

- 1. The STATE shall, pursuant to federal regulation, allow Qualified Individuals and Enrollees to enroll in or change from one QHP to another within sixty (60) days of the following triggering events:¹⁵
 - a. A Qualified Individual or dependent loses minimum essential coverage;
 - b. A Qualified Individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption, or if covered, domestic partnership;
 - c. An individual who was not previously a citizen, national, or lawfully present individual gains such status;
 - d. A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the STATE or HHS, or its instrumentalities as evaluated and determined by the STATE. In such cases, the STATE may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

¹⁵ 45 C.F.R. 155.420(d)

- e. An Enrollee adequately demonstrates to the STATE that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the Enrollee;
 - f. An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The STATE must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
 - g. A Qualified Individual or Enrollee gains access to new QHPs as a result of a permanent move;
 - h. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
 - i. A Qualified Individual or Enrollee demonstrates to the STATE, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the STATE may provide.
2. Except as otherwise provided below, for a QHP selection received by the STATE pursuant to a Special Enrollment Period, provided that the premium has been paid:
- a. the STATE and CONTRACTOR shall ensure a Coverage Effective Date of the first of the following month when a QHP selection is made between the 1st and 15th day of any month;
 - b. the STATE and CONTRACTOR shall ensure a Coverage Effective Date of the first of the second following month when a QHP selection is made between the 16th and the last day of any month;
 - c. in the case of birth, adoption or placement for adoption, the STATE and CONTRACTOR shall ensure that the Coverage Effective Date is the date of birth, adoption, or placement for adoption, and APTC and Cost-Sharing Reductions will be effective on the 1st day of the month;
 - d. in the case of marriage or in the case where a Qualified Individual loses minimum essential coverage, the STATE and CONTRACTOR must ensure a Coverage Effective Date on the 1st day of the following month.

D. Coverage Effective Date in Individual Exchange / SHOP

1. CONTRACTOR must notify a Qualified Individual of his or her effective date of coverage (the "Coverage Effective Date").¹⁶
2. Notification of the Coverage Effective Date may be accomplished through a "Welcome Letter" or similar notification. To the extent practicable, such notification must precede the Coverage Effective Date.
3. As of the Coverage Effective Date, and until the Effective Date of Disenrollment, the CONTRACTOR shall, pursuant to the terms and conditions of the QHP, be responsible for the coverage of all covered care and services provided under the QHP's benefit package and delivered to QHP Enrollees.
4. CONTRACTOR shall not be liable for the cost of any services rendered to an Enrollee prior to or after his or her Coverage Effective Date.

E. Process in Individual Exchange / SHOP

1. CONTRACTOR shall accept enrollments of Qualified Individuals in the order in which the enrollment information is received without regard to the Qualified Individual's sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, or type of illness or condition.
2. CONTRACTOR shall not impose additional or different requirements upon Enrollees than the requirements for individuals or small employers who purchased coverage outside of the Exchange unless required by law.
3. For the Individual Exchange, CONTRACTOR shall be responsible for collecting premium payments from Enrollees, as well as collecting Advance Premium Tax Credit and cost-share subsidies from the federal government. CONTRACTOR shall adhere to the standards set forth by HHS for the administration of ATPC and Cost-Sharing Reductions, including the provisions in 45 C.F.R. 156.410, 156.425, 156.430, 156.440, 156.460, and 156.470.
4. In the Individual Exchange, in accordance with federal regulation, CONTRACTOR shall offer method of payment options to Enrollees that do not discriminate against individuals without bank accounts or credit cards.
5. For the SHOP Exchange, the STATE shall be responsible for collecting premium payments from Qualified Employers. However, in the event that an individual employee obtains certain coverage from CONTRACTOR that is in addition to the coverage provided through the Qualified Employer, causing CONTRACTOR to bill the employee directly (excepting COBRA or State continuation of coverage), CONTRACTOR shall be responsible for collecting such premium payment.

¹⁶ 45 C.F.R. 156.260(b)

6. CONTRACTOR must accept enrollment information in an electronic format, in a manner consistent with applicable privacy and security provisions of state and federal law.¹⁷
7. The STATE shall transmit enrollment data to CONTRACTOR via HIPAA-compliant 834 files and CONTRACTOR must be prepared and able to accept daily enrollment information in a HIPAA compliant 834 file, and acknowledge receipt of enrollment information in HIPAA-compliant transactions. The transfer of enrollment data shall be conducted pursuant to the Trading Partner Agreement attached as an Appendix hereto and the 834 Companion Guide referenced in such Agreement, as may be amended from time to time.
8. For the SHOP, the STATE shall transmit and CONTRACTOR shall be prepared to receive Qualified Employer information in accordance with the Interface Control Document for Group Set-up File (as referenced in the Trading Partner Agreement), as may be amended from time to time.
9. The STATE shall transmit payment remittance data from the SHOP to CONTRACTOR via a HIPAA-compliant 820 transaction file. CONTRACTOR must be prepared and able to accept financial remittance transactions in a HIPAA compliant 820 file on the 1st, 15th and last day of every month, and acknowledge receipt of the file, in accordance with the Health Care Premium Payment (820) Companion Guide developed by the STATE pursuant to applicable law, regulation and guidance (as referenced in the Trading Partner Agreement), as may be amended from time to time.
10. In conducting HIPAA transactions, STATE and CONTRACTOR shall adhere to the Trading Partner Agreement attached hereto as an Appendix.
11. CONTRACTOR shall reconcile enrollment files with the STATE no less than once per month in accordance with 45 C.F.R. 155.400,¹⁸ and in accordance with procedures established by the STATE and as set forth in the Trading Partner Agreement attached hereto as an Appendix.

VIII. ENROLLEE RIGHTS AND NOTIFICATION

A. Information Requirements

1. CONTRACTOR shall provide all Enrollees an information package as required by 45 C.F.R. 156.265(e), including Evidence of Coverage (“EOC”) and Summary of Benefits and Coverage (“SBC”).
2. The CONTRACTOR shall issue such information to the Enrollee as soon as possible but no later than fourteen (14) days after the Coverage Effective Date. The CONTRACTOR may provide such information to the Enrollee through the Member Handbook / Subscriber Contract in the case of the Individual Exchange, or Certificate of Coverage in the case of the SHOP.
3. The CONTRACTOR must provide Enrollees with an annual notice that the EOC and SBC are available upon request.

¹⁷ 45 C.F.R. 156.265(c)

¹⁸ 45 C.F.R. 156.265(f)

4. The CONTRACTOR must make information available to prospective Enrollees and new 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:
 - (i) Provide written materials in a prose that is understood by an eighth-grade reading level and must be printed in at least 10-point type.
 - (ii) 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.
 - (iii) 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.
 - (iv) 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.
 - (v) To the extent that HHS establishes standards on written materials and/or verbal information for the Exchange that provides 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.¹⁹

B. Provider Directories

1. The CONTRACTOR shall maintain and update, on a quarterly basis, a listing by specialty of the names, addresses and telephone numbers of all Participating Providers, including facilities (the “Provider Directory”). Such Provider Directory shall include names, office addresses, telephone numbers, board certification for physicians, information on language capabilities and wheelchair accessibility of Participating Providers. The Provider Directory should also identify providers that are not accepting new patients.
2. CONTRACTOR shall make its provider directory available to the STATE for publication online and to potential enrollees or Enrollees in hard copy upon request.²⁰

¹⁹ 45 C.F.R. 155.205(b)(3)

²⁰ 45 C.F.R. 156.230(b)

3. Enrollees must be notified 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 Participating Providers

CONTRACTOR shall, 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. Treatment Cost Calculator for Out-of-Network Providers

CONTRACTOR will provide the STATE with information on cost-sharing and payments with respect to any out-of-network coverage pursuant to 45 C.F.R. 156.220(a)(7). CONTRACTOR shall, in accordance with and to the extent required by federal regulation, provide access to an out-of-network treatment cost calculator that will be made available to the public during the open enrollment periods.

E. Member Identification Cards

1. CONTRACTOR shall issue an identification card to Enrollees as soon as is possible but no later than seven (7) days following enrollment. 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 shall 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. Newborns under two months of age of Enrollees need not present identification cards in order to receive services from the CONTRACTOR's Participating Providers.

F. Member Handbooks / Subscriber Contracts

The CONTRACTOR shall 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, in the case of the Individual Exchange; a Certificate of Coverage in the case of the SHOP, and, at the option of CONTRACTOR, a Member Handbook.

IX. TERMINATION OF COVERAGE

A. Individual Exchange

1. Obligations of the STATE

a. The STATE shall permit an Enrollee to terminate his or her coverage in a QHP in the event of a qualifying event (including as a result of the Enrollee obtaining other minimum essential coverage), upon thirty (30) days' notice to the STATE.²¹ In such case the last day of coverage is:

(i) The termination date specified by the Enrollee, if the Enrollee provides thirty (30) days' notice;

(ii) Thirty (30) days after the termination is requested by the Enrollee, if the Enrollee does not provide reasonable notice of thirty (30) days; or

(iii) On a date determined by CONTRACTOR, if the CONTRACTOR is able to effectuate termination in fewer than thirty (30) days and the Enrollee requests an earlier termination effective date.

(iv) If the Enrollee is newly eligible for Medicaid or CHP, the last day of coverage is the day before the Medicaid or CHP coverage begins.²²

b. The STATE shall initiate termination of an Enrollee's coverage in a QHP, and shall permit CONTRACTOR to terminate such coverage in the following circumstances:²³

i. Enrollee is no longer eligible for coverage in a QHP, in which case the last day of coverage is the last day of the month following the month in which the notice described in 45 C.F.R. 155.330(e)(1)(ii) is sent by the STATE, unless the Enrollee requests an earlier termination date in accordance with applicable regulation;²⁴ provided, however, for child-only QHPs, coverage terminates at the end of the year in which the child turns twenty-one (21).

ii. Non-payment of premiums for coverage of the Enrollee, and

A) The APTC Grace Period for individuals receiving advance payment of the premium tax credit has been exhausted as described in 45 C.F.R. 156.270(g), in which case the last day of coverage is the last day of the first month of the APTC Grace Period;²⁵ or

²¹ 45 C.F.R. 155.430(b)(i)

²² 45 C.F.R. 155.430(d)(2)(iv)

²³ 45 C.F.R. 155.430(b)(2)

²⁴ 45 C.F.R. 155.430(d)(3)

²⁵ 45 C.F.R. 155.430(d)(4)

- B) The Non-APTC Grace Period required under the New York State Insurance Law (for those not receiving advance payments of the premium tax credit) has expired, in which case the last day of coverage is the last paid in full date, in accordance with the requirements of the New York State Insurance Law;²⁶
 - ii. Enrollee's coverage is rescinded in accordance with 45 C.F.R. 147.128;
 - iii. The QHP is discontinued or is decertified as described in 45 C.F.R. 1080;
 - iv. The Enrollee changes from one QHP to another QHP during an Annual Open Enrollment Period or Special Enrollment Period in accordance with 45 C.F.R. 155.410 and 155.420, in which case the last day of coverage in an Enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP.²⁷
- c. In accordance with 45 C.F.R. 155.430(c), the STATE shall promptly and without undue delay inform CONTRACTOR of Enrollee termination.
- d. In the event that the STATE initiates termination of a QHP in the SHOP, the STATE shall provide the notice required by federal or State law, including the COBRA notice and notice of State Continuation Rights.

2. Obligations of CONTRACTOR Participating in the Individual Exchange

- a. CONTRACTOR shall not terminate coverage because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services.
- b. For the Individual Exchange, CONTRACTOR may cancel a Qualified Individual's enrollment in the event that the initial premium payment is not received during the ten (10) day grace period referred to in section VII(2).
- c. CONTRACTOR may at its own discretion reinstate an Enrollee in the event the Enrollee has failed to pay premium and has exhausted all applicable grace periods.
- d. CONTRACTOR shall make reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before termination of coverage for such individuals.²⁸
- e. CONTRACTOR may only initiate termination for failure to pay initial premium (i.e., Cancellations), rescission, and non-payment of premium after the APTC Grace Period or Non APTC Grace Period, whichever is applicable, 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.

²⁶ 45 C.F.R. 155.430(d)(5)

²⁷ 45 C.F.R. 155.430(d)(6)

²⁸ 45 C.F.R. 155.430(c)(3)

- f. In the event that CONTRACTOR initiates termination, CONTRACTOR shall provide Enrollee with any notices or certificates required by federal or state law, including, as applicable, the Certificate of Creditable Coverage, notice of HIPAA conversion rights, or benefits disclosure notice, as appropriate. The termination notice must notify Enrollees of the option to purchase coverage through the Exchange.
- g. 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.
- h. CONTRACTOR is not responsible for providing benefits after the effective date of disenrollment.
- f. 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.²⁹

B. SHOP

1. Obligations of the STATE

- a. The STATE may process the termination of a Qualified Employee's coverage in a QHP through the SHOP in a standard HIPAA-compliant 834 transaction or pursuant to such other procedures designated by the STATE, in the following circumstances:
 - i. The Qualified Employer or Qualified Employee notifies the Exchange that the Qualified Employee is no longer eligible for coverage in a QHP, in which case the last day of coverage is the last day of the month for which the Exchange has received premium payments;
 - ii. Employee's coverage is rescinded in accordance with 45 C.F.R. 147.128;
 - iii. The QHP is discontinued or is decertified;
 - iv. The Qualified Employee changes from one QHP to another during an Annual Open Enrollment Period or Special Enrollment Period, in which case the last day of coverage in the Qualified Employee's prior QHP shall be the day before the Coverage Effective Date in his or her newly selected QHP.
- b. In the event a Qualified Employee is terminated from a QHP, the STATE shall issue a COBRA or state continuation of coverage notification to the Qualified Employee, and inform the employee of the option to purchase coverage through the Exchange. In the event the Qualified Employee elects COBRA or continuation coverage, and informs the Qualified Employer of such election, the STATE shall bill the Qualified Employer the full premium for the coverage chosen by the Qualified Employee. The Qualified Employer shall remit payment to the STATE and the STATE shall send such payment to CONTRACTOR.

²⁹ 45 C.F.R. 155.430(c)(4)

- c. The STATE may process the termination of a Qualified Employer, in the following circumstances:
 - i. Qualified Employer ceases to purchase coverage through the SHOP, in which case the coverage for all employees of the withdrawing Qualified Employer shall terminate on the last day of the month for which the Exchange has received premium payments;
 - ii. In accordance with the New York State Insurance Law, in the event a Qualified Employer fails to pay their complete premium when due, the STATE shall provide a grace period of thirty (30) days. If such Qualified Employer exhausts this grace period without paying all outstanding premiums, the STATE shall terminate the Qualified Employer's coverage, and the coverage of those employees covered through the Qualified Employer's QHP, effective as of the last day of the last month that premiums were paid. The STATE will permit CONTRACTOR to voluntarily reinstate a Qualified Employer a maximum of two (2) times per Plan Year. For example, in the event a Qualified Employer has been reinstated two (2) times within a Plan Year, and then exhausts a third grace period within the same Plan Year without paying all outstanding premiums, the Qualified Employer will be terminated and shall not be permitted to participate in the SHOP for twelve (12) months;
 - iii. If a Qualified Employer ceases to purchase coverage through the SHOP, the STATE shall ensure that:³⁰
 - 1. Each QHP terminates the coverage of the Employer's Qualified Employees enrolled in the QHP through the SHOP; and
 - 2. Each of the Qualified Employer's Qualified Employees enrolled in a QHP through the SHOP is notified of the termination of coverage prior to such termination. Such notification must also provide information about other potential sources of coverage, including the Individual Exchange.
 - iv. In the event the STATE determines a Qualified Employer has committed fraud.

2. Obligations of CONTRACTOR Participating in the SHOP

- a. CONTRACTOR may only terminate a Qualified Employer and employee as permitted by STATE.³¹
- b. If an employee is terminated for any reason, the CONTRACTOR must provide the employee with a notice that includes the reason for termination thirty (30) days prior to the last date of coverage, consistent with the effective date set forth above, and must notify the STATE of the termination effective date and the reason for such termination.³²

³⁰ 45 C.F.R. 155.715(g)

³¹ 45 C.F.R. 156.285(d)(1)(i)

³² 45 C.F.R. 156.270(d)(1)(ii)

- c. If an employee changes from one QHP to another during an Annual Open Enrollment Period or Special Enrollment Period, CONTRACTOR shall terminate such coverage in the prior QHP on the last day before the Coverage Effective Date of his or her newly selected QHP.³³
- d. If a Qualified Employer decides to withdraw from participation in SHOP, the CONTRACTOR must terminate coverage of all employees of the withdrawing employer on the last day of the month for which premium has been paid;
- e. CONTRACTOR shall promptly and without undue delay inform STATE of employee termination or reinstatement of a Qualified Employer.

C. Transition of Enrollees in Individual Exchange / SHOP

If this Agreement between the STATE and CONTRACTOR is terminated for any reason, the CONTRACTOR agrees to cooperate with the 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 families to enroll with another health plan, in addition to any other requirement under New York State law.

X. RECERTIFICATION / TERMINATION OF QHP AGREEMENT

A. Recertification

- 1. Except with respect to Consumer Operated and Owned Plans (COOPs), the STATE shall notify CONTRACTOR of the opportunity for recertification no later than May 1st each year. Rates and forms must be filed in accordance with DFS processes and timelines, and will be incorporated into the STATE's recertification process. CONTRACTOR may add, remove or modify QHPs during the recertification process in accordance with STATE and DFS instruction.
- 2. The STATE will complete recertification on an annual basis but no later than September 15 of each year.³⁴

B. Non-renewal

In lieu of annual recertification, CONTRACTOR may opt not to renew participation in the Exchange. CONTRACTOR shall notify the STATE of its decision to not renew in a manner and timeframe that consistent with existing State law. The CONTRACTOR must follow applicable laws and regulations in terminating QHPs, including notification to Enrollees. The STATE will monitor the transition process, coordinating processes with Exchange Customer Service and DFS to facilitate transition.

³³ 45 C.F.R. 156.270(d)(1)(iii)

³⁴ 45 C.F.R. 155.1075(b)

C. Contractor Discontinuance of Counties in Service Area

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

In the event that CONTRACTOR proposes to voluntarily discontinue providing QHPs 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 Individual Exchange or SHOP. 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. Process for Termination of Coverage

As set forth above with respect to Termination of Coverage, 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 families to enroll with another health plan, in addition to any other requirement under New York State law.

F. Contractor Initiated Termination of Agreement

CONTRACTOR shall notify the Exchange 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 Exchange with notice to Enrollees of the conclusion of coverage under this AGREEMENT and the availability of conversion rights pursuant to the subscriber contract.

G. State Initiated Termination of Agreement

The STATE may cancel this AGREEMENT in the Individual Exchange, or the SHOP, or both, in the event that the STATE determines:

- (i) 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;
- (ii) 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.
- (iii) that CONTRACTOR does not meet financial requirements, except to the extent that a corrective action plan has been approved by DFS.

XI. MEMBER SERVICES

1. CONTRACTOR shall operate a “Member Services” or “Customer Services” department during regular business hours, which must be accessible to QHP enrollees via toll free telephone number. Customer services representatives must be available during regular business hours to address complaints and utilization.
2. CONTRACTOR must maintain a telephone system capable of accepting incoming calls regarding complaints and utilization review outside of regular business hours and providing callers with instruction or the ability to leave a message.

XII. MARKETING

A. Obligations of State

1. The STATE shall implement a multi-faceted marketing and outreach campaign that is focused on connecting New Yorkers with quality, affordable health insurance through its user friendly website.
2. The STATE shall engage in targeted outreach to consumers through navigators, consumer advocates, small businesses, brokers, Exchange Regional Advisory Committee members and other stakeholders to promote use of the Exchange.
3. The STATE shall initiate an advertising campaign designed to publicize the access to quality, affordable health insurance.

B. Obligations of Contractor

1. CONTRACTOR shall cooperate in good faith with the STATE’s marketing and outreach activities, including the development of advertising and outreach materials for QHPs and communication with the Exchange’s External Affairs, Outreach and Marketing team.
2. CONTRACTOR may maintain a direct link to the Exchange website on CONTRACTOR’s website. The STATE will provide approved links for this purpose (also known as “widgets”).

3. CONTRACTOR shall cooperate with the STATE to educate its agents and brokers about the QHPs available through the SHOP and the Individual Exchange; and the process for agent and broker training and certification by the Exchange to sell such QHPs.
4. CONTRACTOR's marketing of QHPs may, particularly during the Initial Open Enrollment Period and Annual Open Enrollment Periods, include: (i) advertisements in print, radio, television, outdoor advertising and/or social media, (ii) written and electronic communications sent to CONTRACTOR's members, employers, 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 shall use the name and logo designated by the STATE in referring to the Exchange in marketing and outreach activities including any printed materials. Such materials must prominently display the Exchange website and toll free telephone number.
6. CONTRACTOR shall provide the STATE with Brand Symbols in the format necessary for the use on the Exchange website.
7. CONTRACTOR shall not employ marketing practices that are designed to have the effect of discouraging the enrollment of individuals or small businesses with significant health needs in their QHPs.
8. CONTRACTOR shall 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 an Enrollee. Materials must not contain false or misleading information. CONTRACTOR shall not offer incentives of any kind to potential enrollees to enroll in a QHP 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 shall 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 Agreement period;
 - (ii) suspend new Enrollments, other than newborns, for a period up to the remainder of the Agreement period, terminate this Agreement pursuant to termination procedures described in the Termination section of this Agreement, and/or decertify CONTRACTOR's QHP(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 Exchange is not a Business Associate of the CONTRACTOR in performing its statutorily required functions pursuant to 45 C.F.R. 155.200.³⁵
3. CONTRACTOR shall 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 the Health Insurance Portability and Accountability Act ("HIPAA"). This includes individual Medical Records and any other health and enrollment information that identifies a particular Enrollee.
4. CONTRACTOR shall comply with the following requirements:
 - a. In accordance with 42 C.F.R. Part 431, subpart F, CONTRACTOR is prohibited from disclosing information concerning Enrollees unless such disclosure is permitted by applicable law, including the purposes of treatment, payment, or health care operations;
 - b. CONTRACTOR must maintain information in a timely and accurate manner;
 - c. CONTRACTOR must 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, CONTRACTOR must ensure that each Enrollee may request a copy of his or her records and information in a designated records

³⁵ See, Exchange Final Rule, Fed Reg Vol. 77 No. 59, March 27, 2012, p. 18325

set, receive such records and information in a timely manner, and that each Enrollee may request that his or her records be supplemented or corrected.

5. CONTRACTOR shall, following the discovery of any breach in the security of a system used to exchange data in accordance with this Agreement, including Personally Identifiable Information (“PII”) or Protected Health Information (“PHI”), immediately notify the STATE, and shall immediately commence an investigation in accordance with applicable law to determine the scope of the breach and restore the security of the system to prevent any further breach.
6. CONTRACTOR shall 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 shall promptly report to the STATE any security incident of which it becomes aware. “Security incident” shall mean the attempted or successful unauthorized access, use, disclosure, modification or destruction of information, interference with system operations affecting the exchange of data set forth in this Agreement, and data loss due to the loss or misplacement of hardware or storage devices.

XIV. REPORTING/DATA COLLECTION

A. General Requirements

1. CONTRACTOR shall establish and maintain the systems and processes to connect to and transmit data to and from the STATE.
2. CONTRACTOR shall establish and maintain the systems and processes to connect to and transmit data to and from HHS, Treasury and Reinsurance Entities.
3. CONTRACTOR shall 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, 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 shall 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 shall 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 shall submit financial reports, including certified annual financial statements, and make available documents relevant to its financial condition to the STATE and DFS in a timely manner as required by State and federal laws and regulations. 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.
2. 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.
3. CONTRACTOR shall comply with all requirements outlined at 45 C.F.R. § 156.280 regarding segregation of funds.

D. Prescription Drug Cost

1. CONTRACTOR shall 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:
 - (i) the percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies;
 - (ii) 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;
 - (iii) 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 QHP, 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
 - (iv) 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. 156.220:³⁶
 - (i) Claims payment policies and practices;
 - (ii) Periodic financial disclosures;
 - (iii) Data on enrollment;
 - (iv) Data on disenrollment;
 - (v) Data on the number of claims that are denied;
 - (vi) Data on rating practices;
 - (vii) Information on cost-sharing and payments with respect to any out-of-network coverage; and
 - (viii) Information on enrollee rights under Title I of the ACA.
2. CONTRACTOR shall ensure that the above listed information is provided in plain language as defined in 45 C.F.R. 155.20.³⁷
3. CONTRACTOR must make available the amount of Enrollee cost-sharing for in-network services under the individual's Qualified Health 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.³⁸

XV. AMERICAN INDIANS AND ALASKA NATIVES

CONTRACTOR shall 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 American 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. CONTRACTOR shall cover Health Care Services furnished through a health care provider pursuant to a referral under contract for directly furnishing an item or service to an American Indian with no cost-sharing in accordance with applicable federal regulations, including 45 C.F.R. 156.430(a)(1)(ii).
- B. CONTRACTOR shall not impose any cost-sharing on such individuals under three hundred percent (300%) of federal poverty level in accordance with applicable federal regulations, including 45 C.F.R. 156.430(a)(2).
- C. CONTRACTOR shall provide monthly special enrollment periods for American Indians enrolled through the Exchange.

³⁶ 45 C.F.R. 156.220(b)

³⁷ 45 C.F.R. 156.220(c)

³⁸ 45 C.F.R. 156.220(d)

CONTRACTOR shall 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 shall 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 Exchange Data. As between the STATE and CONTRACTOR, all Exchange Data, as defined below, shall be and will remain the property of the STATE. For purposes of this section, Exchange Data means data and information created by the Exchange and relating to the Exchange, 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 Exchange 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 Exchange 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 Exchange Data. Notwithstanding the foregoing, the CONTRACTOR shall be responsible for compliance with all federal or state requirements regarding the security and privacy of Exchange Data that is within the CONTRACTOR's custody, including the requirements of HIPAA and the 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 QHP Certification and Recertification, Provider Network Review, monitoring of Quality and Enrollee Satisfaction, Reporting / Data Collection and other functions of the Exchange 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.

IXX. RECORDS MAINTENANCE / EXAMINATION AND AUDIT

A. Maintenance of Contractor Records

1. The CONTRACTOR shall 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 shall 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 shall subject itself to audits/reviews by the STATE or its designee, as the parties deem necessary to determine the correctness of Enrollee premium payments and Advance Premium Tax Credit 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 shall, 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 shall 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 shall 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 shall 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.