UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JOSEPH GREENE, PAMELA MAZZA, and DEBORAH SCHUTT on behalf of themselves and all others similarly situated, Plaintiffs, v. HEALTHFIRST PHSP, INC., Defendant.	Case No. 25-cv-09058 (ER)

DECLARATION OF JOSHUA H. PIKE IN SUPPORT OF DEFENDANT HEALTHFIRST PHSP, INC.'S MOTION TO DISMISS

I, Joshua H. Pike, declare pursuant to 28 U.S.C. § 1746 as follows:

1. I am a Vice President and Associate General Counsel for Healthfirst PHSP, Inc. ("Healthfirst"). I reside in Darien, Connecticut. I write this declaration in support of the motion to dismiss Plaintiffs' Second Amended Complaint against Healthfirst.

2. Healthfirst is a not-for-profit corporation formed in the State of New York and its principal place of business is New York, New York. It is one of several affiliated health insurance companies operating under the "Healthfirst" name. The Healthfirst family of health insurance companies was founded by New York-area hospitals in the 1990s to improve access to high-quality health care for low-income New Yorkers.

3. Healthfirst is a managed care organization that principally administers government sponsored healthcare programs such as Medicaid and Medicare. Individuals subscribe to Healthfirst to manage their government health insurance benefits or to enroll in private Healthfirst insurance plans.

4. We generally refer to our insureds as "members." Most of Healthfirst's members are enrolled in our Medicaid Managed Care Plan ("MMC Plan"), the managed care version of New York State's Medicaid program. Healthfirst also administers Essential Plans ("EPs"), health insurance plans that are sponsored by New York State, and Qualified Health Plans ("QHPs"), which are private plans certified by New York State. Healthfirst refers to its QHPs as "Leaf" Plans. Healthfirst offers QHPs with different levels of coverage, defined by New Yok State as bronze, silver, and gold. Thus, our QHP products have names like Bronze Leaf, Silver Leaf and Gold Leaf, with other variations. The majority of our members pay no insurance premiums, including individuals enrolled in our MMC Plan (Medicaid) or in our EPs.

5. Healthfirst's insurance plans are available only to New York residents. Our active coverage area is downstate New York, which includes all counties of New York City, as well as Long Island, Westchester, and the lower Hudson Valley.

6. The specific Healthfirst plans, and specific periods, that are relevant to the allegations in Plaintiffs' Second Amended Complaint are the following: Gold Leaf Premier Plan (October 2022 to March 2024); Silver Leaf Premier Plus Plan (January 2024 to December 2025); Bronze Leaf Premier Plan (January 2026 to present); EP 200-250 (April 2024 to August 2025); EP 1 (September 2025 to the present); EP 2 (September 2025 to present); and MMC Plan (January 2024 to September 2025).

7. Managed care organizations like Healthfirst who are selected to administer New York State's MMC Plan enter into a standardized contract, or "model contract," with New York State.

8. The MMC Plan model contract with New York State, effective March 1, 2024 to February 28, 2029 (the "2024 MMC Model Contract"), is available online at the New York State Department of Health ("NYSDOH") website, here:

https://www.health.ny.gov/health_care/managed_care/providers/docs/mmc_fhp_hiv-snp_harp_model_contract.pdf.

Attached hereto as **Exhibit 1** is a true and correct copy of certain excerpts and the executed signature pages between Healthfirst PHSP, Inc. and New York State for the 2024 MMC Model Contract.

9. The MMC Plan model contract with New York State for the period March 1, 2019 to February 29, 2024 (the "2019 MMC Model Contract") is available online at the NYSDOH website, here:

https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.

Attached hereto as **Exhibit 2** is a true and correct copy of certain excerpts and the executed signature pages from the 2019 MMC Model Contract.

10. Members of the MMC Plan do not have a separate, individual contract with Healthfirst governing Healthfirst's administration of health insurance benefits under the MMC Plan.

11. Like the MMC Plan, Healthfirst contracts with New York State to provide health insurance benefits under the Healthfirst EPs.

12. Attached hereto as **Exhibit 3** is a true and correct copy of the contract with New York State, effective January 1, 2026 to December 31, 2030, that currently governs Healthfirst's EPs.

13. The EP model contract with New York State for the period January 1, 2021 to December 31, 2025 is available online at the NYSDOH website, here:

https://info.nystateofhealth.ny.gov/sites/default/files/2024%20EP%20Model%20Contract%204.1%20Updates.zip.

Attached hereto as **Exhibit 4** is a true and correct copy of certain excerpts and the executed signature pages for the 2021 EP Model Contract.

14. In addition to the contract with New York State, Healthfirst also has a contract with members of EPs outlining members' rights and Healthfirst's obligations under the EPs.

15. Attached hereto as **Exhibit 5** is a true and correct copy of the EP 200-250 member contract, effective in 2024.

16. The 2024 EP 200-250 member contract is representative, in all respects relevant here, of the other EP member contracts at issue in Plaintiffs' Second Amended Complaint: the 2025 EP 200-250 Plan member contract; the 2025 EP 1 member contract; the 2025 EP 2 member contract; the 2026 EP 1 member contract; and the 2026 EP 2 member contract. Between the different plan tiers, the contract terms are the same, whereas the differences in plans are reflected in an appended schedule of benefits.

17. In particular, each member contract mentioned in the preceding paragraph states, on its cover page, that the contract constitutes "the entire agreement between" Healthfirst and the member.

18. Attached hereto as **Exhibit 6** are true and correct copies of the cover pages of the following member contracts (in order): the 2025 EP 200-250 member contract; the 2025 EP 1 member contract; the 2025 EP 2 member contract; the 2026 EP 1 member contract; and the 2026 EP 2 member contract.

19. Additionally, true and accurate copies of all 2026 EP member contracts are available online at Healthfirst's website, https://healthfirst.org/healthfirst-subscriber-contracts#%22e0d047%22.

20. Like the MMC Plan and EPs, Healthfirst contracts with New York State to provide health insurance benefits under the QHPs.

21. Attached hereto as **Exhibit 7** is a true and correct copy of the contract with New York State, effective October 1, 2023 to December 31, 2028, that currently governs Healthfirst's QHPs.

22. Attached hereto as **Exhibit 8** is a true and correct copy of the contract with New York State, effective October 1, 2018 to December 31, 2023, that previously governed Healthfirst's QHPs.

23. Like the EPs, members of QHPs receive a contract with Healthfirst outlining members' rights and Healthfirst's obligations under the QHPs.

24. Attached hereto as **Exhibit 9** is a true and correct copy of the QHP Gold Leaf Premier Plan member contract, effective in 2022.

25. The 2022 Gold Leaf Premier Plan member contract is representative, in all respects relevant here, of the other QHP Plan member contracts at issue in Plaintiffs' Second Amended Complaint: the 2023 Gold Leaf Premier Plan member contract; the 2024 Gold Leaf Premier Plan member contract; the 2024 Silver Leaf Premier Plus Plan member contract; the 2025 Silver Leaf Premier Plus Plan member contract; and 2026 Bronze Leaf Premier Plan member contract. Like the EPs, between the different QHP plan tiers, the contract terms are the same, whereas the differences in plans are reflected in an appended schedule of benefits.

26. In particular, each member contract mentioned in the preceding paragraph states, on its cover page, that the contract constitutes "the entire agreement between" Healthfirst and the member.

27. Attached hereto as **Exhibit 10** are true and correct copies of the cover pages of the following member contracts (in order): the 2023 Gold Leaf Premier Plan member contract; the 2024 Gold Leaf Premier Plan member contract; the 2024 Silver Leaf Premier Plus Plan member contract; the 2025 Silver Leaf Premier Plus Plan member contract; and 2026 Bronze Leaf Premier Plan member contract.

28. Additionally, the 2026 versions of all QHP member contracts are available online at https://healthfirst.org/healthfirst-subscriber-contracts#%22e0d047%22.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: New York, New York
June 4, 2026

Respectfully submitted,

Signed by:
Joshua H. Pike
8BC9224D1D524C6...

Joshua H. Pike

EXHIBIT 1

Excerpts, 2024 Medicaid Managed Care

Model Contract between Healthfirst and New York State

MEDICAID MANAGED CARE/

FAMILY HEALTH PLUS/

HIV SPECIAL NEEDS PLAN/

HEALTH AND RECOVERY PLAN

MODEL CONTRACT

March 1, 2024

MISCELLANEOUS/CONSULTANT SERVICES
(Award Without Formal Request For Proposal)

STATE AGENCY (Name and Address):

New York State Department of Health
Office of Health Insurance Programs
Division of Health Plan Contracting and Oversight
One Commerce Plaza
Room 1609
Albany, NY 12260

NYS Comptroller's Number:

Originating Agency GLBU: DOH01
Department ID: 3450000

CONTRACTOR (Name and Address):

TYPE OF PROGRAM(S):

Medicaid Managed Care and/or
Family Health Plus and/or HIV Special Needs Plan

CHARITIES REGISTRATION NUMBER:

Contractor has ( ) has not ( ) timely filed with the Attorney General's Charities Bureau all required period or annual written reports.

CONTRACT TERM:

FROM: March 1, 2024
TO: February 28, 2029

FEDERAL TAX IDENTIFICATION NUMBER:

NYS VENDOR IDENTIFICATION NUMBER:

FUNDING AMOUNT FOR CONTRACT TERM:

MUNICIPALITY NUMBER (if applicable):

STATUS:

CONTRACTOR IS [ ] IS NOT [ ]
A SECTARIAN ENTITY

CONTRACTOR IS [ ] IS NOT [ ]
A NOT-FOR-PROFIT ORGANIZATION

CONTRACTOR IS [ ] IS NOT [ ]
A NY STATE BUSINESS ENTERPRISE

( ) IF MARKED HERE, THIS CONTRACT IS RENEWABLE FOR ____ ADDITIONAL ONE-YEAR PERIOD(S) AT THE SOLE OPTION OF THE STATE AND SUBJECT TO THE APPROVAL OF THE NEW YORK STATE DEPARTMENT OF HEALTH, THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE OFFICE OF THE STATE COMPTROLLER.

13. ENROLLEE RIGHTS AND NOTIFICATION

13.1 Information Requirements

a) The Contractor shall provide new Enrollees with the information identified in PHL § 4408, SSL § 364-j, SSL § 369-ee and 42 CFR § 438.10 (g), (h) and (i).

b) The Contractor shall provide such information to the Enrollee within fourteen (14) days of the Effective Date of Enrollment. The Contractor may provide such information to the Enrollee through the Member Handbook referenced in Section 13.4 of this Agreement.

c) The Contractor must provide Enrollees with an annual notice that this information is available to them upon request.

d) The Contractor must inform Enrollees that oral interpretation service is available for any language and that information is available in alternative formats and how to access these formats.

e) The Contractor shall post on a public section of its website the following information:

i) the Member Handbook described in Appendix E of this Agreement, which is hereby made a part of this Agreement as if set forth fully herein;

ii) the provider directory, as described in Section 13.2 of this Agreement;

iii) the Contractor's formulary drug list; and

iv) in accordance with 42 CFR 438.602(g)(3), the name and title of individuals that have ownership and control interest of the Contractor, as described in 42 CFR 455.104.

v) In accordance with 42 CFR 438.10, the information required in paragraph (ii) and (iii) above must be posted in machine readable file and format specified by CMS.

f) The Contractor shall comply with information and formatting requirements described in 42 CFR 438.10(d).

13.2 Provider Directories/Office Hours for Participating Providers

a) The Contractor shall maintain and update, on a monthly basis, a listing by specialty of the names, addresses and telephone numbers of all Participating Providers, including facilities. Such a list/directory shall include names, office addresses, telephone numbers, board certification for physicians, information

on language capabilities and wheelchair accessibility of Participating Providers. The list should also identify providers that are not accepting new patients.

i) The Contractor shall update applicable records contained in the electronic version of such provider listing no later than thirty (30) days after it receives updated provider information.

b) New Enrollees must receive the most current complete listing in hardcopy, along with any updates to such listing. Alternatively, new Enrollees may be provided written notification that a complete listing/directory is available and will be provided upon request either in hardcopy, or electronically if the Contractor has the capability of providing such data in an electronic format and the data is requested in that format by an Enrollee.

c) Enrollees must be notified of updates in writing at least annually in one of the following methods: (1) provide updates in hardcopy; (2) provide a new complete listing/directory in hardcopy; or (3) provide written notification that a new complete listing/directory is available and will be provided upon request either in hardcopy, or electronically if the Contractor has the capability of providing such data in an electronic format and the data is requested in that format by an Enrollee.

d) In addition, the Contractor must make available to the LDSS the office hours for Participating Providers. This requirement may be satisfied by providing a copy of the list or Provider Directory described in this Section with the addition of office hours or by providing a separate listing of office hours for Participating Providers.

13.3 Member ID Cards

a) The Contractor must issue an identification card to the Enrollee containing the following information:

i) the name of the Enrollee's clinic (if applicable);

ii) the name of the Enrollee's PCP and the PCP's telephone number (if an Enrollee is being served by a PCP team, the name of the individual shown on the card should be the lead provider);

iii) the member services toll free telephone number;

iv) the twenty-four (24) hour toll free telephone number that Enrollees may use to access information on obtaining services when his/her PCP is not available; and

21. Provider Network

21.1 Network Requirements

a) The Contractor will establish and maintain a network of Participating Providers.

i) In establishing the network, the 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 in the Benefit Package, the number of providers who are not accepting new patients, and the geographic location of the providers and Enrollees.

ii) The Contractor's network must contain all of the provider types necessary to furnish the prepaid Benefit Package, including but not limited to: hospitals, physicians (primary care and specialists), mental health and substance abuse providers, allied health professionals, ancillary providers, DME providers, home health providers, and pharmacies, if applicable.

A) The Contractor must demonstrate that its network contains sufficient Indian Health Care Providers to ensure access, within time/distance standards as set forth in Section 15.5 of this Agreement, to Native American Enrollees.

iii) To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population. This includes being geographically accessible (meeting time/distance standards) and being accessible for the disabled. For the HIV SNP Program, this includes the following requirements [Applicable to the HIV SNP Program only]:

A) Designated AIDS Centers: At least one Designated AIDS Center per borough/county or access availability for at least seventy-five percent (75%) of the enrollee population by borough/county, whichever is greater.

B) HIV Primary Care Medicaid Programs: Access availability for at least twenty-five percent (25%) of the enrollee population.

C) Maternal/Pediatric HIV Specialized Care Centers: Access availability for one hundred percent (100%) of HIV infected women enrollees with HIV infected and/or HIV-exposed children up to the age of 18 months.

D) HIV Co-located Substance Abuse & Primary Care Programs: Access availability for at least fifty percent of the enrollee population with diagnosed substance abuse problems.

b) The Contractor shall not include in its network any provider

i) who has been sanctioned or prohibited from participation in Federal health care programs under either Section 1128 or Section 1128A of the SSA; or

ii) who has had his/her licensed suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

iii) who has not enrolled with the State as a Medicaid provider, unless such provider is not required to be enrolled as a Medicaid provider. The Contractor may provisionally credential a non-enrolled provider for 120 days pending enrollment with SDOH.
A) An enrolled Medicaid provider is not required to provide services to a Medicaid beneficiary who is not enrolled in MMC.

c) The Contractor must require that Participating Providers offer hours of operation that are no less than the hours of operation offered to commercial members or, if the provider serves only MMC Enrollees and/or FHPlus Enrollees, comparable to hours offered for Medicaid fee-for-service patients.

d) The Contractor shall submit its network for SDOH to assess for adequacy through the HCS prior to execution of this Agreement, quarterly thereafter throughout the term of this Agreement, and upon request by SDOH when SDOH determines there has been a significant change that could affect adequate capacity and quarterly thereafter.

e) Contractor must limit participation to providers who agree that payment received from the Contractor for services included in the Benefit Package is payment in full for services provided to Enrollees, except for the collection of applicable co-payments from Enrollees as provided by law.

21.2 Absence of Appropriate or Available Network Provider

a) In the event that the Contractor determines that it does not have a Participating Provider with appropriate training and experience to meet the particular health or behavioral health care needs of an Enrollee, or who does not have an available appointment, the Contractor shall make a referral to an appropriate Non-Participating Provider, pursuant to a treatment plan approved by the Contractor in consultation with the Primary Care Provider, the Non-Participating Provider and the Enrollee or the Enrollee's designee. The Contractor shall pay for the cost of the services in the treatment plan provided

expertise in serving special needs populations (e.g., HIV+ and developmentally disabled patients).

21.18 Presumptive Eligibility Providers

The Contractor must offer Presumptive Eligibility Providers the opportunity to be Participating Providers in its MMC product. The terms of the contract must be at least as favorable as the terms offered to other Participating Providers performing equivalent services (prenatal care). Contractors need not contract with every Presumptive Eligibility Provider in their counties, but must contract with a sufficient number to meet the distance/travel time standards defined for primary care.

21.19 Behavioral Health Service Providers

a) The Contractor will include a full array of mental health and Substance Use Disorder Service providers in its networks, in sufficient numbers to assure accessibility to Benefit Package services for both children and adults, using either individual, appropriately licensed practitioners or New York State Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS) licensed programs and clinics, or both.

   i) The Contractor shall monitor Participating Providers and ensure that such providers maintain quality of care pursuant to 42 CFR 438.230 and OASAS or OMH regulations codified in Title 14 of the New York Code of Rules and Regulations as applicable.

   ii) In addition to the requirements set forth in 21.19(b), upon the date of the Behavioral Health Benefit Inclusion in a geographic service area, the Contractor must establish contracts with any providers operated, licensed or certified by OMH or OASAS with five or more active Plan members in treatment, as determined by OMH and OASAS. The Contractor is not required to contract with such providers if they are unwilling to accept the Medicaid fee-for-service rate. Nothing in this subsection is intended to limit the Contractor's obligation to maintain an adequate network of Participating Providers.

b) Except as provided in Subsection (e) of this section, an adequate network shall contain, at a minimum, the following number of providers or, where unavailable, all of the providers in a county:

   i) Mental Health Service Provider Network

      A) Outpatient clinics operated under 14 NYCRR Part 599, other than State-operated clinics, or clinics authorized to deliver integrated outpatient services under 14 NYCRR Part 598:

I) The network must include 50% of all such clinics, or a minimum of two clinics per county, whichever is greater. To ensure Enrollee choice, such clinics must be operated by no fewer than two distinct provider agencies, if available in the Contractor's service area.

II) The network must include clinic providers that offer urgent and non-urgent same day, evening and weekend services; an

III) Where an authorized integrated outpatient service provider is in the Contractor's network, the Contractor shall contract for the full range of integrated outpatient services provided by such provider

B) PROS programs operated under 14 NYCRR Part 512, Continuing Day Treatment (CDT) programs operated under 14 NYCRR Part 587, and Intensive Psychiatric Rehabilitation Treatment (IPRT) programs operated under 14 NYCRR Part 587:

I) For urban counties, the network must include 50% of all such providers or two providers per county, whichever is greater; and

II) For rural counties, the network must include 50% of all such providers or two providers per region, whichever is greater.

C) ACT programs operated under 14 NYCRR Part 508

I) For urban counties, the network must include two providers per county; and,

II) For rural counties, the network must include two providers per region.

D) Partial Hospitalization (PH) programs operated under 14 NYCRR Part 587:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

E) Inpatient Psychiatric Hospitalization Services operated under 14 NYCRR Parts 580 or 582:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region

F) Comprehensive Psychiatric Emergency Programs operated under 14 NYCRR Part 590:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

ii) Substance Use Disorder Services

A) Chemical Dependence Outpatient clinics operated under 14 NYCRR Part 822 or clinics authorized to deliver integrated outpatient services under 14 NYCRR Part 825:

I) The network must include 50% of all such clinics, or a minimum of two clinics per county, whichever is greater. To ensure Enrollee choice, such clinics must be operated by no fewer than two distinct provider agencies, if available in the Contractor's service area.

II) The network must include clinic providers that offer urgent and non-urgent same day, evening and weekend services; and

III) Where an authorized integrated outpatient service provider is in the Contractor's network, the Contractor shall contract for the full range of integrated outpatient services provided by such provider.

B) Chemical Dependence Outpatient Rehabilitation Clinics operated under 14 NYCRR Part 822:

I) The network must include 50% of all such clinics or two clinics per county, whichever is greater.

C) Opioid Treatment Programs operated under 14 NYCRR Part 822 or Opioid Treatment Programs authorized to deliver integrated outpatient services under 14 NYCRR Part 825:

I) For urban counties: the network must include all programs in the county. In addition, for New York City, the network must include all programs in New York City;

II) For rural counties: the network must include all programs in the region; and

III) Where an authorized integrated outpatient service provider is in the Contractor's network, the Contractor shall contract for the full range of integrated outpatient services provided by such provider.

D) Buprenorphine Prescribers:

I) The network must include all authorized prescribers in the Contractor's service area; and

II) The Contractor is not required to contract with providers unwilling to accept the Medicaid fee-for-service rate.

E) Detoxification Services provided in inpatient facilities, including medically-managed and medically-supervised detoxification services, certified pursuant to 14 NYCRR Part 816:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

F) Detoxification Services provided in an outpatient setting certified pursuant to 14 NYCRR Part 816:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

G) Chemical Dependence Inpatient Rehabilitation Services operated under 14 NYCRR Part 818:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

H) Residential Substance Use Disorder Treatment Services Operated Under 14 NYCRR Part 820:

I) For urban counties: The network must include two providers per county;

II) For rural counties: The network must include two providers per region; and

III) If an enrollee is mandated to an out of network residential program, the Contractor must enter into either a subcontract or a single case agreement with such program and that program's allied clinical service providers for coverage of medically necessary Benefit Package Services.

c) [Applicable to the HARP and HIV SNP Programs Only]: Behavioral Health Home and Community Based Services Providers

The Contractor must contract with an adequate network of BHHCBS providers. The State will provide the Contractor with updates of designated BHHCBS providers, as appropriate. Except as provided in Subsection (e) of this section, an adequate network is defined as:

A) For urban counties: The network must include a minimum of two providers of each HCB service per county and

B) For rural counties: The network must include a minimum of two providers of each HCB service per region.

d) Crisis Intervention Services Providers

The Contractor shall contract with an adequate number of Crisis Intervention service providers in accordance with the State issued Behavioral Health Guidance.

e) Essential Community Behavioral Health Providers

The Contactor shall contract with Essential Community Behavioral Health Providers as follows:

i) For State-operated ambulatory mental health services and State-operated providers of Behavioral Health Home and Community Based Services, the Contractor shall contract with all providers in each region that contains a county within the Contractor’s Service Area.

ii) For Opioid Treatment Programs, the Contractor shall comply with the requirements in Section 21.19(b)(ii)(C).

f) Pursuant to Chapter 111 of the Laws of 2010, Chapter 57 of the Laws of 2017, 14 NYCRR 841 and 14 NYCRR Part 599, the Contractor must reimburse hospital-based and free-standing clinics dually licensed and/or certified under Article 28 of the Public Health Law, and Article 31 or Article 32 of the Mental Hygiene Law, or mental health clinics and chemical dependence clinics (including outpatient and opioid treatment clinics) licensed or certified pursuant to either Article 31 or Article 32 of the Mental Hygiene Law for outpatient mental health services or outpatient Substance Use Disorder or opioid treatment services at an amount equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by SDOH, the Office of Alcoholism and Substance Abuse Services or by the Office of Mental Health for rate-setting purposes, including any such modifier codes as may affect the calculated reimbursement.

i) Outpatient mental health services are defined as:

A) For Article 28 facilities, medically necessary mental health assessments and psychotherapy;

B) For Article 31 facilities, ambulatory behavioral health services, medically necessary mental health assessments, psychotherapy, psychotropic medication treatment, complex care management, psychological and developmental testing, health monitoring, smoking cessation counseling (as an additional service when mental health services are already being provided to an Enrollee), comprehensive medication services and crisis intervention, provided on-site or off-site, when such services are rendered by a practitioner affiliated with the clinic and authorized to provide services under Office of Mental Health regulations or guidelines.

ii) Outpatient Substance Use Disorder services are defined as:

A) For facilities licensed or certified under Article 28 and 32 or Article 32, these include substance use disorder and treatment, treatment for addictions, ambulatory behavioral health services, medically necessary chemical dependence screening, assessments, complex care management, collateral visits, individual, group and family counseling, medication administration and management, medication assisted treatment, outreach, peer support services, intensive outpatient and outpatient rehabilitation, problem gambling counseling and smoking cessation counseling (as an additional service when mental health services are already being provided to an Enrollee). Ambulatory behavioral health services may be provided on-site or off-site, when such services are rendered by a practitioner affiliated with the clinic

and authorized to provide services under Office of Alcoholism and Substance Abuse Services regulations or guidelines.

g) For the purposes of this section, urban counties refer to counties with populations of at least 200,000 inhabitants, including the five boroughs of New York City and Albany, Dutchess, Erie, Monroe, Nassau, Niagara, Oneida, Onondaga, Orange, Rockland, Saratoga, Suffolk, and Westchester Counties. For the purpose of determining the adequacy of the Contractor's network in rural counties and for Essential Community Behavioral Health Providers, a region is defined as the catchment area beyond the border of a county as determined by the State and set forth in the State-issued Behavioral Health Guidance.

h) The Contractor, in consultation with RPCs, shall analyze its behavioral health network and shall submit to the State an annual Behavioral Health Network Plan to address unmet Enrollee behavioral health service needs in accordance with the State-issued Behavioral Health Guidance. For HARPs and HIV SNPs only, such annual plan shall include an analysis of unmet Enrollee Behavioral Health Home and Community Based Service needs.

i) The Contractor shall consult with RPCs and the State to develop and implement a comprehensive provider training and support program for behavioral health network providers to gain appropriate knowledge, skills, and expertise and receive technical assistance to operate and provide quality behavioral health care within a managed care payer system, in accordance with State-issued Behavioral Health Guidance.

21.20 Laboratory Procedures

The Contractor agrees to restrict its laboratory provider network to entities having either a CLIA certificate of registration or a CLIA certificate of waiver.

21.21 Federally Qualified Health Centers (FQHCs)

a) In a county where Enrollment in the Contractor's MMC product is voluntary, the Contractor is not required to contract with FQHCs. However, when an FQHC is a Participating Provider of the Contractor network, the Provider Agreement must include a provision whereby the Contractor agrees to compensate the FQHC for services provided to Enrollees at a payment rate that is not less than the level and amount that the Contractor would pay another Participating Provider that is not an FQHC for a similar set of services.

b) In a county where Enrollment in the Contractor's MMC product is mandatory and/or the Contractor offers an FHPlus product, the Contractor shall contract with FQHCs operating in that county. The contract with the FQHC must be

30. INDEPENDENT CAPACITY OF CONTRACTOR

The parties agree that the Contractor is an independent Contractor and that the Contractor, its agents, officers, and employees act in an independent capacity and not as officers or employees of LDSS, SDOH or the DHHS.

31. NO THIRD PARTY BENEFICIARIES

Only the parties to this Agreement and their successors in interest and assigns have any rights or remedies under or by reason of this Agreement.

32. INDEMNIFICATION

32.1 Indemnification by Contractor

a) The Contractor shall indemnify, defend, and hold harmless the SDOH and the LDSS, and their officers, agents, and employees, and the Enrollees and their eligible dependents from:

i) any and all claims and losses accruing or resulting to any and all Contractors, subcontractors, 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;

ii) 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, including Participating Providers, in connection with the performance of this Agreement;

iii) 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.

b) The SDOH will provide the Contractor with prompt written notice of any claim made against the SDOH, and the Contractor, at its sole option, shall defend or settle said claim. The SDOH shall cooperate with the Contractor to the extent necessary for the Contractor to discharge its obligation under Section 32.1 (a). Notwithstanding the foregoing, the SDOH reserves the right to join such action, at its sole expense, when it determines there is an issue involving a significant public interest.

33.3 Requirements of Subcontractors

The Contractor shall include the provisions of this Section in its subcontracts, including its Provider Agreements. For all subcontracts, including Provider Agreements, that exceed $100,000, the Contractor shall require the subcontractor, including any Participating Provider to certify and disclose accordingly to the Contractor.

34. NON-DISCRIMINATION

34.1 Equal Access to Benefit Package

Except as otherwise provided in applicable sections of this Agreement the Contractor shall provide the Medicaid Managed Care and/or Family Health Plus Benefit Package(s) to MMC and/or FHPlus Enrollees, respectively, in the same manner, in accordance with the same standards, and with the same priority as members of the Contractor enrolled under any other contracts.

34.2 Non-Discrimination

The Contractor shall not discriminate against Eligible Persons or Enrollees for Medicaid Managed Care and/or Family Health Plus on the basis of age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, need for health services, or Capitation Rate that the Contractor will receive for such Eligible Persons or Enrollees.

34.3 Equal Employment Opportunity

Contractor must comply with Executive Order 11246, entitled "Equal Employment Opportunity", as amended by Executive Order 11375, and as supplemented in Department of Labor regulations.

34.4 Native Americans Access to Services From Tribal or Urban Indian Health Facility

The Contractor shall not prohibit, restrict or discourage enrolled Native Americans from receiving care from or accessing: a) Medicaid reimbursed health services from or through a tribal health or urban Indian health facility or center and/or b) Family Health Plus covered benefits from or through a tribal health or urban Indian health facility or center which is included in the Contractor's network.

35. COMPLIANCE WITH APPLICABLE LAWS

35.1 Contractor and SDOH Compliance With Applicable Laws

Notwithstanding any inconsistent provisions in this Agreement, the Contractor and SDOH shall comply with all applicable requirements of the State Public Health Law; the State Social Services Law; the State Finance Law; the State Mental Hygiene Law; the State Insurance Law; Title XIX of the Social Security Act; Title VI of the Civil Rights Act of 1964 and 45 CFR Part 80, as amended; Title IX of the Education Amendments of 1972; Section 504 of the Rehabilitation Act of 1973 and 45 CFR Part 84, as amended; the Age Discrimination Act of 1975 and 45 CFR Part 91, as amended; the ADA; Title XIII of the Federal Public Health Services Act, 42 U.S.C § 300e et seq., regulations promulgated thereunder; the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and related regulations; the Federal False Claims Act, 31 U.S.C. § 3729 et seq.; Mental Health Parity and Addiction Equity Act of 2008, (P.L. 110-345);for Contractors operating in New York City, the New York City Health Code; and all other applicable legal and regulatory requirements in effect at the time that this Agreement is signed and as adopted or amended during the term of this Agreement. The parties agree that this Agreement shall be interpreted according to the laws of the State of New York.

35.2 Nullification of Illegal, Unenforceable, Ineffective or Void Contract Provisions

Should any provision of this Agreement be declared or found to be illegal or unenforceable, ineffective or void, then each party shall be relieved of any obligation arising from such provision; the balance of this Agreement, if capable of performance, shall remain in full force and effect.

35.3 Certificate of Authority Requirements

The Contractor must satisfy conditions for issuance of a certificate of authority, including proof of financial solvency, as specified in 10 NYCRR Part 98.

35.4 Notification of Changes in Certificate of Incorporation

The Contractor shall notify SDOH of any amendment to its Certificate of Incorporation or Articles of Organization pursuant to 10 NYCRR Part 98.

35.5 Contractor's Financial Solvency Requirements

The Contractor, for the duration of this Agreement, shall remain in compliance with all applicable state requirements for financial solvency for MCOs offering Medicaid Managed Care and/or Family Health Plus products, as applicable. The Contractor shall continue to be financially responsible as defined in PHL § 4403(1)(c) and shall comply with the contingent reserve fund and escrow deposit requirements of 10 NYCRR Part 98 and must meet minimum net worth requirements established by SDOH and the State Insurance Department. The Contractor shall make provision, satisfactory to SDOH, for protections for SDOH, LDSSs and the Enrollees in the event of Contractor or subcontractor insolvency,

including but not limited to, hold harmless and continuation of treatment provisions in all provider agreements which protect SDOH, LDSSs and Enrollees from costs of treatment and assures continued access to care for Enrollees.

35.6 Compliance With Care for Maternity Patients

Contractor must comply with § 2803-n of the PHL and § 3216 (i) (10) (a) of the State Insurance Law related to hospital care for maternity patients.

35.7 Informed Consent Procedures for Hysterectomy and Sterilization

The Contractor is required and shall require Participating Providers to comply with the informed consent procedures for Hysterectomy and Sterilization specified in 42 CFR Part 441, sub-part F, and 18 NYCRR § 505.13.

35.8 Non-Liability of Enrollees for Contractor's Debts

Contractor agrees that in no event shall the Enrollee become liable for the Contractor's debts as set forth in SSA § 1932(b)(6).

35.9 SDOH Compliance With Conflict of Interest Laws

SDOH and its employees shall comply with Article 18 of the General Municipal Law and all other appropriate provisions of New York State law, local laws and ordinances and all resultant codes, rules and regulations pertaining to conflicts of interest.

35.10 Compliance With PHL Regarding External Appeals

Contractor must comply with Article 49 Title II of the PHL regarding external appeal of adverse determinations.

35.11 Fair Labor Standards Act

The Contractor is required to comply with all applicable provisions of the Fair Labor Standards Act (FLSA). The Contractor shall develop protocols to demonstrate compliance with requirements of the FLSA. Such protocols shall include appropriate record keeping methodologies, tracking of aide travel time, hours worked on live-in cases, and appropriate rate of reimbursement. Such verification system and protocols are subject to audit by DOH, OMIG, and the Department of Labor.

35.12 MMC Program Features Invalidated by Courts of Law, or by Changes to Federal Statutes, Regulations, or Approvals

a) Should any part of the scope of work under this Agreement relate to a program or activity of the State Medicaid Program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor shall do no work on that part after the effective date of the loss of authority. The SDOH shall adjust Capitation Rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor shall not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Agreement the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state in accordance with direction from SDOH. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

b) The SDOH shall provide notice to the Contractor that shall include the effective date of the loss of authority for a program or activity of the State Medicaid Program and identify the affected parts of this Agreement pursuant to the requirements of Section 35.12(a) of this Agreement.

c) Notwithstanding the requirements of paragraphs (a) and (b) above, as directed by SDOH, the Contractor shall continue work under this Agreement related to a program or activity of the State Medicaid Program that is solely authorized under New York State law. Such work may not be subject to federal financial participation.

36. STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

Appendix A (Standard Clauses as required by the Attorney General for all State contracts) is attached and incorporated by reference as if set forth fully herein and any amendment thereto, and takes precedence over all other parts of this Agreement.

37. Medicaid Update

The Contractor shall comply with all applicable guidance contained within the Medicaid Update publication issued by SDOH.

38. Special Contract Provisions in Response to the novel coronavirus (COVID-19) Pandemic

IN WITNESS WHEREOF, the parties hereto have executed or approved this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE

By: Kathryn Howell

Kathryn Howell
Printed Name

Title: Chief Legal Officer

Date: 02/28/24 KH

STATE AGENCY SIGNATURE

By: _____

_____
Printed Name

Title: Director, DHPCO

Date: _____

State Agency Certification:
In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract.

STATE OF NEW YORK)
) SS.:
County of New York)

On the 28th day of February in the year 2024, before me, the undersigned, personally appeared Kathryn Howell, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose names(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Robert E. Schiller

(Notary)

ROBERT E. SCHILLER
Notary Public, State of New York
No. 02SC6379664
Qualified in New York County
Commission Expires August 20, 2026

ATTORNEY GENERAL

_____

Title: _____

Date: _____

Thomas P. DiNapoli
STATE COMPTROLLER

_____

Title: _____

Date: _____

EXHIBIT 2

Excerpts, 2019 Medicaid Managed Care

Model Contract between Healthfirst and New York State

MEDICAID MANAGED CARE/

FAMILY HEALTH PLUS/

HIV SPECIAL NEEDS PLAN/

HEALTH AND RECOVERY PLAN

MODEL CONTRACT

March 1, 2019

MISCELLANEOUS/CONSULTANT SERVICES
(Award Without Formal Request For Proposal)

STATE AGENCY (Name and Address):

New York State Department of Health
Office of Health Insurance Programs
Division of Health Plan Contracting and Oversight
One Commerce Plaza
Room 1609
Albany, NY 12260

NYS Comptroller's Number: C034544

Originating Agency GLBU: DOH01
Department ID: 3450000 (Use Unit ID)

CONTRACTOR (Name and Address):

HealthFirst PHSP, Inc.
100 Church Street, 18th Floor
New York NY 10007

TYPE OF PROGRAM(S):

Medicaid Managed Care and/or
Family Health Plus and/or HIV Special Needs Plan

CHARITIES REGISTRATION NUMBER:
05-41-57

Contractor has (x) has not ( ) timely filed with the Attorney General's Charities Bureau all required period or annual written reports.

CONTRACT TERM:

FROM: March 1, 2019
TO: February 29, 2024

FEDERAL TAX IDENTIFICATION NUMBER:
133783732

NYS VENDOR IDENTIFICATION NUMBER:
1000026827

FUNDING AMOUNT FOR CONTRACT TERM:
$37,654,968,146

MUNICIPALITY NUMBER (if applicable):

STATUS:

CONTRACTOR IS [ ] IS NOT [X]
A SECTARIAN ENTITY

CONTRACTOR IS [X] IS NOT [ ]
A NOT-FOR-PROFIT ORGANIZATION

CONTRACTOR IS [x] IS NOT [ ]
A NY STATE BUSINESS ENTERPRISE

( ) IF MARKED HERE, THIS CONTRACT IS RENEWABLE FOR ____ ADDITIONAL ONE-YEAR PERIOD(S) AT THE SOLE OPTION OF THE STATE AND SUBJECT TO THE APPROVAL OF THE NEW YORK STATE DEPARTMENT OF HEALTH, THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE OFFICE OF THE STATE COMPTROLLER.

IN WITNESS WHEREOF, the parties hereto have executed or approved this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE

By: Pat Wang

Pat Wang
Printed Name

Title: Chief Executive Officer

Date: June 30, 2020

STATE AGENCY SIGNATURE

By:

Jonathan Bick
Printed Name

Title: Director, DHPCO

Date: 7/10/2020

State Agency Certification:
In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract.

STATE OF NEW YORK)
) SS.:
County of New York)

On the 30th day of June in the year 2020, before me, the undersigned, personally appeared Pat Wang, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose names(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Pearl Smith
(Notary)

PEARL SMITH
Notary Public - State of New York
NO. 01SM6175960
Qualified in New York County
My Commission Expires Nov 28, 2023

ATTORNEY GENERAL

Title:

Date:

Thomas P. DiNapoli
STATE COMPTROLLER

Title:

Date:

APPROVED
DEPT. OF AUDIT & CONTROL
Aug 04 2020
James M. Iwaneczko
FOR THE STATE COMPTROLLER

13. ENROLLEE RIGHTS AND NOTIFICATION

13.1 Information Requirements

a) The Contractor shall provide new Enrollees with the information identified in PHL § 4408, SSL § 364-j, SSL § 369-ee and 42 CFR § 438.10 (f) and (g).

b) The Contractor shall provide such information to the Enrollee within fourteen (14) days of the Effective Date of Enrollment. The Contractor may provide such information to the Enrollee through the Member Handbook referenced in Section 13.4 of this Agreement.

c) The Contractor must provide Enrollees with an annual notice that this information is available to them upon request.

d) The Contractor must inform Enrollees that oral interpretation service is available for any language and that information is available in alternative formats and how to access these formats.

e) The Contractor shall post on a public section of its website the following information:

i) the Member Handbook described in Appendix E of this Agreement, which is hereby made a part of this Agreement as if set forth fully herein;

ii) the provider directory, as described in Section 13.2 of this Agreement;

iii) the Contractor's formulary drug list; and

iv) in accordance with 42 CFR 438.602(g)(3), the name and title of individuals that have ownership and control interest of the Contractor, as described in 42 CFR 455.104.

v) In accordance with 42 CFR 438.10, the information required in paragraph (ii) and (iii) above must be posted in machine readable file and format specified by CMS.

f) The Contractor shall comply with information and formatting requirements described in 42 CFR 438.10(d).

13.2 Provider Directories/Office Hours for Participating Providers

a) The Contractor shall maintain and update, on a monthly basis, a listing by specialty of the names, addresses and telephone numbers of all Participating Providers, including facilities. Such a list/directory shall include names, office addresses, telephone numbers, board certification for physicians, information

on language capabilities and wheelchair accessibility of Participating Providers. The list should also identify providers that are not accepting new patients.

i) The Contractor shall update applicable records contained in the electronic version of such provider listing no later than thirty (30) days after it receives updated provider information.

b) New Enrollees must receive the most current complete listing in hardcopy, along with any updates to such listing. Alternatively, new Enrollees may be provided written notification that a complete listing/directory is available and will be provided upon request either in hardcopy, or electronically if the Contractor has the capability of providing such data in an electronic format and the data is requested in that format by an Enrollee.

c) Enrollees must be notified of updates in writing at least annually in one of the following methods: (1) provide updates in hardcopy; (2) provide a new complete listing/directory in hardcopy; or (3) provide written notification that a new complete listing/directory is available and will be provided upon request either in hardcopy, or electronically if the Contractor has the capability of providing such data in an electronic format and the data is requested in that format by an Enrollee.

d) In addition, the Contractor must make available to the LDSS the office hours for Participating Providers. This requirement may be satisfied by providing a copy of the list or Provider Directory described in this Section with the addition of office hours or by providing a separate listing of office hours for Participating Providers.

13.3 Member ID Cards

a) The Contractor must issue an identification card to the Enrollee containing the following information:

i) the name of the Enrollee's clinic (if applicable);

ii) the name of the Enrollee's PCP and the PCP's telephone number (if an Enrollee is being served by a PCP team, the name of the individual shown on the card should be the lead provider);

iii) the member services toll free telephone number;

iv) the twenty-four (24) hour toll free telephone number that Enrollees may use to access information on obtaining services when his/her PCP is not available; and

21. Provider Network

21.1 Network Requirements

a) The Contractor will establish and maintain a network of Participating Providers.

i) In establishing the network, the 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 in the Benefit Package, the number of providers who are not accepting new patients, and the geographic location of the providers and Enrollees.

ii) The Contractor's network must contain all of the provider types necessary to furnish the prepaid Benefit Package, including but not limited to: hospitals, physicians (primary care and specialists), mental health and substance abuse providers, allied health professionals, ancillary providers, DME providers, home health providers, and pharmacies, if applicable.

A) The Contractor must demonstrate that its network contains sufficient Indian Health Care Providers to ensure access, within time/distance standards as set forth in Section 15.5 of this Agreement, to Native American Enrollees.

iii) To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population. This includes being geographically accessible (meeting time/distance standards) and being accessible for the disabled. For the HIV SNP Program, this includes the following requirements [Applicable to the HIV SNP Program only]:

A) Designated AIDS Centers: At least one Designated AIDS Center per borough/county or access availability for at least seventy-five percent (75%) of the enrollee population by borough/county, whichever is greater.

B) HIV Primary Care Medicaid Programs: Access availability for at least twenty-five percent (25%) of the enrollee population.

C) Maternal/Pediatric HIV Specialized Care Centers: Access availability for one hundred percent (100%) of HIV infected women enrollees with HIV infected and/or HIV-exposed children up to the age of 18 months.

D) HIV Co-located Substance Abuse & Primary Care Programs: Access availability for at least fifty percent of the enrollee population with diagnosed substance abuse problems.

b) The Contractor shall not include in its network any provider

i) who has been sanctioned or prohibited from participation in Federal health care programs under either Section 1128 or Section 1128A of the SSA; or

ii) who has had his/her licensed suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

iii) who has not enrolled with the State as a Medicaid provider, unless such provider is not required to be enrolled as a Medicaid provider. The Contractor may provisionally credential a non-enrolled provider for 120 days pending enrollment with SDOH.
A) An enrolled Medicaid provider is not required to provide services to a Medicaid beneficiary who is not enrolled in MMC.

c) The Contractor must require that Participating Providers offer hours of operation that are no less than the hours of operation offered to commercial members or, if the provider serves only MMC Enrollees and/or FHPlus Enrollees, comparable to hours offered for Medicaid fee-for-service patients.

d) The Contractor shall submit its network for SDOH to assess for adequacy through the HCS prior to execution of this Agreement, quarterly thereafter throughout the term of this Agreement, and upon request by SDOH when SDOH determines there has been a significant change that could affect adequate capacity and quarterly thereafter.

e) Contractor must limit participation to providers who agree that payment received from the Contractor for services included in the Benefit Package is payment in full for services provided to Enrollees, except for the collection of applicable co-payments from Enrollees as provided by law.

21.2 Absence of Appropriate or Available Network Provider

a) In the event that the Contractor determines that it does not have a Participating Provider with appropriate training and experience to meet the particular health or behavioral health care needs of an Enrollee, or who does not have an available appointment, the Contractor shall make a referral to an appropriate Non-Participating Provider, pursuant to a treatment plan approved by the Contractor in consultation with the Primary Care Provider, the Non-Participating Provider and the Enrollee or the Enrollee's designee. The Contractor shall pay for the cost of the services in the treatment plan provided

expertise in serving special needs populations (e.g., HIV+ and developmentally disabled patients).

21.18 Presumptive Eligibility Providers

The Contractor must offer Presumptive Eligibility Providers the opportunity to be Participating Providers in its MMC product. The terms of the contract must be at least as favorable as the terms offered to other Participating Providers performing equivalent services (prenatal care). Contractors need not contract with every Presumptive Eligibility Provider in their counties, but must contract with a sufficient number to meet the distance/travel time standards defined for primary care.

21.19 Behavioral Health Service Providers

a) The Contractor will include a full array of mental health and Substance Use Disorder Service providers in its networks, in sufficient numbers to assure accessibility to Benefit Package services for both children and adults, using either individual, appropriately licensed practitioners or New York State Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS) licensed programs and clinics, or both.

   i) The Contractor shall monitor Participating Providers and ensure that such providers maintain quality of care pursuant to 42 CFR 438.230 and OASAS or OMH regulations codified in Title 14 of the New York Code of Rules and Regulations as applicable.

   ii) In addition to the requirements set forth in 21.19(b), upon the date of the Behavioral Health Benefit Inclusion in a geographic service area, the Contractor must establish contracts with any providers operated, licensed or certified by OMH or OASAS with five or more active Plan members in treatment, as determined by OMH and OASAS. The Contractor is not required to contract with such providers if they are unwilling to accept the Medicaid fee-for-service rate. Nothing in this subsection is intended to limit the Contractor's obligation to maintain an adequate network of Participating Providers.

b) Except as provided in Subsection (e) of this section, an adequate network shall contain, at a minimum, the following number of providers or, where unavailable, all of the providers in a county:

   i) Mental Health Service Provider Network

      A) Outpatient clinics operated under 14 NYCRR Part 599, other than State-operated clinics, or clinics authorized to deliver integrated outpatient services under 14 NYCRR Part 598:

I) The network must include 50% of all such clinics, or a minimum of two clinics per county, whichever is greater. To ensure Enrollee choice, such clinics must be operated by no fewer than two distinct provider agencies, if available in the Contractor's service area.

II) The network must include clinic providers that offer urgent and non-urgent same day, evening and weekend services; an

III) Where an authorized integrated outpatient service provider is in the Contractor's network, the Contractor shall contract for the full range of integrated outpatient services provided by such provider

B) PROS programs operated under 14 NYCRR Part 512, Continuing Day Treatment (CDT) programs operated under 14 NYCRR Part 587, and Intensive Psychiatric Rehabilitation Treatment (IPRT) programs operated under 14 NYCRR Part 587:

I) For urban counties, the network must include 50% of all such providers or two providers per county, whichever is greater; and

II) For rural counties, the network must include 50% of all such providers or two providers per region, whichever is greater.

C) ACT programs operated under 14 NYCRR Part 508

I) For urban counties, the network must include two providers per county; and,

II) For rural counties, the network must include two providers per region.

D) Partial Hospitalization (PH) programs operated under 14 NYCRR Part 587:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

E) Inpatient Psychiatric Hospitalization Services operated under 14 NYCRR Parts 580 or 582:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region

F) Comprehensive Psychiatric Emergency Programs operated under 14 NYCRR Part 590:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

ii) Substance Use Disorder Services

A) Chemical Dependence Outpatient clinics operated under 14 NYCRR Part 822 or clinics authorized to deliver integrated outpatient services under 14 NYCRR Part 825:

I) The network must include 50% of all such clinics, or a minimum of two clinics per county, whichever is greater. To ensure Enrollee choice, such clinics must be operated by no fewer than two distinct provider agencies, if available in the Contractor's service area.

II) The network must include clinic providers that offer urgent and non-urgent same day, evening and weekend services; and

III) Where an authorized integrated outpatient service provider is in the Contractor's network, the Contractor shall contract for the full range of integrated outpatient services provided by such provider.

B) Chemical Dependence Outpatient Rehabilitation Clinics operated under 14 NYCRR Part 822:

I) The network must include 50% of all such clinics or two clinics per county, whichever is greater.

C) Opioid Treatment Programs operated under 14 NYCRR Part 822 or Opioid Treatment Programs authorized to deliver integrated outpatient services under 14 NYCRR Part 825:

I) For urban counties: the network must include all programs in the county. In addition, for New York City, the network must include all programs in New York City;

II) For rural counties: the network must include all programs in the region; and

III) Where an authorized integrated outpatient service provider is in the Contractor's network, the Contractor shall contract for the full range of integrated outpatient services provided by such provider.

D) Buprenorphine Prescribers:

I) The network must include all authorized prescribers in the Contractor's service area; and

II) The Contractor is not required to contract with providers unwilling to accept the Medicaid fee-for-service rate.

E) Detoxification Services provided in inpatient facilities, including medically-managed and medically-supervised detoxification services, certified pursuant to 14 NYCRR Part 816:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

F) Detoxification Services provided in an outpatient setting certified pursuant to 14 NYCRR Part 816:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

G) Chemical Dependence Inpatient Rehabilitation Services operated under 14 NYCRR Part 818:

I) For urban counties, the network must include two providers per county; and

II) For rural counties, the network must include two providers per region.

H) Residential Substance Use Disorder Treatment Services Operated Under 14 NYCRR Part 820:

I) For urban counties: The network must include two providers per county;

II) For rural counties: The network must include two providers per region; and

III) If an enrollee is mandated to an out of network residential program, the Contractor must enter into either a subcontract or a single case agreement with such program and that program's allied clinical service providers for coverage of medically necessary Benefit Package Services.

c) [Applicable to the HARP and HIV SNP Programs Only]: Behavioral Health Home and Community Based Services Providers

The Contractor must contract with an adequate network of BHHCBS providers. The State will provide the Contractor with updates of designated BHHCBS providers, as appropriate. Except as provided in Subsection (e) of this section, an adequate network is defined as:

A) For urban counties: The network must include a minimum of two providers of each HCB service per county and

B) For rural counties: The network must include a minimum of two providers of each HCB service per region.

d) Crisis Intervention Services Providers

The Contractor shall contract with an adequate number of Crisis Intervention service providers in accordance with the State issued Behavioral Health Guidance.

e) Essential Community Behavioral Health Providers

The Contactor shall contract with Essential Community Behavioral Health Providers as follows:

i) For State-operated ambulatory mental health services and State-operated providers of Behavioral Health Home and Community Based Services, the Contractor shall contract with all providers in each region that contains a county within the Contractor's Service Area.

ii) For Opioid Treatment Programs, the Contractor shall comply with the requirements in Section 21.19(b)(ii)(C).

f) Pursuant to Chapter 111 of the Laws of 2010, Chapter 57 of the Laws of 2017, 14 NYCRR 841 and 14 NYCRR Part 599, the Contractor must reimburse hospital-based and free-standing clinics dually licensed and/or certified under Article 28 of the Public Health Law, and Article 31 or Article 32 of the Mental Hygiene Law, or mental health clinics and chemical dependence clinics (including outpatient and opioid treatment clinics) licensed or certified pursuant to either Article 31 or Article 32 of the Mental Hygiene Law for outpatient mental health services or outpatient Substance Use Disorder or opioid treatment services at an amount equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by SDOH, the Office of Alcoholism and Substance Abuse Services or by the Office of Mental Health for rate-setting purposes, including any such modifier codes as may affect the calculated reimbursement.

i) Outpatient mental health services are defined as:

A) For Article 28 facilities, medically necessary mental health assessments and psychotherapy;

B) For Article 31 facilities, ambulatory behavioral health services, medically necessary mental health assessments, psychotherapy, psychotropic medication treatment, complex care management, psychological and developmental testing, health monitoring, smoking cessation counseling (as an additional service when mental health services are already being provided to an Enrollee), comprehensive medication services and crisis intervention, provided on-site or off-site, when such services are rendered by a practitioner affiliated with the clinic and authorized to provide services under Office of Mental Health regulations or guidelines.

ii) Outpatient Substance Use Disorder services are defined as:

A) For facilities licensed or certified under Article 28 and 32 or Article 32, these include substance use disorder and treatment, treatment for addictions, ambulatory behavioral health services, medically necessary chemical dependence screening, assessments, complex care management, collateral visits, individual, group and family counseling, medication administration and management, medication assisted treatment, outreach, peer support services, intensive outpatient and outpatient rehabilitation, problem gambling counseling and smoking cessation counseling (as an additional service when mental health services are already being provided to an Enrollee). Ambulatory behavioral health services may be provided on-site or off-site, when such services are rendered by a practitioner affiliated with the clinic

and authorized to provide services under Office of Alcoholism and Substance Abuse Services regulations or guidelines.

g) For the purposes of this section, urban counties refer to counties with populations of at least 200,000 inhabitants, including the five boroughs of New York City and Albany, Dutchess, Erie, Monroe, Nassau, Niagara, Oneida, Onondaga, Orange, Rockland, Saratoga, Suffolk, and Westchester Counties. For the purpose of determining the adequacy of the Contractor's network in rural counties and for Essential Community Behavioral Health Providers, a region is defined as the catchment area beyond the border of a county as determined by the State and set forth in the State-issued Behavioral Health Guidance.

h) The Contractor, in consultation with RPCs, shall analyze its behavioral health network and shall submit to the State an annual Behavioral Health Network Plan to address unmet Enrollee behavioral health service needs in accordance with the State-issued Behavioral Health Guidance. For HARPs and HIV SNPs only, such annual plan shall include an analysis of unmet Enrollee Behavioral Health Home and Community Based Service needs.

i) The Contractor shall consult with RPCs and the State to develop and implement a comprehensive provider training and support program for behavioral health network providers to gain appropriate knowledge, skills, and expertise and receive technical assistance to operate and provide quality behavioral health care within a managed care payer system, in accordance with State-issued Behavioral Health Guidance.

21.20 Laboratory Procedures

The Contractor agrees to restrict its laboratory provider network to entities having either a CLIA certificate of registration or a CLIA certificate of waiver.

21.21 Federally Qualified Health Centers (FQHCs)

a) In a county where Enrollment in the Contractor's MMC product is voluntary, the Contractor is not required to contract with FQHCs. However, when an FQHC is a Participating Provider of the Contractor network, the Provider Agreement must include a provision whereby the Contractor agrees to compensate the FQHC for services provided to Enrollees at a payment rate that is not less than the level and amount that the Contractor would pay another Participating Provider that is not an FQHC for a similar set of services.

b) In a county where Enrollment in the Contractor's MMC product is mandatory and/or the Contractor offers an FHPlus product, the Contractor shall contract with FQHCs operating in that county. The contract with the FQHC must be

30. INDEPENDENT CAPACITY OF CONTRACTOR

The parties agree that the Contractor is an independent Contractor and that the Contractor, its agents, officers, and employees act in an independent capacity and not as officers or employees of LDSS, SDOH or the DHHS.

31. NO THIRD PARTY BENEFICIARIES

Only the parties to this Agreement and their successors in interest and assigns have any rights or remedies under or by reason of this Agreement.

32. INDEMNIFICATION

32.1 Indemnification by Contractor

a) The Contractor shall indemnify, defend, and hold harmless the SDOH and the LDSS, and their officers, agents, and employees, and the Enrollees and their eligible dependents from:

i) any and all claims and losses accruing or resulting to any and all Contractors, subcontractors, 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;

ii) 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, including Participating Providers, in connection with the performance of this Agreement;

iii) 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.

b) The SDOH will provide the Contractor with prompt written notice of any claim made against the SDOH, and the Contractor, at its sole option, shall defend or settle said claim. The SDOH shall cooperate with the Contractor to the extent necessary for the Contractor to discharge its obligation under Section 32.1 (a). Notwithstanding the foregoing, the SDOH reserves the right to join such action, at its sole expense, when it determines there is an issue involving a significant public interest.

33.3 Requirements of Subcontractors

The Contractor shall include the provisions of this Section in its subcontracts, including its Provider Agreements. For all subcontracts, including Provider Agreements, that exceed $100,000, the Contractor shall require the subcontractor, including any Participating Provider to certify and disclose accordingly to the Contractor.

34. NON-DISCRIMINATION

34.1 Equal Access to Benefit Package

Except as otherwise provided in applicable sections of this Agreement the Contractor shall provide the Medicaid Managed Care and/or Family Health Plus Benefit Package(s) to MMC and/or FHPlus Enrollees, respectively, in the same manner, in accordance with the same standards, and with the same priority as members of the Contractor enrolled under any other contracts.

34.2 Non-Discrimination

The Contractor shall not discriminate against Eligible Persons or Enrollees for Medicaid Managed Care and/or Family Health Plus on the basis of age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, need for health services, or Capitation Rate that the Contractor will receive for such Eligible Persons or Enrollees.

34.3 Equal Employment Opportunity

Contractor must comply with Executive Order 11246, entitled "Equal Employment Opportunity", as amended by Executive Order 11375, and as supplemented in Department of Labor regulations.

34.4 Native Americans Access to Services From Tribal or Urban Indian Health Facility

The Contractor shall not prohibit, restrict or discourage enrolled Native Americans from receiving care from or accessing: a) Medicaid reimbursed health services from or through a tribal health or urban Indian health facility or center and/or b) Family Health Plus covered benefits from or through a tribal health or urban Indian health facility or center which is included in the Contractor's network.

35. COMPLIANCE WITH APPLICABLE LAWS

35.1 Contractor and SDOH Compliance With Applicable Laws

Notwithstanding any inconsistent provisions in this Agreement, the Contractor and SDOH shall comply with all applicable requirements of the State Public Health Law; the State Social Services Law; the State Finance Law; the State Mental Hygiene Law; the State Insurance Law; Title XIX of the Social Security Act; Title VI of the Civil Rights Act of 1964 and 45 CFR Part 80, as amended; Title IX of the Education Amendments of 1972; Section 504 of the Rehabilitation Act of 1973 and 45 CFR Part 84, as amended; the Age Discrimination Act of 1975 and 45 CFR Part 91, as amended; the ADA; Title XIII of the Federal Public Health Services Act, 42 U.S.C § 300e et seq., regulations promulgated thereunder; the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and related regulations; the Federal False Claims Act, 31 U.S.C. § 3729 et seq.; Mental Health Parity and Addiction Equity Act of 2008, (P.L. 110-345);for Contractors operating in New York City, the New York City Health Code; and all other applicable legal and regulatory requirements in effect at the time that this Agreement is signed and as adopted or amended during the term of this Agreement. The parties agree that this Agreement shall be interpreted according to the laws of the State of New York.

35.2 Nullification of Illegal, Unenforceable, Ineffective or Void Contract Provisions

Should any provision of this Agreement be declared or found to be illegal or unenforceable, ineffective or void, then each party shall be relieved of any obligation arising from such provision; the balance of this Agreement, if capable of performance, shall remain in full force and effect.

35.3 Certificate of Authority Requirements

The Contractor must satisfy conditions for issuance of a certificate of authority, including proof of financial solvency, as specified in 10 NYCRR Part 98.

35.4 Notification of Changes in Certificate of Incorporation

The Contractor shall notify SDOH of any amendment to its Certificate of Incorporation or Articles of Organization pursuant to 10 NYCRR Part 98.

35.5 Contractor's Financial Solvency Requirements

The Contractor, for the duration of this Agreement, shall remain in compliance with all applicable state requirements for financial solvency for MCOs offering Medicaid Managed Care and/or Family Health Plus products, as applicable. The Contractor shall continue to be financially responsible as defined in PHL § 4403(1)(c) and shall comply with the contingent reserve fund and escrow deposit requirements of 10 NYCRR Part 98 and must meet minimum net worth requirements established by SDOH and the State Insurance Department. The Contractor shall make provision, satisfactory to SDOH, for protections for SDOH, LDSSs and the Enrollees in the event of Contractor or subcontractor insolvency,

including but not limited to, hold harmless and continuation of treatment provisions in all provider agreements which protect SDOH, LDSSs and Enrollees from costs of treatment and assures continued access to care for Enrollees.

35.6 Compliance With Care for Maternity Patients

Contractor must comply with § 2803-n of the PHL and § 3216 (i) (10) (a) of the State Insurance Law related to hospital care for maternity patients.

35.7 Informed Consent Procedures for Hysterectomy and Sterilization

The Contractor is required and shall require Participating Providers to comply with the informed consent procedures for Hysterectomy and Sterilization specified in 42 CFR Part 441, sub-part F, and 18 NYCRR § 505.13.

35.8 Non-Liability of Enrollees for Contractor's Debts

Contractor agrees that in no event shall the Enrollee become liable for the Contractor's debts as set forth in SSA § 1932(b)(6).

35.9 SDOH Compliance With Conflict of Interest Laws

SDOH and its employees shall comply with Article 18 of the General Municipal Law and all other appropriate provisions of New York State law, local laws and ordinances and all resultant codes, rules and regulations pertaining to conflicts of interest.

35.10 Compliance With PHL Regarding External Appeals

Contractor must comply with Article 49 Title II of the PHL regarding external appeal of adverse determinations.

35.11 Fair Labor Standards Act

The Contractor is required to comply with all applicable provisions of the Fair Labor Standards Act (FLSA). The Contractor shall develop protocols to demonstrate compliance with requirements of the FLSA. Such protocols shall include appropriate record keeping methodologies, tracking of aide travel time, hours worked on live-in cases, and appropriate rate of reimbursement. Such verification system and protocols are subject to audit by DOH, OMIG, and the Department of Labor.

36. STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

EXHIBIT 3

2026 Essential Plan Model Contract

between Healthfirst and New York State

MISCELLANEOUS/CONSULTANT SERVICES

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

NYS COMPTROLLER'S # C042073

ORIGINATING AGENCY GLBU: DOH01
DEPARTMENT ID: 3450000

CONTRACTOR (Name and Address):

Healthfirst PHSP, Inc.
100 Church Street
New York, NY 10007

TYPE OF PROGRAM(S):

Essential Plan [Title 11-D of Article 5 of NY Social Services Law]

CHARITIES REGISTRATION NUMBER:

05-41-57

CONTRACTOR HAS (X) HAS NOT ( ) TIMELY FILED WITH THE ATTORNEY GENERAL'S CHARITIES BUREAU ALL REQUIRED

PERIODIC OR ANNUAL WRITTEN REPORTS

FEDERAL TAX IDENTIFICATION NUMBER:
13-3783732

NYS VENDOR IDENTIFICATION NUMBER:
1000026827

MUNICIPALITY NO. (if applicable)

CONTRACT TERM

FROM: January 1, 2026
TO: December 31, 2030

FUNDING AMOUNT FOR CONTRACT TERM: NOT TO EXCEED
$16,278,032,208.00

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

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

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

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

APPENDICES ATTACHED AND PART OF THIS CONTRACT
Precedence shall be given to these documents in the order listed below.

-X- APPENDIX A Standard Clauses as Required by the Attorney General for all State Contracts.
-X- APPENDIX X Contract Amendment Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)
-X- APPENDIX Q Modification of Standard Department of Health Contract Language
-X- NEW YORK STATE DEPARTMENT OF HEALTH CONTRACT
-X- APPENDIX M Participation by Minority and Women-Owned Business Enterprises
-X- APPENDIX C Program Specific Requirements
-X- APPENDIX C-1 Marketplace Facilitated Enroller Program
-X- APPENDIX D NY State of Health Invitation and Requirements for Certification and Recertification for Participation and any Questions and Answers, as posted on the NY State of Health website
-X- APPENDIX D-1 Contractor's Proposal for plan certification
-X- APPENDIX I Trading Partner Agreement
-X- APPENDIX J Capitation Rates

IN WITNESS WHEREOF, the Parties hereto have executed this Contract # C042073 on the dates below their signature.

CONTRACTOR

Insert Contractor Name

Healthfirst PHSP, Inc.

By: Kathryn A. Howell

Kathryn A. Howell

Printed Name

Title: Chief Legal Officer

Date: 11/12/25

STATE AGENCY

New York State Department of Health

By: Danielle Holahan

Danielle Holahan

Printed Name

Title: Executive Director

Date: 12/22/25

State Agency Certification:
"In addition to the acceptance of this Contract, I also certify that original copies of this signature page will be attached to all other exact copies of this Contract."

STATE OF NEW YORK)
)SS.:
County of New York)

On the 12th day of November in the year 2025 before me, the undersigned, personally appeared Kathryn Howell personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that they executed the same in their capacity(ies), and that by their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Joshua Harris Pike
Notary Public, State of New York
Registration No. 02PI6379662
Qualified in New York County
My Commission Expires November 18, 2026

(Signature and office of the individual taking acknowledgment)

ATTORNEY GENERAL'S SIGNATURE

Title:

Date:

NYS COMPTROLLER'S SIGNATURE

APPROVED
DEPT. OF AUDIT & CONTROL
Feb 13 2026
James M. Iwaneczko
FOR THE STATE COMPTROLLER

Title:

Date:

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

PLEASE RETAIN THIS DOCUMENT
FOR FUTURE REFERENCE.

June 2023

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STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law, if this contract exceeds $50,000 (or $75,000 for State University of New York or City University of New York contracts for goods, services, construction and printing, and $150,000 for State University Health Care Facilities) or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $25,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services, either for itself or its customer agencies by the Office of General Services Business Services Center, is required when such contracts exceed $85,000. Comptroller's approval of contracts established as centralized contracts through the Office of General Services is required when such contracts exceed $125,000, and when a purchase order or other procurement transaction issued under such centralized contract exceeds $200,000.

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment, nor subject any individual to harassment, because of age, race, creed, color, national origin, citizenship or immigration status, sexual orientation, gender identity or expression, military status, sex, disability, predisposing genetic characteristics, familial status, marital status, or domestic violence victim status or because the individual has opposed any practices forbidden under the Human Rights Law or has filed a complaint, testified, or assisted in any proceeding under the Human Rights Law. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in

accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be a condition precedent to payment by the State of any State approved sums due and owing for work done upon the project.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2 NYCRR § 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, the "Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or (iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, must give the reason or reasons why the payee does not have such number or numbers.

(b) Privacy Notification. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law and 5 NYCRR Part 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "(a), (b) and (c)" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this clause. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this

law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in § 165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority- and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business and Technology Development
625 Broadway
Albany, New York 12245
Telephone: 518-292-5100

A directory of certified minority- and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
633 Third Avenue 33rd Floor
New York, NY 10017
646-846-7364
email: mwbebusinessdev@esd.ny.gov
https://ny.newnycontracts.com/FrontEnd/searchcertifieddirectory.asp

The Omnibus Procurement Act of 1992 (Chapter 844 of the Laws of 1992, codified in State Finance Law § 139-i and Public Authorities Law § 2879(3)(n)–(p)) requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority- and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively, codified in State Finance Law § 165(6) and Public Authorities Law § 2879(5)) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 2023, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii.

22. COMPLIANCE WITH BREACH NOTIFICATION AND DATA SECURITY LAWS. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law §§ 899-aa and 899-bb and State Technology Law § 208).

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW. If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4)(g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

24. PROCUREMENT LOBBYING. To the extent this agreement is a "procurement contract" as defined by State Finance Law §§ 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law §§ 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.
To the extent this agreement is a contract as defined by Tax Law § 5-a, if the contractor fails to make the certification required by Tax Law § 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law § 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

26. IRAN DIVESTMENT ACT. By entering into this Agreement, Contractor certifies in accordance with State Finance Law § 165-a that it is not on the "Entities Determined to be Non-Responsive Bidders/Offerers pursuant to the New York State Iran Divestment Act of 2012" ("Prohibited Entities List") posted at: https://ogs.ny.gov/iran-divestment-act-2012

Contractor further certifies that it will not utilize on this Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that should it seek to renew or extend this Contract, it must provide the same certification at the time the Contract is renewed or extended. Contractor also agrees that any proposed Assignee of this Contract will be required to certify that it is not on the Prohibited Entities List before the contract assignment will be approved by the State.

During the term of the Contract, should the state agency receive information that a person (as defined in State Finance Law § 165-a) is in violation of the above-referenced certifications, the state agency will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the state agency shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the Contractor in default.

The state agency reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

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

APPENDIX X
CONTRACT AMENDMENT FORM
ORIGINATING AGENCY: DOH01

Contract Number:_____ CONTRACTOR:_____

Amendment Number X-_____ BSC Unit ID: 3450000

This is a Contract Amendment between THE STATE OF NEW YORK, acting by and through NYS Department of Health, having its principal office at Corning Tower, Empire State Plaza, Albany, New York 12237 (hereinafter referred to as the DEPARTMENT), and _____ (hereinafter referred to as the CONTRACTOR), having its mailing address at 100 Church Street, _____, for this Contract.

This amendment makes the following changes to the Contract (check all that apply):

- ☐ Modifies the Contract Term at no increase in Funding Amount
- ☐ Modifies the Contract Term at an increase in Funding Amount
- ☐ Modifies the budget or payment terms
- ☐ Modifies the work plan or deliverables
- ☐ Replaces appendix(es)___with the attached appendix(es) ___
- ☐ Adds the attached appendix(es) _____
- ☐ Other: (describe): _____

This amendment *is* ☐ *is not* ☐ a Contract renewal as allowed for in the existing Contract.

All other provisions of said Contract shall remain in full force and effect.

Additionally, CONTRACTOR certifies that it is not included on the prohibited entities list published at https://ogs.ny.gov/iran-divestment-act-2012 as a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York. Under the Act, the Commissioner of the Office of General Services (OGS) has developed a list (prohibited entities list) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). CONTRACTOR further certifies that it has not used, and will not use, in the performance of this Contract any subcontractor that is included on such prohibited entities list.

Prior to this amendment, the Contract Term and Funding Amount of this Contract were:

$_____ From_____ to _____.
(Value before amendment) (Initial Start date) (Initial End date)

This Contract Amendment makes the following modification(s) (complete only terms being modified):

$_____ From_____ to _____.

This Contract Amendment will result in the following new Contract Terms:

$_____ From_____ to _____.
(All years thus far combined) (Initial Start date) (Amendment end date)

Signature Page for:

Contract Number:_____ CONTRACTOR:_____

Amendment Number X-_____ Unit ID: 34500000

IN WITNESS WHEREOF, the Parties hereto have executed this Contract Amendment as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE:

By:_____ Date:_____
(signature)

Printed Name:_____

Title:_____

STATE OF NEW YORK)
)SS.:
County of_____)

On the ____ day of_____in the year_____before me, the undersigned, personally appeared_____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that they executed the same in their capacity(ies), and that by their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

(Signature and office of the individual taking acknowledgement)

STATE AGENCY SIGNATURE

"In addition to the acceptance of this Contract Amendment, I also certify that original copies of this signature page will be attached to all other exact copies of this Contract Amendment."

By:_____ Date:_____
(signature)

Printed Name:_____

Title:_____

ATTORNEY GENERAL'S SIGNATURE

By:_____ Date:_____

STATE COMPTROLLER'S SIGNATURE

By:_____ Date:_____

Appendix Q

MODIFICATION OF STANDARD DEPARTMENT OF HEALTH CONTRACT LANGUAGE

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

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

New York State Department of Health Appendix, Section II, Payment and Reporting, is replaced in its entirety with the following:

II. Payment and Reporting

Payment by the DEPARTMENT (New York State Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. **Payment terms will be in Accordance with Appendix C.**

Payment shall only be rendered electronically unless payment by paper check is expressly authorized by the New York State Commissioner of Health (the "Commissioner"), in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary DEPARTMENT procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at helpdesk@sfs.ny.gov or by telephone at 1-855-233-8363. CONTRACTOR acknowledges that it will not receive payment under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us/vendors/vendorguide/guide.htm.

Funds provided pursuant to this Agreement shall not be used for any partisan political activity, or for activities that may influence legislation or the election or defeat of any candidate for public office.

NEW YORK STATE DEPARTMENT OF HEALTH APPENDIX

This Appendix is entered into by and between the New York State Department of Health (hereinafter, the "DEPARTMENT") and the CONTRACTOR named on the Face Page of this Contract Number C042073.

WITNESSETH:

☐ **WHEREAS**, the DEPARTMENT has formally requested offerors to submit bid proposals for the project described in Appendix B for which bids were opened on the date noted on the Face Page of this APPENDIX; the DEPARTMENT has determined that the CONTRACTOR is the successful bidder; and the CONTRACTOR covenants that it is willing and able to undertake the services and provide the necessary materials, labor, equipment, and other resources to complete the project in accordance with the terms of this APPENDIX;

OR

☒ **WHEREAS**, the DEPARTMENT has determined, without a formal competitive procurement process, that it is in need of the services described in Appendix C; the DEPARTMENT has chosen the CONTRACTOR to perform those services under the terms of this APPENDIX; and the CONTRACTOR covenants that it is willing and able to undertake the services and provide the necessary materials, labor, equipment, and other resources required to perform the services in accordance with the terms of this APPENDIX;

The DEPARTMENT and CONTRACTOR may, from time to time, be referred to in this Appendix, individually as a "Party" and, collectively, as the "Parties".

NOW THEREFORE, in consideration of the terms, promises, responsibilities, and covenants set forth below the Parties agree as follows:

I. General Terms and Conditions

A. This Contract incorporates the Face Pages attached and all of the marked appendices identified on the Face Page.

B. The maximum compensation for the Contract Term of this Contract shall not exceed the Funding Amount specified on the Face Page.

C. This Contract may be renewed for an additional period (PERIOD), as specified on the Face Page.

D. To amend or exercise any renewal option of this Contract, the Parties shall prepare new appendices, to the extent that any require modification, and a Contract Amendment Form in the format provided by the DEPARTMENT (Appendix X). Any terms of this Contract not modified shall remain in effect for each PERIOD of the Contract. The Contract Amendment is subject to the approval of the Office of the State Comptroller. This Contract may not be amended orally. The CONTRACTOR shall not make any changes in the scope of work at any time without prior authorization in writing from the DEPARTMENT and without prior approval in writing of the amount of compensation for such changes.

E. Appendix A (STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS) takes precedence over all other parts of the Contract.

F. For the purposes of this Contract, the term "Proposal" includes all Appendix C documents

as marked on the Face Page.

G. The CONTRACTOR is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the DEPARTMENT nor make any claims, demand or application to or for any right based upon any different status.

H. The CONTRACTOR agrees, throughout the term of this Contract, to maintain, at CONTRACTOR'S expense, those benefits to which its employees are entitled by law, including health benefits, any necessary insurance for its employees, including professional liability, worker's compensation, disability and unemployment insurance, and to provide the DEPARTMENT with certification of such insurance upon request. The CONTRACTOR remains responsible for all applicable federal, state, and local taxes, and all FICA contributions.

I. For the purposes of this Contract, the Appendix B includes all Scope of Work / Request for Proposal (RFP) / Invitation for Bids (IFB) or Funding Availability Solicitation (FAS) documents including questions and answer documents, amendments and attachments.

J. CONTRACTOR is under an affirmative duty to be informed by personal examination of the specifications and location of the proposed work and by such other means as it may select, of character, quality and extent of work to be performed and the conditions under which the Contract is to be executed. The DEPARTMENT will make no allowance or concession to a CONTRACTOR for any alleged misunderstanding or deception because of quantity, quality, character, location or other conditions.

K. The CONTRACTOR shall have a representative to provide supervision of the work which CONTRACTOR's employees are performing to ensure complete and satisfactory performance of the terms of this Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the DEPARTMENT. A confirmation in writing of such orders or directions will be given by the DEPARTMENT when so requested from the CONTRACTOR.

L. If the DEPARTMENT is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, the DEPARTMENT shall have the authority to require the CONTRACTOR to use such additional personnel AND to take ANY OTHER steps necessary to perform the REQUIRED services satisfactorily at no additional cost to the DEPARTMENT.

M. The DEPARTMENT may conduct any inspection at a time during normal business hours where the activities of the work under this Contract are taking place and in a manner so as not to unreasonably disrupt the CONTRACTOR'S business. During its inspection the DEPARTMENT may view and audit any materials related to this Contract.

N. No failure by the DEPARTMENT at any time to give notice of any breach by the other Party of, or to require compliance with, any condition or provision of this Contract shall be deemed a waiver of similar or dissimilar provisions or conditions at the same or at any prior or subsequent time.

II. Payment and Reporting

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

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

   Subject: **Unit ID:** 3450475 **Contract Number:** C042073
   (Note: **Do not** send a paper copy in addition to your emailed voucher.)

2. Alternate Method: Mail vouchers to BSC at the following U.S. postal address:

   NYS Department of Health
   Unit ID: 3450475 **Contract Number:** C042073
   Building 5, 5th Floor 1220 Washington Ave
   Albany, NY 12226-1900

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

Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the New York State Commissioner of Health (the "Commissioner"), in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary DEPARTMENT procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at helpdesk@sfs.ny.gov, or by telephone at 1-855-233-8363. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9 must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us./vendors/vendorguide/guide.htm.

Payment terms shall be:

The Contractor will submit monthly invoices, due 30 days after the end of each month, which must be accompanied by a New York State Claim for Payment (form AC3253-S) to ensure payment.

III. Term and Termination

A. Upon approval of the Office of the State Comptroller this Contract shall be effective for the Contract Term specified on the Face Page of this Contract.

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

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

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

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

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

G. Provisions Upon Default

1. In the event that the CONTRACTOR, through any cause, fails to perform any of the terms, covenants or promises of this Contract, the DEPARTMENT thereupon shall have the right to terminate this Contract by giving notice in writing of the fact and date of such termination to the CONTRACTOR.

2. If, in the judgment of the DEPARTMENT, the CONTRACTOR acts in a way which is likely to or does impair or prejudice the interests of the DEPARTMENT, the

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

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

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

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

IV. Contract Insurance Requirements

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

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

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

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

period must be provided to the DEPARTMENT prior to the policy's expiration or cancellation.

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

   Name/Title: Director, Bureau of Contracts
   Organization: NYS DOH, Bureau of Contracts
   Address: Room 2834, Corning Tower ESP
   Address: Albany NY 12237

   Unless otherwise agreed, policies must include the following provisions: the policy will not be canceled, materially changed, or not renewed, except for non-payment, as required by law, without at least 30 days prior written notice to the DEPARTMENT at the address specified above in this paragraph. In addition, if required by the DEPARTMENT, the CONTRACTOR shall deliver to the DEPARTMENT within forty-five (45) days of such request a copy of any or all policies of insurance not previously provided, certified by the insurance carrier as true and complete.

Certificates of Insurance shall:

a. Be in the form approved by the DEPARTMENT.

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

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

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

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

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

Only original documents (Certificates of Insurance, Supplemental Insurance Certificates, and other attachments) will be accepted.
Electronic forms will be accepted as original documents, provided the subject electronic document can be directly traced back to the insurance carrier, agent, or broker via email distribution or similar means.

4. Primary Coverage. The liability and protective liability insurance policies shall provide primary and non-contributory coverage to the DEPARTMENT for any claim arising from the CONTRACTOR'S Work under this CONTRACT, or as a result of the CONTRACTOR'S activities. Insurance policies that remove or restrict blanket contractual liability located in the "Insured Contract" definition (as stated in Section V, Number 9, Item f in the ISO CGL policy) so as to limit coverage against claims that arise out of the work, or that remove or modify the "Insured Contract" exception to the

employer's liability exclusion, or that do not cover the additional insured for claims involving injury or employees of the named insured or subcontractors, are not acceptable.

5. Policy Renewal/Expiration. At least two weeks prior to the expiration of any policy required by this Contract, evidence of renewal or replacement policies of insurance with terms no less favorable to the DEPARTMENT than the expiring policies shall be delivered to the DEPARTMENT in the manner required for service of notice certificates of insurance, insurance policies and notices thereunder set forth in Section IV.B.3, above. Certificates of Insurances/Notices of this Section. If, at any time during the term of this Contract, the coverage provisions and limits of the policies required herein do not meet the provisions and limits set forth in this Contract or proof thereof is not provided to the DEPARTMENT, the CONTRACTOR shall immediately cease work under this Contract. The CONTRACTOR shall not resume work under this Contract until authorized to do so by the DEPARTMENT. Any delay, time lost, or additional cost incurred as a result of the CONTRACTOR not having insurance required by this Contract or not providing proof of same in a form acceptable to the DEPARTMENT shall not give rise to a delay claim or any other claim against the DEPARTMENT. Should the CONTRACTOR fail to provide or maintain any insurance required by this Contract, or proof thereof is not provided to the DEPARTMENT, the DEPARTMENT may withhold further Contract payments, treat such failure as a breach or default of the Contract, and/or, after providing written notice to the CONTRACTOR, require the Surety, if any, to secure appropriate coverage and/or purchase insurance complying with this Contract and charge back such purchase to the CONTRACTOR.

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

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

C. Specific Coverages and Limits

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

1. Workers' Compensation

For work to be performed in New York State, the CONTRACTOR shall provide and maintain coverage during the life of this Contract for the benefit of such employees as are required to be covered by the NYS Workers' Compensation Law. The CONTRACTOR shall provide notice to the DEPARTMENT immediately if CONTRACTOR'S Workers' Compensation coverage has lapsed or terminated during the PERIOD of this Contract.

If the Contract involves work on or near a shoreline, a U.S. Longshore and Harbor Workers' Compensation Act and/or Jones Act policy as applicable must be provided.

Any waiver of this requirement must be approved by the DEPARTMENT and will only be granted in unique or unusual circumstances.

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

a. C-105.2 (September 2007, or most current version) – Certificate of Workers' Compensation Insurance.
b. U-26.3 – Certificate of Workers' Compensation Insurance from the State Insurance Fund.
c. GSI-105/SI-12 – Certificate of Workers' Compensation Self Insurance.
d. CE-200 – Certificate of Attestation of Exemption (If CONTRACTOR meets the requirements)

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

2. Disability Benefits

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

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

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

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

3. Commercial General Liability

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

a. Each Occurrence limit - $1,000,000
b. General Aggregate - $2,000,000
c. Products/Completed Operations must be equivalent to the "General Aggregate" limit
d. Personal/Advertising Injury - $1,000,000

e. Damage to Rented Premises - $50,000
f. Medical Expense - $5,000

Coverage shall include, if applicable, the following:

g. premises liability;
h. independent contractors/subcontractors;
i. blanket Contractual liability, including tort liability of another assumed in a Contract;
j. defense and/or indemnification obligations, including obligations assumed under this Contract;
k. cross liability for additional insureds;
l. products/completed operations for a term of no less than 3 years, commencing upon acceptance of the work, as required by this Contract;
m. explosion, collapse, and underground hazards;
n. CONTRACTOR means and methods;
o. liability resulting from Section 240 or Section 241 of the New York State Labor Law; and
p. Cybersecurity Liability.

The following ISO forms must be endorsed to the policy:
q. CG 00 01 01 96 or an equivalent – Commercial General Liability Coverage Form
r. CG 20 10 11 85 or an equivalent – Additional Insured-Owner, Lessees or CONTRACTORS (Form B)

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

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

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

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

4. Commercial Automobile Liability

Commercial Auto Liability insurance covering liability arising out of the use of any motor vehicle in connection with the work, including owned, leased, hired and non-owned vehicles bearing or, under the circumstances under which they are being used, required by the Motor Vehicle Laws of the State of New York to bear, license plates. Such policy shall have a combined single limit for Bodily Injury and Property Damage of at least one

million dollars and shall name the State of New York as additional insured. The limits may be provided through a combination of primary and umbrella/excess liability policies. If this Contract involves the removal of hazardous waste from the project site or otherwise transporting hazardous materials, pollution liability coverage for covered autos shall be provided by form CA 99 48 03 06 or CA 00 12 03 06 and the Motor Carrier Act Endorsement (MCS90) shall be attached.

5. Umbrella and Excess Liability

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

V. Conflicts of Interest

A. CONTRACTOR hereby attests, represents and warrants that, at the time of its execution of this Contract, the CONTRACTOR'S performance of the services provided for under the terms of this Contract does not and will not create a conflict of interest with, nor position the CONTRACTOR to breach, any other contract currently in force with the State of New York, and that the CONTRACTOR will not act in any manner that is detrimental to any State of New York project in which the CONTRACTOR is rendering services.

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

C. Prior to entering into any subcontract under this Contract, CONTRACTOR shall obtain and deliver to the DEPARTMENT, in a form acceptable to the DEPARTMENT, an acknowledgement, representation and covenant, duly executed by an authorized executive or legal representative of the proposed subcontractor, to the effect that (i) the subcontractor's performance of its obligations under the proposed subcontract will not create a conflict of interest with, nor position the subcontractor to breach, any other contract currently in force with the State of New York, (ii) the subcontractor will not act in any manner that is detrimental to any State of New York project on which the subcontractor is currently rendering services, (iii) there is and shall be no actual or potential conflict of interest that could prevent subcontractor's satisfactory or ethical performance of the duties required to be performed pursuant to the terms of the subcontract, and (iv) the subcontractor shall have a duty to notify the CONTRACTOR and the DEPARTMENT immediately of any actual or potential conflicts of interest. The CONTRACTOR shall also require that any subcontractor obtain a similar acknowledgement, representation and covenant, in a form acceptable to the DEPARTMENT, prior to entering into any further subcontract under this Contract.

D. The CONTRACTOR shall disclose any existing or contemplated relationship with any other person or entity, including relationships with (a) any parent, subsidiary or other affiliated entity, and any other member or holder of 5% or more of the equity ownership, of CONTRACTOR, or (b) any client or customer of the CONTRACTOR or such other person or entity, or (c) any former employee or officer of the DEPARTMENT, which would constitute an actual or potential conflict of interest or appearance of impropriety with respect to the performance of the obligations of the CONTRACTOR under this Contract. If a conflict does or might exist, please describe how you will eliminate or prevent it. Indicate what procedures will be followed to detect, notify the DEPARTMENT of, and resolve any such conflicts. The DEPARTMENT will review the nature of any relationships and reserves the right to terminate this Contract for any reason, or for cause, if, in the judgment of the DEPARTMENT, a real or potential conflict of interest cannot be cured.

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

VI. Public Officers Law

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

VII. Ethics Requirements

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

prohibitions. The DEPARTMENT may request that the CONTRACTOR provide whatever information the DEPARTMENT deems appropriate about each such person's engagement, work cooperatively with the DEPARTMENT to solicit advice from the New York State Commission on Ethics and Lobbying in Government, and, if deemed appropriate by the DEPARTMENT, instruct any such person to seek the opinion of the New York State Commission on Ethics and Lobbying in Government. The DEPARTMENT shall have the right to withdraw or withhold approval of any subcontractor if utilizing such subcontractor for any work performed hereunder would be in conflict with any of the Ethics Requirements. The DEPARTMENT shall have the right to terminate this Contract at any time if any work performed hereunder is in conflict with any of the Ethics Requirements.

VIII. Subcontracting

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

B. The CONTRACTOR may arrange for a portion/s of its responsibilities under this Contract to be subcontracted to qualified, responsible subcontractors, subject to approval of the DEPARTMENT. If the CONTRACTOR determines to subcontract a portion of the services, once known, the subcontractors must be clearly identified and the nature and extent of their involvement in and/or proposed performance under this Contract must be fully explained by the CONTRACTOR to the DEPARTMENT. As part of this explanation, the CONTRACTOR must submit to the DEPARTMENT the acknowledgement, representation and covenant from the subcontractor specified in Section V.C.

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

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

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

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

G. If at any time during performance under this Contract total compensation to a subcontractor

exceeds or is expected to exceed $100,000, that subcontractor shall be required to submit and certify a Vendor Responsibility Questionnaire.

IX. General Specifications

A. The work shall be commenced and shall be actually undertaken within such time as the DEPARTMENT may direct by notice, whether by mail, e-mail, or other writing, whereupon the undersigned will give continuous attention to the work as directed to the end and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the DEPARTMENT may prescribe.

B. The CONTRACTOR will be required to complete the entire work or any part thereof as the case may be, to the satisfaction of the DEPARTMENT in strict accordance with the specifications and pursuant to this Contract.

C. CONTRACTOR will possess, and maintain, at no cost to the DEPARTMENT and for the term of the Contract, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this Contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

D. Certification Regarding Debarment and Suspension

Regulations of the Department of Health and Human Services, located at Part 376 of Title 2 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive Departments and agencies shall participate in a government-wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and non-financial assistance and benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the DEPARTMENT (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the DEPARTMENT must require its prospective CONTRACTORS, as prospective lower tier participants, to provide the certification as set forth below:

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

a. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to the other remedies available, the Federal Government, New York State or the DEPARTMENT may pursue available remedies, including suspension and/or

debarment.

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

c. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered Transaction, principal, proposal, and voluntarily excluded, as used in this Section, are defined in 2 CFR Part 180, as supplemented by 2 CFR Part 376.

d. The prospective lower tier participant agrees by signing this Contract or submitting a proposal pursuant to a solicitation issued by the DEPARTMENT that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 2 CFR Part 180, as supplemented by 2 CFR Part 376, or 48 CFR Part 9, Subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the DEPARTMENT.

e. The prospective lower tier participant further agrees by signing this Contract or proposal that it will include this clause titled “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction,’ without modification, in all lower tier covered transactions.

f. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 2 CFR Part 180, as supplemented by 2 CFR Part 376, or 48 CFR Part 9, Subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. The DEPARTMENT strongly encourages each participant to check the List of Parties Excluded from Federal Procurement and Non-procurement Programs in the System for Award Management.

g. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this Section.

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

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

   i. The prospective lower tier participant certifies, by signing this Contract or submitting a proposal to the Department, that neither it nor its principals is

presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal agency.

ii. Where the prospective lower tier participant is unable to certify to any of the statements in its certification, such prospective participant shall attach an explanation to this proposal.

E. Ownership Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this Contract shall contain the following, or similar acknowledgment: “Funded by the New York State Department of Health.” Any such materials must be reviewed and approved by the DEPARTMENT for conformity with the policies and guidelines of the DEPARTMENT prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the CONTRACTOR shall be free to publish in scholarly journals along with a disclaimer that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health. The DEPARTMENT reserves the right to disallow funding for any educational materials not approved through its review process.

2. Any publishable or otherwise reproducible material developed under or in the course of performing this Contract, dealing with any aspect of performance under this Contract, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the DEPARTMENT, and shall not be published or otherwise disseminated by the CONTRACTOR to any other Party unless prior written approval is secured from the DEPARTMENT or under circumstances as indicated in paragraph 1 of this subsection. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the DEPARTMENT. The DEPARTMENT shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

3. No report, document or other data produced in whole or in part with the funds provided under this Contract may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report, document or other data developed pursuant to this Contract, without express written permission of the DEPARTMENT.

4. All reports, data sheets, documents, etc. generated under this Contract shall be the sole and exclusive property of the DEPARTMENT. The CONTRACTOR shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the DEPARTMENT or its authorized agents.

5. This is a “Work for Hire” Contract. The DEPARTMENT will be the sole owner of all source code and any software which is developed for use in any application software provided to the DEPARTMENT as a part of this Contract.

F. Confidentiality Clause

The CONTRACTOR, its officers, agents and employees and subcontractors shall treat all

information which is obtained by it through its performance under this CONTRACT, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.

G. Date/Time Warranty

1. Definitions: For the purposes of this warranty, the following definitions apply:
"Product" shall include, without limitation: when solicited from a vendor in a state government entity's Contracts, RFPs, IFBs, or mini-bids, any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition, function, calculation, comparing or sequencing. Where services are being furnished, e.g., consulting, systems integration, code or data conversion or data entry, the term "Product" shall include resulting deliverables.

"Third Party Product" shall include product manufactured or developed by a corporate entity independent from the vendor and provided by the vendor on a non-exclusive licensing or other distribution Contract with the third Party manufacturer. "Third Party Product" does not include product where vendor is: (a) a corporate subsidiary or affiliate of the third Party manufacturer/developer; and/or (b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

2. Date/Time Warranty Statement
CONTRACTOR warrants that Product(s) furnished pursuant to this Contract shall, when used in accordance with the Product documentation, be able to accurately process date/time data (including, but not limited to, calculating, comparing, and sequencing) transitions, including leap year calculations.

Where a CONTRACTOR proposes or an acquisition requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

Where CONTRACTOR is providing ongoing services, including but not limited to:
(a) consulting, integration, code or data conversion, b) maintenance or support services, c) data entry or processing, or d) contract administration services (e.g., billing, invoicing, claim processing), CONTRACTOR warrants that services shall be provided in an accurate and timely manner without interruption, failure or error due to the inaccuracy of CONTRACTOR'S business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) various date/ time transitions, including leap year calculations. CONTRACTOR shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom, including but not limited to the failure or untimely performance of such services. This Date/Time Warranty shall survive beyond termination or expiration of this Contract through: (a) ninety (90) days or (b) the CONTRACTOR'S or Product manufacturer or developer's stated date/time warranty term, whichever is longer. Nothing in this warranty statement shall be construed to limit any rights or remedies otherwise available under this Contract for breach of warranty.

H. Lead Guidelines

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

DEPARTMENT'S acceptance of this Contract.

I. On-Going Responsibility

1. General Responsibility Language: The CONTRACTOR shall at all times during the Contract Term remain responsible. The CONTRACTOR agrees, if requested by the Commissioner or their designee, to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity.

2. Suspension of Work (for Non-Responsibility): The Commissioner or their designee, in their sole discretion, reserves the right to suspend any or all activities under this Contract, at any time, when he or she discovers information that calls into question the responsibility of the CONTRACTOR. In the event of such suspension, the CONTRACTOR will be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the CONTRACTOR must comply with the terms of the suspension order. Contract activity may resume at such time as the Commissioner or their designee issues a written notice authorizing a resumption of performance under this Contract.

3. Termination (for Non-Responsibility): Upon written notice to the CONTRACTOR, and a reasonable opportunity to be heard with appropriate DEPARTMENT officials or staff, this Contract may be terminated by Commissioner or their designee at the CONTRACTOR'S expense where the CONTRACTOR is determined by the Commissioner of Health or their designee to be non-responsible. In such event, the Commissioner of Health or their designee may complete the contractual requirements in any manner he or she may deem advisable and pursue available legal or equitable remedies for breach.

J. Indemnification

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

K. Indemnification Relating to the Third-Party Rights

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

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

L. Force Majeure

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

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

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

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

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

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

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

M. Notices

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

a. via certified or registered United States mail, return receipt requested;
b. by facsimile transmission;
c. by personal delivery;
d. by expedited delivery service; or
e. by e-mail

Such notices shall be addressed as follows or to such different addresses as the Parties may from time to time designate:

Contact at State of New York Department of Health

Name/Title: Margaret Middleton, Director of Plan Management
Address: NYS Department of Health, NY State of Health, Corning Tower, Rm 2378, Albany, NY
Email: margaret.middleton@health.ny.gov
Phone/Fax: 518-473-9635

Contact at Contractor

Name/Title: Pat Wang, CEO
Address: 100 Church Street, New York, NY 10007
Email: pwang@healthfirst.org

Any such notices shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

The Parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Contract by giving fifteen (15) days written notice to the other Party sent in accordance herewith. The Parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this Contract. Additional individuals may be designated in writing by the Parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

N. Provision Related to Consultant Disclosure Legislation

If this Contract is for the provision of consulting services as defined in Subdivision 17 of Section 8 of the State Finance Law, the CONTRACTOR shall submit a "State Consultant Services Form B, CONTRACTOR'S Annual Employment Report" no later than May 15th following the end of each DEPARTMENT fiscal year included in this Contract Term. This report must be submitted to:

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

2. The NYS Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th Floor, Albany NY 12236 ATTN: Consultant Reporting or via fax at (518) 474-8030 or (518) 473-8808; and

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

O. Provisions Related to New York State Information Security Breach and Notification Act

CONTRACTOR shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). CONTRACTOR shall be liable for the costs associated with such breach if caused by CONTRACTOR'S negligent or willful acts or omissions, or the negligent or willful acts or omissions of CONTRACTOR'S agents, officers, employees or subcontractors.

P. Technology Purchases Notification

The following provisions apply if this Contract contains "Technology."

1. For the purposes of this policy, "Technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.

2. If this Contract results in procurement of software over $20,000, or of other technology over $50,000, or where the DEPARTMENT determines that the potential exists for coordinating purchases among New York State agencies and/or the purchase may be of interest to one or more other New York State agencies, prior to award selection, this Contract is subject to review by the New York State Office for Information Technology Services.

3. Accessibility of State Agency Web-based Intranet and Internet Information and Applications. Any web-based intranet and Internet information and applications development, or programming delivered pursuant to the Contract or procurement, will comply with New York State Enterprise IT Policy NYS-P08-005, Accessibility of Web-Based Information and Applications as such policy may be amended, modified

or superseded, which requires that state agency web-based intranet and Internet information and applications are accessible to persons with disabilities. Web content must conform to New York State Enterprise IT Policy NYS-P08-005, as determined by quality assurance testing. Such quality assurance testing will be conducted by the DEPARTMENT and awarded CONTRACTOR and the results of such testing must be satisfactory to the DEPARTMENT before web content will be considered a qualified deliverable under the Contract or procurement.

Appendix M
Participation by Minority and Women-Owned Business Enterprises

I. General Provisions

A. The New York State Department of Health is required to implement the provisions of New York State Executive Law Article 15-A and 5 NYCRR Parts 142-144 ("MWBE Regulations") for all State contracts as defined therein, with a value (1) in excess of $25,000 for labor, services, equipment, materials, or any combination of the foregoing or (2) in excess of $100,000 for real property renovations and construction.

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

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

II. Contract Goals

A. For purposes of this Contract, the New York State Department of Health hereby establishes an overall goal of 0 % for Minority and Women-Owned Business Enterprises ("MWBE") participation, 0 % for Minority-Owned Business Enterprises ("MBE") participation and 0 % for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs).

B. For purposes of providing meaningful participation by MWBEs on the Contract and achieving the Contract Goals established in Section II-A hereof, Contractor should reference the directory of New York State Certified MBWEs found at the following internet address: https://ny.newnycontracts.com/.

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

C. Where MWBE goals have been established herein, pursuant to 5 NYCRR §142.8, Contractor must document "good faith efforts" to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract. In accordance with Section 316-a of Article 15-A and 5 NYCRR §142.13, the Contractor acknowledges that if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation Goals set forth in the Contract, such a finding constitutes a breach of Contract and the Contractor shall be liable to the New York State Department of Health for liquidated or other appropriate damages, as set forth herein.

III. **Equal Employment Opportunity (EEO)**

A. Contractor agrees to be bound by the provisions of Article 15-A and the MWBE Regulations promulgated by the Division of Minority and Women's Business Development of the Department of Economic Development (the "Division"). If any of the provisions of this Contract conflicts with applicable law or regulations, including, without limitation, Articles 15 and 15-A of the Executive Law or the MWBE Regulations, the terms of such law(s) or Regulations shall control and take precedence.

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

1. Contractor and Subcontractors shall undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, EEO shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.
2. The Contractor shall submit an EEO policy statement to the New York State Department of Health within seventy-two (72) hours after the date of the notice by New York State Department of Health to award the Contract to the Contractor.
3. If Contractor or Subcontractor does not have an existing EEO policy statement, the New York State Department of Health may provide the Contractor or Subcontractor a model statement.
4. The Contractor's EEO policy statement shall include the following language:

   a. The Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force.
   b. The Contractor shall state in all solicitations or advertisements for employees that, in the performance of the Contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.
   c. The Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed, color, national origin, sex age, disability or marital status and that such employment agency union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein.
   d. The Contractor will include the provisions of Subdivisions (a) through (c) of this Subsection 4 and Paragraph "E" of this Section III, which provides for relevant provisions of the Human Rights Law, in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the Contract.

C. Staffing Plan

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

D. Workforce Employment Utilization Report ("Workforce Report")

1. Once a Contract has been awarded and during the term of Contract, Contractor is responsible for updating and providing notice to the New York State Department of Health of any changes to the previously submitted Staffing Plan. This information is to be submitted on a quarterly basis during the term of the Contract to report the actual workforce utilized in the performance of the Contract by the specified categories listed including ethnic background, gender, and Federal occupational categories. The Workforce Report must be submitted to report this information.
2. Separate forms shall be completed by Contractor and any subcontractor performing work on the Contract.
3. In limited instances, Contractor may not be able to separate out the workforce utilized in the performance of the Contract from Contractor's and/or subcontractor's total workforce. When a separation can be made, Contractor shall submit the Workforce Report and indicate that the information provided related to the actual workforce utilized on the Contract. When the workforce to be utilized on the Contract cannot be separated out from Contractor's and/or subcontractor's total workforce, Contractor shall submit the Workforce Report and indicate that the information provided is Contractor's total workforce during the subject time frame, not limited to work specifically under the Contract.

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

IV. MWBE Utilization Plan

A. The Contractor represents and warrants that Contractor has submitted a MWBE Utilization Plan either prior to, or at the time of, the execution of the Contract.

B. Contractor agrees to use such MWBE Utilization Plan for the performance of MWBEs on the Contract pursuant to the established MWBE Goals set forth in Section II-A of this Appendix.

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

V. Waivers

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

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

VI. Quarterly MWBE Contractor Compliance Report

Contractor is required to submit a Quarterly MWBE Contractor Compliance Report to the New York State Department of Health by the 10th day following each end of quarter over the term of the Contract documenting the progress made towards achievement of the MWBE Goals of the Contract.

VII. Liquidated Damages - MWBE Participation

A. Where New York State Department of Health determines that Contractor is not in compliance with the requirements of the Contract and Contractor refuses to comply with such requirements, or if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation Goals, Contractor shall be obligated to pay to the New York State Department of Health liquidated damages.

B. Such liquidated damages shall be calculated as an amount equaling the difference between:
   1. All sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE Goals; and
   2. All sums actually paid to MWBEs for work performed or materials supplied under the Contract.

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

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Appendix C

I. DEFINITIONS

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

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

"Agreement" means this Agreement by and between CONTRACTOR and the New York State Department of Health acting by and on behalf of the State of New York ("STATE") with respect to the purchase and sale of Essential Plans through the NY State of Health, The Official Health Plan Marketplace.

"Basic Health Program Blueprint" or **"BHP Blueprint"** means the comprehensive operational plan submitted by the New York State Department of Health to the U.S. Department of Health and Human Services in accordance with 42 CFR 600.110, which outlines the elements necessary for certification of a Basic Health Program ("BHP") in accordance with applicable law.

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

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

"Certification" or **"Essential Plan Certification"** means the Marketplace's authorization of a health plan to be offered on the Marketplace as an Essential Plan based on verification that a plan complies with the requirements of the Invitation, as modified by the Marketplace, as well as provisions of applicable law.

"Cost Sharing" means any expenditure required by or on behalf of an Enrollee with respect to covered health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes Premiums, balance billing amounts for non-network providers, and spending for non-covered services.

"Coverage Effective Date" is the date when Essential Plan coverage becomes effective for a particular Enrollee.

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

"Eligible Individual" is an individual eligible to enroll in an Essential Plan in accordance with the BHP Blueprint or the 1332 STC and applicable law.

"Enrollee" means an Eligible Individual enrolled in an Essential Plan offered through the Marketplace.

"Essential Community Provider" means a provider as defined in 45 CFR 156.235(c).

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

"Essential Plan" means a health benefit plan that has been certified by the STATE as an Essential Plan under Title 11-D of the NY Social Services Law to be offered through the Marketplace in accordance with applicable law.

"Federal Poverty Level (FPL)" means the most recently published Federal Poverty Level, updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2).

"Health Care Services" means the provision of medical, dental, and vision services, supplies and benefits that are medically necessary and covered services, in accordance with CONTRACTOR's subscriber contract, including medical, behavioral health, chemical dependency, inpatient and outpatient services.

"Health Information Technology for Economic and Clinical Health Act (HITECH Act)" means the Health Information Technology for Economic and Clinical Health Act enacted as part of the American Recovery and Reinvestment Act of 2009, and the regulations issued pursuant thereto or as thereafter amended.

"Health Insurance Portability and Accountability Act of 1996 (HIPAA)" means the Health Insurance Portability and Accountability Act of 1996 and the regulations issued pursuant thereto or as thereafter amended.

"Indian" means a person who is a member of an Indian tribe.

"Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 USCS §§ 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"Insurance Affordability Program" means a program that is one of the following:

(1) A State Medicaid program under title XIX of the Social Security Act.

(2) A State children's health insurance program (CHIP) under title XXI of the Social Security Act.

(3) A State basic health program established under section 1331 of the Affordable Care Act.

(4) A program that makes coverage in a qualified health plan through the Marketplace with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals.

(5) A program that makes available coverage in a qualified health plan through the Marketplace with cost-sharing reductions established under section 1402 of the Affordable Care Act.

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

"Invitation" means the Invitation and Requirements for Insurer Certification and Recertification and the attachments thereto, issued by the Marketplace to health plan issuers to participate in the Marketplace, as modified by the Questions and Answers regarding the Invitation posted on the Marketplace website. "Marketplace" means the NY State of Health, The Official Health Plan Marketplace, established within the New York State Department of Health pursuant to NY Public Health Law sections 268 – 268-h.

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

"Medical Record" means a complete record of care rendered by a provider documenting the care rendered to the Enrollee, including inpatient, outpatient, and emergency care, in accordance with all applicable federal, State and local laws, rules and regulations. Such record shall be signed by the medical professional rendering the services.

"Member Handbook" means the publication that must be prepared by the CONTRACTOR, subject to STATE approval, which is issued to new Enrollees to inform them of how to access covered Health Care Services and explains their rights and responsibilities as an Enrollee of the CONTRACTOR.

"Non-Participating Provider" means a provider of Health Care Services with which the CONTRACTOR has no Provider Agreement.

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

"Personally Identifiable Information (PII)" means information that can be used to distinguish or trace a person's identity, such as their name, social security number, etc., alone or when combined with other personal or identifying information that is linked or linkable to a particular individual.

"**Producer**" means an insurance agent or insurance broker, in accordance with section 2101 of NY Insurance Law.

"Protected Health Information (PHI)" refers to individually identifiable health information as defined in 45 CFR 164.402.

"Premium" means the dollar amount payable by the Enrollee to the CONTRACTOR to effectuate and maintain coverage.

"Provider Agreement" means any written contract between the CONTRACTOR and Participating Providers to provide Health Care Services to CONTRACTOR's Enrollees in Essential Plan.

"Recertification" refers to the Marketplace's annual review and verification of an Essential Plan's compliance with the requirements for Certification and the provisions of applicable law regarding Essential Plans.

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

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

"Subscriber Contract" means the contract between CONTRACTOR and a Subscriber which is based on the model policy form created by the STATE and issued to each Enrollee by the CONTRACTOR at the time of Enrollment which details the provision of health care coverage under this Agreement.

"Summary of Benefits and Coverage (SBC)" refers to the document provided by CONTRACTOR to Enrollees for each tier of Essential Plan in accordance with 45 CFR 147.200, describing basic and consistent information about plan benefits and coverage and what the Enrollee pays for covered services. The SBC helps Enrollees to better understand their coverage and compare coverage options.

II. AGREEMENT / RELATIONSHIP OF PARTIES

A. Essential Plans

The terms and conditions and obligations of the Parties set forth in this Agreement pertain to Essential Plans offered through the Marketplace.

B. Independent Contractors

1. The Parties acknowledge and agree that in carrying out its responsibilities, the STATE is not acting on behalf of CONTRACTOR. In the performance of this Agreement the STATE and the CONTRACTOR will at all times act as independent contractors and nothing in this Agreement will be deemed to create a relationship of employer or employee or principal or agent between the STATE and CONTRACTOR.

2. Neither CONTRACTOR nor its Participating Providers, authorized subcontractors, agents, officers or employees are agents, officers, employees or representatives of the STATE. Neither the STATE nor its authorized subcontractors, agents, officers, or employees are representatives of the CONTRACTOR.

C. Application of Law

The Parties acknowledge and agree that federal and state laws and regulation with respect to Essential Plans, the BHP Blueprint, the 1332 STC, and related issues addressed in this Agreement continue to develop on an ongoing basis. If laws and regulations pertaining to Essential Plans, the BHP Blueprint, and/or the 1332 STC change the requirements or processes set forth in this Agreement, the requirements of federal and state laws and regulations will govern. The STATE will issue procedural guidance and administrative instructions for CONTRACTOR with respect to certain requirements and processes set forth in this Agreement, to provide clarification in accordance with applicable law and regulations.

D. Coordination

CONTRACTOR and the STATE acknowledge and agree that the delivery of services to Enrollees pursuant to this Agreement will require the joint effort, coordination and cooperation of the Parties. As set forth in detail herein, the Parties will support each other in their marketing, enrollment, and Enrollee transition efforts in accordance with applicable law. The Parties will communicate and cooperate with each other on an ongoing basis in accordance with the terms of this Agreement.

III. ESSENTIAL PLANS

A. Terms and Conditions for Essential Plan Certification

1. At all times during the Contract Term, pursuant to a 1332 State Innovation Waiver and NY Social Services Law section 369-ii(2)(a), or pursuant to 42 C.F.R. 600.415(a) and NY Social Services Law 369-gg(1)(a), CONTRACTOR must be duly licensed pursuant to NY State Insurance Law Article 42 or 43, or certified pursuant to NY State Public Health Law Article 44 to provide health insurance in New York, in good standing and in compliance with state solvency requirements as determined by DFS and/or the STATE; or, have applied for such licensure or certification and reasonably anticipate being (a) licensed or certified prior to September 1st of the year in which they respond to the Invitation and (b) demonstrate to the satisfaction of the STATE that they have the capacity to be fully operational by September 1st of the year in which they respond to the Invitation.

2. CONTRACTOR, for certification pursuant to NY Social Services Law section 369-ii(2)(b) (1332 State Innovation Program), must offer all variations of the Essential Plan product based on Enrollee income as a percentage of FPL and other criteria delineated by the STATE. These variations include:

   - Essential Plan 200-250
   - Essential Plan 1
   - Essential Plan 2
   - Essential Plan 3
   - Essential Plan 4
   - AI / AN Variant (for EP 200-250, EP 1 and EP 2)
   - Pregnancy Variant (for all EP levels)

3. CONTRACTOR, for certification pursuant to NY Social Services Law section 369-gg(2)(b) (Basic Health Program), if applicable, must offer all variations of the Essential Plan product based on Enrollee income as a percentage of FPL and other criteria delineated by the STATE. These variations include:

   - Essential Plan 1
   - Essential Plan 2
   - Essential Plan 3
   - Essential Plan 4
   - AI / AN Variant (EP 1 and EP 2)

4. The STATE must certify Essential Plans to be offered to potential enrollees through the Marketplace.

5. Certification of CONTRACTOR's health insurance plan(s) as Essential Plan(s) by the STATE confirms that the plan(s) also comply with the following provisions of the Invitation:

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

b. the Quality and Enrollee Satisfaction requirements;

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

d. the Premium Rate and Policy Form and Filing requirements

6. STATE will notify the CONTRACTOR of Essential Plan certification by e-mail and/or regular mail.

B. Contractor's Essential Plans

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

2. CONTRACTOR must make Essential Plans 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 an Essential Plan be offered in CONTRACTOR'S entire Service Area requires the prior approval of the STATE during the certification process, following review of a written statement of facts justifying the exception. Any such exception must be determined to be necessary, non-discriminatory and in the best interest of the public.

4. CONTRACTOR's Essential Plans must cover established geographic areas without regard to racial, ethnic, language or health status related factors, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

5. CONTRACTOR's Essential Plans must comply with the following documentation submitted by CONTRACTOR and approved by the STATE or DFS, which is incorporated by reference and made a part of this Agreement:

a. Participation Proposal, attached to this Agreement as Appendix D-1; and

b. Network information submitted and approved by the STATE.

6. CONTRACTOR'S Essential Plans must include the following features:

a. Care coordination and care management for Enrollees, with a focus on Enrollees with chronic health conditions;

b. Initiatives to foster patient involvement in their health care decision-making, including the use of incentives for appropriate health care utilization and patient choice of provider;

c. Incentives for use of preventive services. Incentives may not be in the form of cash or instruments convertible to cash (e.g., checks, money orders, or debit cards) and must be related to the delivery of preventive care services to the Enrollee or the Enrollee achieving a health goal. The value of such incentives must be proportional to the preventive care service or health-related activity completed by the Enrollee. CONTRACTOR shall not offer to Enrollees an incentive or incentive program that has not been approved by the STATE.

7. CONTRACTOR must submit to the STATE a URL link that provides access to the CONTRACTOR's formulary. The formulary must be an up-to-date list of all covered drugs and must clearly identify that the list is applicable to its Essential Plan(s). The formulary must clearly identify the applicable cost-sharing of individual drugs.

8. CONTRACTOR must comply with NY State Public Health Law section 4406-c and Insurance Law section 3216(i)(27), 3221(a)(16) and 4303(jj), as applicable, 42 C.F.R. 600.405(d) and 45 CFR 156.125, which prohibits discriminatory benefit design. STATE will review CONTRACTOR's formulary to assure compliance with State law.

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

10. CONTRACTOR must comply with STATE processes, procedures, and requirements established for the certification of individual health plans as Essential Plans, including Member Services, Accessibility and procedures to handle Consumer Complaints, as outlined in the Invitation.

11. CONTRACTOR must have Information Technology systems and processes in place to accomplish data transfers in compliance with this Agreement and applicable law, including Enrollment, Reconciliation, claims and encounter data, and Reports, as set forth herein.

12. CONTRACTOR, if approved pursuant to NY Social Services Law 369-ii(2)(b) (1332 State Innovation Program), must provide necessary information to the STATE so that the STATE may comply with 45 CFR 156.604, related to recognition of Essential Plans as minimum essential coverage.

13. CONTRACTOR must comply with applicable law and STATE guidance regarding the use of Artificial Intelligence, including guidance issued by the NYS Department of Financial Services to address cybersecurity risks and to prevent unfair or unlawful discrimination.

14. CONTRACTOR must develop and maintain policies and procedures to address the use of Artificial Intelligence in areas including but not limited to the delivery of care, utilization management, risk adjustment and claims adjudication, as outlined in the Invitation.

C. Essential Plan Maintenance

1. CONTRACTOR acknowledges and agrees that the certification of Essential Plan(s) is conditioned upon ongoing compliance with applicable federal and state law and regulation governing Essential Plan certification; federal and state law regarding the provision of health and/or dental insurance in New York State; as well as the terms and conditions of this Agreement. CONTRACTOR's Essential Plans may be decertified if CONTRACTOR: (i) fails to adhere to material certification standards set forth in this Agreement, its Participation Proposal and applicable law; (ii) fails to resolve State agency sanctions, (iii) fails to comply with any applicable corrective action plan following reasonable notice and opportunity to cure, or (iv) fails to recertify.

2. In the event that the STATE determines decertification of an Essential Plan(s) is required pursuant to this Agreement and applicable law, the STATE will provide CONTRACTOR with written notice of this determination and the opportunity for a hearing prior to decertification. The hearing will be before the Commissioner of Health or his or her designee. Decertification must occur in accordance with all applicable laws and regulations governing the removal of an Essential Plan from the Marketplace, including notification to Enrollees.

3. During the Contract Term (excepting the Recertification process) CONTRACTOR must not change Essential Plan standardized benefits or cost-sharing features, including Essential Health Benefits, unless required pursuant to federal or state law or guidance issued by the STATE.

4. CONTRACTOR may change or discontinue an Essential Plan only in accordance with this Agreement.

5. STATE may suspend enrollment in an Essential Plan if a state agency requires suspension, or in the event that the STATE determines that it is in the best interest of the public. Notification of such suspension must occur in accordance with applicable laws and regulations.

IV. PROVIDER NETWORKS

A. Network Adequacy Requirements

1. For Essential Plans offered through the Marketplace, CONTRACTOR will establish and maintain a network of Participating Providers that satisfies the

access standards in 45 C.F.R. 156.230 and 156.235, the Invitation, existing STATE managed care network adequacy standards, and the requirements of this Agreement, together with instructions and guidance issued by the STATE. The network adequacy requirements and standards for Essential Plans must be consistent with the network adequacy requirements and standards that exist outside of the Marketplace pursuant to the NY Public Health Law and regulation.

2. In establishing the network, CONTRACTOR must consider the following: anticipated enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services covered in each product, the number of providers who are not accepting new patients, and the geographic location of the providers and Enrollees.

3. To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population and to assure that Enrollees have access to all services without undue delay. This includes geographic accessibility (i.e. meeting time / distance standards) and accessibility for people with disabilities.

4. STATE may, on a case-by-case basis, defer certain network adequacy requirements set forth in this Agreement if it determines there is sufficient access to services in a county. The STATE reserves the right to rescind the deferment at any time, upon thirty (30) days' notice to the CONTRACTOR, should circumstances in a county change.

5. CONTRACTOR must identify any existing network that it intends to use to satisfy network adequacy requirements for Essential Plan.

B. Network Composition

1. CONTRACTOR's network must contain all the provider types necessary to furnish the Essential Plan, including but not limited to hospitals, physicians (primary care and specialists), mental health and substance abuse providers, allied health professionals, ancillary providers, Durable Medical Equipment (DME) providers, home health providers, and pharmacies. Specifically, the CONTRACTOR's network must meet the following:

   a. Each county network must include at least one hospital; however, for the following counties, the network must include at least three (3) hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, New York, Queens;

   b. Hospitals that have 50 or more beds must meet the patient safety standards set forth in 45 CFR 156.1110, including a quality assessment and performance improvement program and discharge planning;

c. Each county network must include the core provider types and ratios established through the Provider Network Data System ("PNDS");

d. Provide a choice of three (3) primary care physicians ("PCPs") in each county, but more may be required based on enrollment and geographic accessibility;

e. Include at least two (2) of each required specialist provider types in each county, but more may be required based on enrollment and geographic accessibility;

f. Time and distance standards:

i. Primary Care Providers: For Metropolitan areas, 30 minutes by public transportation or by car. For non-Metropolitan areas, 30 minutes or 30 miles by public transportation or by car. In rural areas, transportation standards may exceed these thresholds if justified.

ii. Other Providers: CONTRACTOR will undertake its best efforts to meet the 30-minute / 30-mile standard.

2. In its behavioral health network, CONTRACTOR must include individual providers, outpatient facilities, residential treatment facilities, and inpatient facilities. The network must include facilities that provide inpatient and outpatient alcohol and substance use services. Facilities providing inpatient alcohol and substance use services must be capable of providing detoxification and rehabilitation services.

3. In its dental network, CONTRACTOR must include geographically accessible general dentists sufficient to offer each Enrollee a choice of two (2) primary care dentists in their service area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 Enrollees. In addition, dental networks must include at least one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders (TMD) and oral / maxillofacial prosthodontic must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral. The network must include dentists with expertise serving special needs populations (e.g. HIV-positive and developmentally disabled patients).

4. CONTRACTOR must, in accordance with NY Public Health Law section 268-d(1)(b)(vi), contract with any National Cancer Institute-designated cancer center licensed by the STATE within the CONTRACTOR's service area that is willing to agree to provide cancer-related inpatient, outpatient and medical services to Enrollees in such cancer center's service area under the prevailing terms and conditions that the CONTRACTOR requires of other similar providers to be included in the CONTRACTOR's provider network, provided that such terms

shall include reimbursement of such center at no less than the fee-for-service Medicaid payment rate and methodology applicable to the center's inpatient and outpatient services.

C. Essential Community Providers

1. CONTRACTOR must have a sufficient number and geographic distribution of Essential Community Providers, where available, to provide reasonable and timely access to a broad range of such providers for predominantly low-income, medically underserved Enrollees in the CONTRACTOR's service area.

2. CONTRACTOR must include a federally qualified health center and a tribal operated health clinic in each county network, to the extent such providers are available.

D. Sanctioned Providers

1. CONTRACTOR must not include in its network any provider who:

   a. Has, over the previous five (5) year period, been sanctioned or prohibited from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act and/or 18 NYCRR 515.3, and/or 18 NYCRR 515.7.

   b. Has had his or her license suspended by the New York State Education Department or the State Office of Professional Medical Conduct.

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

E. Network Adequacy Review / Process

1. STATE:

   a. Will review network adequacy on a county-by-county basis. For certain network adequacy purposes, the county may be extended by approximately ten (10) miles beyond the county line if CONTRACTOR demonstrates a lack of health care resources or demonstrates that utilization patterns of consumers typically reside outside of the county. In such cases, and in rural areas in particular, CONTRACTOR may contract with providers in adjacent counties to fulfill network adequacy requirements.

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

c. Will, in the event STATE identifies a deficiency in CONTRACTOR's network in the course of the quarterly network review process, provide CONTRACTOR with a Statement of Agreement to: (i) identify the specific deficiency(ies) and (ii) require CONTRACTOR to permit Enrollees to access out-of-network providers in the county / specialty for which a deficiency has been identified; until STATE confirms in writing that the deficiency has been addressed.

d. If CONTRACTOR fails to address the deficiency identified in the Statement of Agreement for two consecutive quarters, STATE may issue a Statement of Deficiency that will require CONTRACTOR to submit a plan of correction for the deficiency that has been identified.

e. If STATE determines that the plan of correction submitted by CONTRACTOR does not adequately address the deficiency identified, STATE may provide CONTRACTOR with written notice that CONTRACTOR'S authority to enroll new Essential Plan applicants will be suspended in the county in which STATE finds the CONTRACTOR's network deficient.

f. If STATE determines in its sole discretion that CONTRACTOR'S network fails to provide appropriate access to services covered by an Essential Plan, after the CONTRACTOR has had notice and an opportunity to cure such deficiency and has failed to do so, the STATE may terminate this Agreement.

g. Reserves the right to update or modify the process for CONTRACTOR'S submission of its network for review and approval by the STATE, with at least sixty (60) days advance notice to CONTRACTOR.

2. CONTRACTOR:

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

b. Must include telehealth indicators on their website to indicate the availability of appointments via telehealth;

c. Will update the provider directory on its website and in the PNDS submission(s) no later than fifteen (15) days following the addition or termination of a provider from its network or a change in a physician's hospital affiliation;

d. Will submit its network through the PNDS in accordance with the instructions included in the Invitation, or as otherwise directed by the STATE. The network submission must include, as applicable, out-of-state providers within the CONTRACTOR's network and must include agreements with specialty centers and centers of excellence. The STATE reserves the right to request further explanation and/or details if the system is not able to capture or accurately identify particular providers.

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

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

g. Must ensure that the consumer network protections set forth in applicable law are available to Enrollees, including those related to emergency medical services and surprise bills;

h. Must notify STATE as soon as they are made aware of any potential network disruptions, including loss of a hospital, pharmacy or large provider group by completing the Disruption Analysis forms on the NY PNDS website.

V. POLICY FORM AND PREMIUM RATE FILING

A. Review of Rates and Forms

1. CONTRACTOR must use the model policy forms provided by STATE, with revisions to the model language limited to the bracketed sections of the model policy forms.

2. CONTRACTOR must accept the Capitation Rate approved by STATE, as further described in this Agreement, and apply the applicable cost-sharing.

3. Form changes to Essential Plans will occur on an annual basis in accordance with instructions from STATE. Annual approval of forms will be incorporated into the STATE's Recertification process for Essential Plans.

B. Plan Management Templates

1. CONTRACTOR must submit to STATE the required Essential Plan templates that provide prescription drug information, service area and contact information, on or before the date provided by STATE.

2. CONTRACTOR acknowledges that data contained within the Essential Plan plan management templates supply information necessary to populate the Marketplace web portal and populate the Essential Plan information for other data transactions. As a result, CONTRACTOR must adhere to instructions and guidance provided by the STATE when populating such templates and correcting information contained in the templates.

VI. QUALITY AND ENROLLEE SATISFACTION

A. Quality Strategy

1. CONTRACTOR must develop and maintain a quality strategy that encompasses all the requirements set forth in section 1311(g) of the ACA (42 USC § 18031(g)). This strategy must be implemented and updated annually with progress reported as designated by STATE. The quality strategy must address the following:

   a. The implementation of quality improvement activities that include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan;

   b. The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

   c. The implementation of activities to improve health outcomes, and patient safety, as well as to reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine and health information technology under the plan or coverage;

   d. The implementation of wellness and health promotion activities;

   e. The implementation of activities to reduce health care disparities, including through the use of language services, community outreach, and cultural competency trainings, and including evaluation of such activities;

   f. A description of any current or proposed innovative programs to expand access to mental health services including but not limited to telepsychiatry or consultative services for co-management of common behavioral health conditions in adults.

2. CONTRACTOR must screen Enrollees for social determinants of health in their preferred language at enrollment or renewal, in accordance with guidelines provided by the STATE.

3. CONTRACTOR must participate in the DOH Quality Assurance Reporting Requirements ("QARR"). The quality indicators in QARR are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance's ("NCQA") health Care Effectiveness Data and Information Set ("HEDIS") with New York State specific measures added to address health issues of importance to the State. QARR data will be used as a major component of issuer quality rankings that will appear on the Marketplace website and will also be used in identifying clinical best practices, as well as areas of concern with respect to quality of care and the administration of the Essential Plan benefit package. The QARR data collected by CONTRACTOR will also be posted on the DOH website.

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

5. CONTRACTOR must collect and report quality measures as well as all other required member-level files as detailed in the QARR annual reporting specifications, as amended. Reporting on quality measures includes:

    a. Providing data required by HEDIS Volume 2;

    b. Use of the NCQA IDSS tool;

    c. Programming for all required measures;

    d. A HEDIS audit of QARR data conducted by a licensed audit organization prior to submission to DOH.

    e. Administering satisfaction surveys through a certified and federally approved CAHPS vendor.

6. CONTRACTOR must annually survey a sample of their Essential Plan Enrollees using the standardized CAHPS Health Plan Survey tool. The CAHPS Health Plan Survey allows STATE to assess many aspects of the Enrollees' experience of care, including their access to care and services and their interactions with their providers and Essential Plan.

7. CONTRACTOR must have the infrastructure in place that allows them to implement their Quality Strategy and related improvement activities as well as to participate in quality improvement initiatives sponsored by STATE. Such infrastructure incudes the ability to administer Enrollee surveys, to offer

member education / outreach or incentive programs, physician training and/or incentive programs, and practice level assessments, among other things.

8. In the event STATE identifies a pattern of deficiency in CONTRACTOR's performance in submitting the QARR data, STATE will provide CONTRACTOR with written notice of such deficiency and an opportunity to cure within the specific time period required by the STATE, which shall be no less than thirty (30) days. If CONTRACTOR fails to cure the deficiency timely, STATE may (i) issue a statement of deficiency, or (ii) suspend CONTRACTOR'S authority to enroll new applicants in the county in which STATE has identified the deficiency. If STATE determines in its sole discretion that CONTRACTOR is failing to provide appropriate access to services covered by Essential Plan after CONTRACTOR has been provided with notice and an opportunity to cure and has failed to do so, the STATE may terminate this Agreement.

B. Essential Plan Quality Incentive Program

1. STATE has established an Essential Plan Quality Incentive Program, subject to available funding, to provide financial incentives to Essential Plan issuers based upon QARR and CAHPS survey results for Enrollees and quality measures established by the STATE.

2. STATE shall, on an annual basis, provide CONTRACTOR with the methodology for awarding points under the Essential Plan Quality Incentive Program based on quality and satisfaction measures established by STATE. STATE shall also provide CONTRACTOR with direction on the format and timing for the submission of data required by the Essential Plan Quality Incentive Program to assess compliance with the established measures and award points under the Program.

3. STATE will produce statements of deficiency within the prescribed time period as detailed in the Quality Incentive Program announcement letter, for CONTRACTOR's failure to meet established quality measures that may include QARR, plan network, provider directory, member services, behavioral health parity, claims payment, race and ethnicity reporting and social needs screening. STATE will deduct points from Essential Plan Quality Incentive Program scores for failure to meet the established measures.

4. STATE may, based on available funding, provide opportunities for CONTRACTOR to receive bonus points through the Quality Incentive Program for varying measures established by STATE. CONTRACTOR may earn bonus points based on reports required by STATE with respect to such measures.

VII. ELIGIBILITY AND ENROLLMENT

A. Obligations of STATE

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

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

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

4. The STATE will redetermine Essential Plan eligibility every 12 months and allow for transition to another Insurance Affordability Program in accordance with the BHP Blueprint or the 1332 STC, the requirements of state and federal law and state policies and procedures.

5. Enrollees will have at least twelve (12) months of continuous coverage regardless of changes in circumstances, as long as the enrollees are under age 65, are not otherwise enrolled in minimum essential coverage and remain New York State residents; unless eligibility is re-determined sooner based on new information received and verified from Enrollee reports or data sources. If an Enrollee becomes pregnant and remains in Essential Plan, the Enrollee will have coverage for the duration of the pregnancy and for one (1) year post-partum.

6. STATE will provide Enrollees with an annual notice of redetermination of eligibility. If an Enrollee remains eligible for coverage in an Essential Plan, the STATE will provide Enrollee with notice of a reasonable opportunity at least annually to change plans. Enrollee will remain in the plan selected for the previous year unless the Enrollee terminates coverage in the plan by selecting a new plan, withdrawing from a plan, or the plan is no longer available.

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

8. To ensure coverage is effective in a timely manner, the STATE will provide to the CONTRACTOR and to potential enrollees a transaction identification number. The CONTRACTOR may require potential enrollees to provide the transaction identification number when making an initial payment of premium to CONTRACTOR, if any.

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

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

11. STATE will communicate and coordinate with the CONTRACTOR with respect to the processes, file formats and technology required for the transmission of enrollment data by and between the STATE and the CONTRACTOR.

12. STATE must initiate termination of the enrollment of individual Enrollees and permit CONTRACTOR to terminate such coverage in accordance with applicable law, including the following circumstances: Enrollee is no longer eligible for coverage; rescission of coverage; termination or decertification of an Essential Plan; Enrollee change from one plan to another ; and non-payment of premiums for coverage of the Enrollee and the exhaustion of the 30-day grace period to pay any premium prior to disenrollment.

B. Obligations of CONTRACTOR

1. CONTRACTOR must accept new Essential Plan enrollments all year, meaning that Eligible Individuals may enroll in an Essential Plan in accordance with applicable law at any time of the year.

2. To the extent that CONTRACTOR authorizes employees or representatives to provide application assistance to individuals applying for Insurance Affordability Programs through the Marketplace, including Essential Plans, CONTRACTOR must comply with the provisions of Appendix C-1 of this Agreement and the Invitation regarding the Marketplace Facilitated Enrollment ("MFE") Program

3. To the extent that CONTRACTOR authorizes Producers to provide application assistance to individuals applying for Insurance Affordability Programs through the Marketplace, including Essential Plan, starting January 1, 2026, CONTRACTOR must not pay commissions to Producers for new Essential Plan enrollment or the renewal of existing Essential Plan enrollment. CONTRACTOR must not provide remuneration to Producers based upon the volume of enrollment or the number of Marketplace applications submitted.

4. CONTRACTOR must make available for purchase in the Marketplace the Essential Plans that have been certified by the Marketplace. Eligible individuals will be able to enroll directly through the Marketplace website, or may use an authorized agent or broker, Navigator, Certified Application Counselor, or Marketplace Facilitated Enroller; and, to the extent permitted by federal and State law and regulation, other third-party assistors or CONTRACTOR customer service representatives.

5. Applicants who meet the eligibility standards qualify for an Essential Plan as follows:

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

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

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

d. individuals with income greater than 100 percent and less than or equal to 138 percent of FPL Not Eligible for Medicaid Due to Immigration Status ("Essential Plan 3"), or

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

6. Individuals who are determined eligible to enroll in the Essential Plan offered through the Marketplace shall have a coverage effective date of the first of the month in which an Essential Plan is selected. For example, an individual who selects an Essential Plan on February 20, 2026 will have coverage in the Essential Plan starting February 1, 2026.

7. For Essential Plan renewals, the effective date is the first day of the following month.

8. Enrollees who fail to renew before their eligibility end date, but who renew within thirty (30) days of the end date and remain eligible for Essential Plan and for the same health plan will have retroactive enrollment to the first of the month so there is no gap in coverage. For example, an Enrollee with an end date of June 30, 2026 who fails to renew timely, but who completes a renewal on July 12, 2026 and elects to remain enrolled with the same health plan will have a July 1, 2026 start date.

9. Enrollees who renew coverage in an Essential Plan after the fifteenth of the month in their last month of coverage will have no gap in coverage. Coverage will begin on the first day of the following month and they will be enrolled in the same plan. Enrollees who renew coverage in an Essential Plan after the fifteenth of the month in their last month of coverage who opt to select a new plan will be enrolled in their current plan the first of the following month and will transition into their new plan the first of the next month. For example, an Enrollee whose coverage ends on December 31, 2026 who returns to their Marketplace account on December 20, 2026 and completes necessary updates and remains eligible for

the Essential Plan will be enrolled in their same plan beginning January 1, 2027. If the Enrollee selects a new Essential Plan, they will be enrolled in their same plan beginning January 1, 2027 and the coverage in their new plan will begin February 1, 2027.

10. For a Qualified Health Plan (QHP) enrollee who transitions from a QHP to Essential Plan, the coverage effective date will generally be the first day of the following month. For example, if the QHP enrollee is found eligible for Essential Plan and enrolls on February 20th, the first day of Essential Plan coverage is March 1st.

11. For a Medicaid or Child Health Plus enrollee who transitions to Essential Plan, the coverage effective date for Essential Plan is generally the first of the following month. For example, if the Medicaid enrollee is found eligible for Essential Plan and enrolls on February 20th, the first day of Essential Plan coverage is March 1st.

12. Enrollment is not effectuated until CONTRACTOR receives initial payment of Premium, if applicable, from the prospective enrollee and sends a confirmation 834 transaction to the STATE (the "Coverage Effective Date"). Unless otherwise required under federal law, CONTRACTOR must provide a ten (10) day grace period to Enrollees for their initial premium payment, if applicable, to effectuate coverage. Initial payments received by the 10th of the month in which the initial coverage is in effect will be considered timely.

13. CONTRACTOR will not be financially responsible for any claims incurred by a prospective enrollee until the initial Premium payment, if applicable, is made prior to or during the ten (10) day grace period. CONTRACTOR will be financially responsible for any claims incurred during the ten (10) day grace period if the prospective enrollee pays the initial Premium prior to or during such ten (10) day grace period.

14. After enrollment is effectuated, CONTRACTOR must provide Enrollee with a thirty (30) day grace period to pay Premiums, if applicable, prior to disenrollment.

15. CONTRACTOR must provide Enrollees with reasonable notice of past due Premiums, if applicable, and an opportunity to pay prior to disenrollment.

16. If CONTRACTOR receives an application directly from a potential enrollee for enrollment in a Essential Plan, the CONTRACTOR must either (i) direct the applicant to the Marketplace for a determination of eligibility and enrollment in an Essential Plan if eligible, or (ii) ensure the applicant received an eligibility determination from the Marketplace through the Marketplace website, whether

through an assistor (i.e. Navigator) or by enrolling the individual directly if and when permitted by federal regulation.

17. CONTRACTOR must not, with respect to its Essential Plan(s), discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

18. CONTRACTOR must accept retroactive enrollments from the STATE in special circumstances as determined by the STATE. Such circumstances include retroactive enrollments required to comply with eligibility appeals processes, or retroactive enrollments required to correct an error of the STATE or the CONTRACTOR, and other such cases agreed to by STATE and CONTRACTOR. In such cases, the Enrollee must pay in full his or her share of Premiums for all months of coverage received.

C. Enrollment / Disenrollment Transactions

1. CONTRACTOR must accept enrollment information in an electronic format, in a manner consistent with applicable privacy and security provisions of state and federal law and administrative guidance. CONTRACTOR must enter into a Trading Partner Agreement with STATE to address the secure exchange of HIPAA compliant health care transactions.

2. The STATE must transmit enrollment data to CONTRACTOR via HIPAA compliant 834 transactions. CONTRACTOR must be prepared and able to accept daily enrollment information in a HIPAA compliant 834 transaction and acknowledge receipt of enrollment information by returning HIPAA compliant 999 transactions to STATE, as well as such other HIPAA compliant transactions as may be necessary pursuant to this Agreement. The transfer of enrollment data and other HIPAA compliant transactions shall be conducted pursuant to the Trading Partner Agreement attached as an Appendix to this Agreement and Trading Partner Guides referenced in such Trading Partner Agreement, as amended from time to time.

3. STATE will transmit 834 transactions to CONTRACTOR on a daily basis and CONTRACTOR must process these transactions regularly, in accordance with the following timeframes:

   a. Transaction files, including maintenance and termination transactions, must be picked up daily;

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

c. Effectuation transactions must be sent within five (5) business days of the grace period end date for those enrollees with premium, or within five (5) business days of receipt of the enrollment transaction, for those enrollees with no premium;

d. Terminations and cancellations must be sent within five (5) business days of the termination or cancellation;

e. Error files must be reviewed and errors corrected on a regular basis, but no less often than once per week.

4. In conducting HIPAA transactions, STATE and CONTRACTOR must adhere to the Trading Partner Agreement attached hereto as an Appendix and the individual Trading Partner Guides referenced therein.

5. CONTRACTOR must reconcile enrollment files with the STATE no less than once per month, and in accordance with procedures established by the STATE and as set forth in the Trading Partner Agreement attached hereto as an Appendix.

D. Coverage Effective Date

1. CONTRACTOR must notify an Enrollee of his or her effective date of coverage (the “Coverage Effective Date”).

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

3. As of the Coverage Effective Date, and until the Effective Date of Disenrollment, the CONTRACTOR is, pursuant to the terms and conditions of the Essential Plan, responsible for the coverage of all covered care and services provided under the Essential Plan’s benefit package and delivered to Essential Plan Enrollees, with the exception of benefits provided through state fee for service programs.

4. CONTRACTOR will not be liable for the cost of any services rendered to an Enrollee prior to his or her Coverage Effective Date.

E. Process

1. CONTRACTOR must accept enrollments of Eligible Individuals in the order in which the enrollment information is received without regard to the Eligible Individual’s sex, race, creed, physical or mental handicap/developmental

disability, national origin, sexual orientation, gender identity or type of illness or condition.

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

3. In accordance with federal regulation, CONTRACTOR must offer method of payment options, if applicable, to Enrollees that do not discriminate against individuals without bank accounts or credit cards.

VIII. ENROLLEE RIGHTS AND NOTIFICATION

A. Information Requirements

1. CONTRACTOR must provide all Enrollees an information package as required by 45 C.F.R. 156.265(e), including: (i) a Subscriber Contract and (ii) a Summary of Benefits and Coverage ("SBC") for each tier of Essential Plan

2. The CONTRACTOR must issue such information to the Enrollee as soon as possible but no later than fourteen (14) days after the Coverage Effective Date.

3. The CONTRACTOR must provide Enrollees with an annual notice that the Subscriber Contract and SBC are available upon request.

4. The CONTRACTOR must make information available to prospective Enrollees and Enrollees (including information regarding internal and external appeals rights) in plain language and in a manner that is accessible and timely to individuals with disabilities, including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. CONTRACTOR must:

   a. Provide written materials in a prose that is understood by an eighth-grade reading level except as otherwise required by STATE and must be printed in at least 10-point type.

   b. Make available written materials and other informational materials in a language other than English whenever at least five percent (5%) of the prospective Enrollees or Enrollees of the CONTRACTOR in any county of the service area speak that particular language and do not speak English as a first language; or, alternatively, provide taglines in common non-English languages indicating the availability of written translation materials in any language the prospective or current Enrollees speak.

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

d. Make available verbal interpretation services in any language to current or potential enrollees who speak a language other than English as a primary language to the extent reasonably practicable. Interpreter services must be offered in person where practical but otherwise may be offered by telephone.

e. Have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include readers to assist the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies.

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

B. Provider Directories

1. The CONTRACTOR must maintain and update, and make publicly available, a listing by specialty of all Participating Providers, including facilities (the "Provider Directory"). Such Provider Directory shall include names, office addresses, telephone numbers, specialty, board certification for physicians, any affiliations with participating hospitals, whether telehealth appointments are available, information on language capabilities and wheelchair accessibility of Participating Providers. The Provider Directory should also identify providers that are considered Primary Care Physicians and providers that are not accepting new patients. Consistent with applicable law, electronic versions of such directories shall be updated within fifteen (15) days of the addition or

termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

2. CONTRACTOR must make available to the STATE a URL link that provides access to the CONTRACTOR's Provider Directory. The directory must clearly identify the network of providers participating in Essential Plans. If multiple network configurations are offered by the CONTRACTOR, the directories must clearly identify the network for the particular Essential Plan(s). The directory must clearly distinguish this network(s) from other networks offered by CONTRACTOR so that a consumer using the directory can clearly and easily access the correct directory via the URL link provided to the Marketplace.

3. CONTRACTOR must indicate within its online provider directory when an individual provider, group or facility will be leaving the network when the CONTRACTOR has been made aware in advance.

4. CONTRACTOR must implement a system to periodically verify the accuracy of its reported Essential Plan provider network(s), to validate participation by individual providers and assure that individual providers are aware of their participation in the Essential Plan network(s). Such system may include, but not be limited to, direct outreach to providers listed by the CONTRACTOR as participating in the Essential Plan network(s).

5. CONTRACTOR shall provide to STATE, upon request: (i) a description of its procedures to verify, on an ongoing basis, the availability of individual Participating Providers in its networks and the frequency of its verification efforts; and (ii) reports regarding the results of such verification efforts within a timeframe specified by STATE.

6. CONTRACTOR must develop and implement protocols to address inquiries and complaints concerning provider directories. CONTRACTOR shall provide to STATE the protocols developed within a timeframe specified by STATE.

7. CONTRACTOR must notify Enrollees in writing at least annually that updates to its provider directory are available online, and that updates and/or a copy of the directory may be provided in hardcopy upon request.

C. Appointment Availability

1. CONTRACTOR must, upon request, provide STATE with a description of its appointment availability standards for Participating Providers, for routine and urgent care (office hours / after office hours), including follow-up visits following emergency / hospital discharge, behavioral health and substance use appointments. Such description must include the CONTRACTOR's mechanisms

to verify compliance with appointment availability standards and the manner in which appointment availability standards are made available to the public.

2. STATE shall perform Access and Appointment Availability surveys to assess appointment availability for Participating Providers and the accuracy of CONTRACTOR'S Provider Directory. STATE reserves the right to publicly post Access and Appointment Availability surveys on the NY State of Health website.

3. If CONTRACTOR fails to meet the thresholds for appointment availability set forth in the Invitation and applicable law, including 10 NYCRR 98-5.5, STATE may issue a Statement of Deficiency and require CONTRACTOR to submit a corrective action plan to address deficiency(ies).

4. STATE may deduct points from insurer Essential Plan Quality Incentive Program scores for lack of compliance with appointment availability thresholds (failing to meet the 75% accuracy threshold) starting with Measurement Year 2024.

D. Treatment Cost Calculator for Services Rendered by a Participating Provider

CONTRACTOR must, in accordance with and to the extent required by federal regulations, have a treatment cost calculator available through an Internet Web site and by toll free telephone number for individuals without access to the Internet. Such treatment cost calculators must be able to demonstrate Enrollee cost sharing under the individual's plan, or coverage with respect to the furnishing of a specific item or service by a Participating Provider in a timely manner upon the request of the individual.

E. Member Identification Cards

1. CONTRACTOR must issue an identification card to Enrollees as soon as is possible but no later than seven (7) days following receipt of enrollment transaction from STATE. The identification card shall contain pertinent information including the CONTRACTOR's member services toll free telephone number.

2. If unforeseen circumstances prevent the CONTRACTOR from issuing the official identification card to new Enrollees within the above timeframe, the CONTRACTOR must implement an alternative method by which individuals may identify themselves as Enrollees prior to receiving the card or otherwise make the enrollment and cost-sharing information readily available to the Enrollees and Participating Providers.

F. Member Handbooks / Subscriber Contracts

The CONTRACTOR must issue to a new Enrollee as soon as possible but no later than fourteen (14) days after the Coverage Effective Date, a Subscriber Contract and a Member Handbook.

IX. TERMINATION OF COVERAGE

A. Obligations of STATE

1. STATE must permit an Enrollee to terminate his or her coverage in an Essential Plan in the event of a qualifying event (including as a result of the Enrollee obtaining other minimum essential coverage), upon fourteen (14) days' notice to the STATE before the requested effective date of termination. In such case the last day of coverage is:

    a. The termination date specified by the Enrollee, if the Enrollee provides fourteen (14) days' notice before the requested date of termination;

    b. Fourteen (14) days after the termination is requested by the Enrollee, if the Enrollee does not provide notice at least fourteen (14) days before the requested effective date of termination; or

    c. On a date determined by CONTRACTOR on or after the date on which termination has been requested by the Enrollee, if the CONTRACTOR agrees to effectuate termination in fewer than fourteen (14) days and the Enrollee requests an earlier termination effective date.

    d. If the Enrollee is newly eligible for Medicaid or CHP, the last day of enrollment in an Essential Plan is the day before the individual is determined eligible for Medicaid or CHP.

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

    a. Enrollee is no longer eligible for coverage in an Essential Plan, in which case the last day of enrollment is the last day of eligibility, unless the Enrollee requests an earlier termination date. ;

    b. Non-payment of Premiums, if applicable, for coverage of the Enrollee following the expiration of the thirty (30) day grace period, in which case the last day of coverage is the last day of the month of the grace period.

c. The Essential Plan is discontinued or is decertified in accordance with applicable law.

3. In accordance with 45 C.F.R. 155.430(c), the STATE shall promptly and without undue delay inform CONTRACTOR of Enrollee termination.

B. Obligations of CONTRACTOR

1. CONTRACTOR must not terminate coverage because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services.

2. CONTRACTOR may cancel an Eligible Individual's enrollment in the event that the initial Premium payment is not received during the ten (10) day grace period referred to in this Agreement.

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

4. CONTRACTOR may only initiate termination for failure to pay initial Premium (i.e., Cancellations), rescission, and non-payment of Premium after the thirty (30) day grace period has ended. In all other circumstances, CONTRACTOR may only terminate coverage for an Enrollee after such termination is initiated by the STATE in a standard HIPAA compliant 834 transaction or pursuant to such other procedures designated by the STATE.

5. If the CONTRACTOR determines that termination of Enrollee coverage is warranted in accordance with 45 C.F.R. 155.430, CONTRACTOR may request that termination be initiated by the STATE by providing notice to the STATE in writing or in such other format as the STATE may determine, and shall provide such request promptly and without undue delay. Upon examination and successful validation of such request, the STATE will promptly initiate such termination and provide notice of termination to the CONTRACTOR.

6. CONTRACTOR is not responsible for providing benefits after the effective date of disenrollment.

7. CONTRACTOR must maintain reasonably sufficient records of termination of coverage and retain these records for a period of ten (10) years to facilitate audit functions.

X. RECERTIFICATION / TERMINATION OF ESSENTIAL PLAN AGREEMENT

A. Recertification

1. The STATE shall notify CONTRACTOR of the opportunity for Recertification no later than May 15th each year. CONTRACTOR may add, remove or modify

Essential Plans during the Recertification process in accordance with STATE instruction.

2. The STATE will complete Recertification on an annual basis but no later than two weeks prior to the beginning of the open enrollment date of the applicable calendar year.

B. Non-renewal

In lieu of annual Recertification, CONTRACTOR may opt not to renew Essential Plan(s). CONTRACTOR shall notify the STATE of its decision to not renew in a manner and timeframe that is consistent with existing State law and in accordance with this Agreement. The CONTRACTOR must follow applicable laws and regulations in terminating Essential Plans, including notification to Enrollees. The STATE will monitor the transition process, coordinating processes with Marketplace Customer Service to facilitate transition.

C. Contractor Discontinuance of Counties in Service Area

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

2. In the event that CONTRACTOR proposes to voluntarily discontinue providing Essential Plan(s) in a particular county or counties in its Service Area, the CONTRACTOR shall provide the STATE with a written statement of facts justifying the discontinuance. Any such discontinuance must be determined to be necessary and non-discriminatory.

D. Contractor Failure, Delay or Inability to Comply with the Agreement

Any delay by, or failure or inability of the CONTRACTOR to comply with the terms and conditions of this Agreement, either in whole or in part, in accordance with provisions, specifications, and/or schedules contained herein shall be excused and a reasonable time for performance pursuant to this Agreement, shall be extended to include the period of such delay or nonperformance, if caused by or resulting from fire, explosion, accident, labor dispute, flood, war, riot, acts of God, legal action including injunction, present or future law, governmental order, rule or regulation, or any other reasonable cause beyond the CONTRACTOR'S immediate and direct control, including STATE or another government agency postponing or deferring certain pertinent functions related to the operation of the Marketplace. It is agreed, however, that a cause itemized or referred to above shall not excuse a delay, failure or inability to the CONTRACTOR to perform if such cause arose as a result of the negligence or willful act or omission of the CONTRACTOR which in the exercise of reasonable judgment, could have been avoided by the CONTRACTOR. Pending the restoration, settlement or resolution of the cause for delay, failure or inability of the CONTRACTOR to perform, the

CONTRACTOR shall continue to perform those obligations of this Agreement which are not related or subject to such cause.

E. Contractor Initiated Termination of Agreement

CONTRACTOR must notify STATE of circumstances causing the CONTRACTOR to be unable to perform activities and services required under this Agreement.

If circumstances result in the CONTRACTOR'S inability to perform services, sixty (60) days' notice of termination should be provided by the CONTRACTOR to the STATE with notice to Enrollees of the conclusion of coverage under this Agreement and the availability of conversion rights pursuant to the Subscriber Contract.

F. State Initiated Termination of Agreement

The STATE may cancel this AGREEMENT in the event that the STATE determines:

(i) 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) CONTRACTOR fails to cure statement(s) of deficiency issued by STATE with respect to network adequacy, quality measures, or other requirements of this Agreement within the time period prescribed by STATE;

(iii) 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;

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

G. Process for Termination and Transition of Enrollees

If this Agreement between STATE and CONTRACTOR is terminated for any reason, the CONTRACTOR must work in conjunction with STATE to develop a plan to transition Enrollees to another Contractor in the Enrollee's service area. This plan must include notifying Enrollees of other available health plan options, at least one hundred and eighty (180) days prior to termination and providing follow up letters to remind individuals to enroll with another health plan, in addition to any other requirement under New York State law.

XI. MEMBER SERVICES

1. CONTRACTOR must operate a "Member Services" or "Customer Services" department during regular business hours, which must be accessible to Enrollees via toll free telephone number. Customer service representatives must be available during regular business hours to address complaints and utilization inquiries.

2. CONTRACTOR must maintain a telephone system capable of accepting incoming calls regarding complaints and utilization review outside of regular business hours, providing instructions for leaving a message, and have measures in place to ensure a response to those calls the next business day after the call was received.

3. CONTRACTOR must be prepared to adjust customer service staff to meet expected performance levels on peak Marketplace volume days.

4. Consumer complaints received through the Marketplace and sent to the CONTRACTOR require a response from CONTRACTOR no later than three (3) business days from the day the Marketplace sends the complaint. If the matter involves an urgent coverage issue, the CONTRACTOR must respond and act upon the complaint within 24 hours of receipt. The timeframes in this subparagraph apply regardless of whether the complaint is generated as a result of technical problems with the CONTRACTOR's system or technical problems with the Marketplace system. In the event that the complaint involves a technical error by the Marketplace, or the applicant or Enrollee needs a technical transaction to resolve the complaint, the CONTRACTOR will work cooperatively and diligently with the Marketplace to ensure that coverage is not delayed pending resolution of technical issues.

5. CONTRACTOR shall provide STATE with periodic call center performance reports regarding member services call statistics in accordance with instructions provided by STATE in the Invitation. .

XII. MARKETING

A. Obligations of STATE

1. The STATE must implement a multi-faceted marketing and outreach campaign that is focused on connecting New Yorkers with quality, affordable health insurance through its user-friendly Marketplace website.

2. The STATE must engage in targeted outreach to consumers through navigators, consumer advocates, brokers, Marketplace Regional Advisory Committee members and other stakeholders to promote use of the Marketplace.

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

B. Obligations of CONTRACTOR

1. CONTRACTOR must cooperate in good faith with the STATE's marketing and outreach activities, including the development of advertising and outreach materials for Essential Plans and communication with the Marketplace's External Affairs, Outreach and Marketing team.

2. CONTRACTOR may maintain a direct link to the Marketplace website on CONTRACTOR's website. The STATE will provide approved links for this purpose (also known as "widgets").

3. CONTRACTOR must cooperate with STATE to educate its Marketplace Facilitated Enrollers and Producers about the Essential Plans available through the Marketplace and the process for training and certification by the Marketplace.

4. CONTRACTOR's marketing of Essential Plans may include: (i) advertisements in print, radio, television, outdoor advertising and/or social media, (ii) written and electronic communications sent to CONTRACTOR's members, Participating Providers and brokers, such as newsletters; and (iii) distribution of materials at local community centers, health fairs and other areas where potential enrollees are likely to gather.

5. CONTRACTOR must use the NY State of Health name, logo and branding designated by the STATE in referring to the Marketplace or Insurance Affordability Programs in marketing and outreach activities including any printed materials. Such materials must prominently display the Marketplace website and toll-free telephone number. Such materials must be developed in accordance with the Marketplace co-branding guidelines and receive co-branding approval prior to distribution or publication. STATE will provide co-branding guidelines to CONTRACTOR upon CONTRACTOR's request.

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

7. CONTRACTOR must not employ marketing practices that are designed to have the effect of discouraging the enrollment of individuals with significant health needs in their Essential Plans.

8. CONTRACTOR must comply with provisions of federal and state law regulating advertising materials and marketing practices. CONTRACTOR's advertising materials must accurately reflect general information that would be applicable to potential enrollees. Materials must not contain false or misleading information. CONTRACTOR shall not offer incentives of any kind to potential enrollees to enroll in an Essential Plan or renew their coverage.

9. CONTRACTOR is prohibited from the door-to-door solicitation of potential enrollees or distribution of material, and may not engage in "cold calling" inquiries or solicitation. For purposes of this section, "cold calling" shall not include outreach to individuals enrolled in other products or plans offered by CONTRACTOR or individuals formerly enrolled in products or plans offered by CONTRACTOR.

10. CONTRACTOR may not require Participating Providers to distribute CONTRACTOR prepared communications to their patients. Marketing may not take place in patient rooms or treatment areas.

11. CONTRACTOR must provide copies of advertising materials and/or descriptions of its advertising campaigns to the STATE upon request.

C. Corrective and Remedial Actions

1. If the CONTRACTOR's marketing activities fail to comply with the requirements of this Agreement, the STATE may take any of the following actions as it, in its sole discretion, deems necessary to protect the interests of potential enrollees. CONTRACTOR shall take the corrective and remedial actions directed by the STATE within the specified time frames.

   a. If CONTRACTOR engages in marketing activities that the STATE determines, in its discretion, to be a minor or unintentional violation of the marketing guidelines set forth in this Agreement, the STATE may issue a warning letter to the CONTRACTOR.

   b. If CONTRACTOR engages in marketing activities that the STATE determines, in its sole discretion, to be an intentional or serious breach of the marketing guidelines, or engages in a pattern of minor breaches, the STATE may require the CONTRACTOR to implement a corrective action plan acceptable to the STATE within a specified timeframe.

   c. If CONTRACTOR fails to implement a corrective action plan in a timely manner or commits an egregious violation or breach of this Agreement, the STATE may in addition to any other legal remedy available to the STATE in law or equity:

      i. direct the CONTRACTOR to suspend its marketing activities for a period up to the end of the term of the Agreement;

      ii. suspend new Enrollments, for a period up to the end of the term of the Agreement, terminate this Agreement pursuant to termination procedures set forth herein, and/or decertify CONTRACTOR's Essential Plan(s).

XIII. HIPAA COMPLIANCE / SECURITY

1. CONTRACTOR acknowledges and agrees that it is a Covered Entity, as defined in 45 C.F.R. 160.103.

2. CONTRACTOR acknowledges and agrees that the Marketplace is not a Business Associate of the CONTRACTOR in performing its statutorily required functions pursuant to 45 C.F.R. 155.200.

3. CONTRACTOR must comply with all applicable federal and state laws and regulations to ensure the privacy, security, integrity and availability of information about Enrollees, including but not limited to HIPAA and HITECH. This includes individual Medical Records and any other health and enrollment information that identifies a particular Enrollee.

4. CONTRACTOR must:

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

   b. Maintain information in a timely and accurate manner;

   c. Specify and make available to any Enrollee requesting it (i) the purpose for which information is maintained or used, and (ii) to whom and for what purposes information will be disclosed; and

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

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

6. CONTRACTOR must safeguard PII and PHI with reasonable operational, administrative, technical and physical controls to ensure its confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure. CONTRACTOR must monitor, periodically assess and update these controls to ensure their continued effectiveness.

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

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

9. CONTRACTOR must report to the STATE fully and promptly any use or disclosure of Enrollee data not provided for by this Agreement of which CONTRACTOR becomes aware. Further, the CONTRACTOR must promptly report to the STATE any security incident of which it becomes aware. "Security incident" means the attempted or successful (i) unauthorized access, use, disclosure, modification or destruction of Enrollee information, including PII or PHI, (ii) interference with system operations affecting the exchange of data set forth in this Agreement, and/or (iii) loss of Enrollee information, including PII or PHI, due to the loss or misplacement of hardware, storage devices or paper documents.

XIV. REPORTING / DATA COLLECTION

A. General Requirements

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

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

3. CONTRACTOR must maintain a health information system that collects, analyzes and reports data. The system must be able to report on utilization, claims payment policies and practices, periodic financial disclosures, enrollment and disenrollment information, claim denials, customer service information, rating of provider practices, cost-sharing and payments with respect to out-of-network coverage, prescription drug distribution and cost reporting, quality and customer satisfaction reporting pursuant to the STATE reporting requirements, and any other information requested by the STATE and/or required under applicable federal and state laws or regulations.

4. CONTRACTOR must submit required reports to the STATE in a manner consistent with federal requirements under Section 45 C.F.R. Part 156, or as otherwise instructed by the STATE. STATE must provide at least ninety (90)

days advance notice of its reporting requirements and consult with CONTRACTOR prior to implementation of such reporting requirements.

B. Encounter Data

CONTRACTOR must submit encounter data for all contracted services obtained by each of their Enrollees. Encounters are records of each face-to-face interaction an Enrollee has with the health care system and includes outpatient visits, inpatient admissions, dental care, emergency room and urgent care visits. Encounters for ordered services such as pharmacy and labs shall also be submitted. An encounter is comprised of the procedure(s) or service(s) rendered during the contact and includes information on site of service and may also include diagnosis information. An encounter should be operationalized in an information system as each unique occurrence of recipient and provider. Encounters are to be submitted on at least a monthly or more frequent basis through the STATE designated vendor in a format and manner to be prescribed by the STATE. STATE shall provide at least ninety (90) days advance notice of its reporting requirements and consult with CONTRACTOR prior to implementation of such reporting requirements.

C. Financial Reporting

1. CONTRACTOR must submit financial reports to STATE in a manner and form consistent with the Medicaid Managed Care Operating Report, and as required by State and federal laws and regulations.

2. CONTRACTOR shall achieve a Medical Loss Ratio no less than eighty-six percent (86%) beginning January 1, 2023.

3. CONTRACTOR must agree to also submit separate Premium and expenditure reports, and any additional relevant financial reports and documents related to its financial condition, in a manner and form required by the STATE. STATE shall provide at least ninety (90) days advance notice of its reporting requirements and consult with CONTRACTOR prior to implementation of such reporting requirements.

4. CONTRACTOR shall comply with all requirements outlined at 45 C.F.R. § 156.280 regarding segregation of funds.

D. Prescription Drug Cost

1. CONTRACTOR must report to HHS and/or the STATE prescription drug cost and distribution information in the form, manner and timelines specified by HHS, in accordance with 45 C.F.R. 156.295, including:

a. the percentage of all prescriptions that were provided under the Essential Plan through retail pharmacies compared to mail order pharmacies;

b. the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type, which includes an independent pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State of New York and that dispenses medication to the general public, that is paid by the CONTRACTOR or the CONTRACTOR's contracted pharmacy benefit manager;

c. the aggregate amount and type of rebates, discounts or price concessions (excluding bona fide service fees) that the CONTRACTOR or its contracted pharmacy benefit manager negotiates that are attributable to Enrollee utilization under the Essential Plan, and the aggregate amount of rebates, discounts, or price concessions that are passed through to the CONTRACTOR and the total number of prescriptions that were dispensed; and

d. the aggregate amount of the difference between the amount the CONTRACTOR pays to its contracted pharmacy benefit manager and the amounts that the pharmacy benefit manager pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

E. Transparency Requirements

1. CONTRACTOR must provide, in an accurate and timely manner to be determined by HHS or STATE, the information set forth below and must make such information available to the public:

   a. Claims payment policies and practices;
   b. Periodic financial disclosures;
   c. Data on enrollment;
   d. Data on disenrollment;
   e. Data on the number of claims that are denied;
   f. Data on rating practices;
   g. Information on cost-sharing and payments with respect to any out-of-network coverage; and
   h. Information on enrollee rights under Title I of the ACA.

2. CONTRACTOR must ensure that the above listed information is provided in plain language as defined in 45 C.F.R. 155.20.

3. CONTRACTOR must make available the amount of Enrollee Cost-Sharing for in-network services under the individual's Essential Plan or coverage with respect to the furnishing of a specific item or service by a Participating Provider in a timely manner upon the request of an individual. At a minimum, such information must be made available to such individual through the Internet web site and such other means for individuals without access to the Internet.

XV. INDIANS AND ALASKA NATIVES

1. CONTRACTOR must comply with all applicable laws, rules and regulations relating to the provision of Health Care Services to any Enrollee who is determined by the STATE to be an eligible Indian or Alaska Native as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304(d)). Such requirements include the following:

   a. Indians shall be permitted to enroll in, or change enrollment in, Essential Plans one (1) time per month.

   b. No Cost Sharing shall be imposed on Indians.

   c. CONTRACTOR may not reduce the payment for services to Indian health providers by the amount of any Cost Sharing that would be due from the Indian but for the prohibition in 42 C.F.R. 600.160(b).

2. CONTRACTOR must pay primary to health programs operated by Indian Health Service, Indian tribes, tribal organizations and urban Indian organizations for services covered by an Essential Plan.

3. CONTRACTOR must comply with other applicable laws, rules and regulations relating to the provision of Health Care Services to American Indians, including, the Indian Health Care Improvement Act Sections 206 (25 U.S.C. 1621e) and 408 (25 U.S.C. 1647a).

XVI. INDEMNIFICATION

A. Indemnification by Contractor

1. CONTRACTOR must indemnify, defend and hold harmless the STATE, its officers, agents and employees (the STATE Indemnified Parties) from and against any and all claims, actions, losses, costs, liabilities, damages or deficiencies, including interest, penalties and attorney's fees suffered, incurred or sustained by the STATE Indemnified Parties or to which any STATE Indemnified Parties become subject, resulting from, arising out of or relating to:

a. any and all claims and losses accruing or resulting to any and all CONTRACTOR's subcontractors, 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. Notwithstanding the foregoing, the STATE reserves the right to join such action, at its sole expense, when it determines there is an issue involving a significant public interest.

3. CONTRACTOR shall have no obligation under this section with respect to any claim or cause of action for damages to persons or property solely caused by the negligence of the STATE, its employees, or agents.

4. The indemnity obligation described in this section shall not limit any other rights or remedies available to the STATE or the CONTRACTOR under this Agreement.

B. Indemnification by the STATE

Subject to the availability of lawful appropriations as required by State Finance Law § 41 and consistent with § 8 of the State Court of Claims Act, the STATE shall hold the CONTRACTOR harmless from and indemnify it for any final judgment of a court of competent jurisdiction to the extent attributable to the negligence of the STATE or its officers or employees when acting within the course and scope of their employment. Provisions concerning the STATE's responsibility for any claims for liability as may arise during the term of this

Agreement are set forth in the New York State Court of Claims Act, and any damages arising for such liability shall issue from the New York State Court of Claims Fund or any applicable, annual appropriation of the Legislature of the State of New York.

XVII. CONSEQUENTIAL DAMAGES

Except with regard to claims indemnifiable under the Indemnification section above, or claims arising from the gross negligence or willful misconduct of a Party, neither Party shall be liable to the other Party for any indirect, incidental, special, punitive, exemplary or consequential damages (including, without limitation, any damages arising from loss of use or lost business, revenue, profits, data or goodwill) arising in connection with this Agreement, whether in an action in contract, tort, strict liability or negligence, or other actions, even if advised of the possibility of such damages.

XVIII. OWNERSHIP OF DATA

A. Ownership of Marketplace Data

As between the STATE and CONTRACTOR, all Marketplace Data, as defined below, shall be and will remain the property of the STATE. For purposes of this section, Marketplace Data means data and information created by the Marketplace and relating to the Marketplace, its employees and agents, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the STATE's approval (in its sole discretion), the Marketplace Data will not be (1) used by CONTRACTOR or its subcontractors other than in connection with carrying out its obligations under this Agreement; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by CONTRACTOR or its subcontractors other than in connection with carrying out its obligations under this Agreement; or (3) commercially exploited by or on behalf of CONTRACTOR or its subcontractors. CONTRACTOR hereby irrevocably assigns, transfers and conveys, and will cause its subcontractors to assign, transfer and convey to the STATE without further consideration all of its and their right, title and interest in and to the Marketplace Data. Upon request by the STATE, CONTRACTOR will execute and deliver and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve or enable the STATE to enforce its rights with respect to the Marketplace Data. Notwithstanding the foregoing, the CONTRACTOR shall be responsible for compliance with all federal or state requirements regarding the security and privacy of Marketplace Data that is

within the CONTRACTOR's custody, including the requirements of HIPAA and the NY State Technology Law.

B. Ownership of Contractor Data

As between the STATE and the CONTRACTOR, all CONTRACTOR Data, as defined below, shall be and will remain the property of the CONTRACTOR. For purposes of this section, CONTRACTOR Data means data and information created by the CONTRACTOR and relating to the CONTRACTOR, its directors, officers, employees and agents, Enrollees, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the CONTRACTOR's approval (in its sole discretion), the CONTRACTOR Data will not be (1) used by the STATE or its subcontractors other than in connection with carrying out its obligations under this Agreement and its obligations pursuant to applicable law; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by the STATE or its subcontractors other than in connection with carrying out its obligations under this Agreement and its obligations pursuant to applicable law; or (3) commercially exploited by or on behalf of the STATE or its subcontractors. The STATE hereby irrevocably assigns, transfers and conveys, and will cause its subcontractors to assign, transfer and convey, to the CONTRACTOR without further consideration all of its and their right, title and interest in and to the CONTRACTOR Data, provided however, such assignment shall not be construed to prevent or delay the STATE from access to and use of the CONTRACTOR Data to fulfill its obligations with respect to Essential Plan Certification and Recertification, Provider Network Review, monitoring of Quality and Enrollee Satisfaction, Reporting / Data Collection and other functions of the Marketplace as set forth in this Agreement and in federal and state law and regulation. Upon request by the CONTRACTOR, the STATE will execute and deliver and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve or enable the CONTRACTOR to enforce its rights with respect to the CONTRACTOR Data. Notwithstanding the foregoing, the STATE shall be responsible for compliance with all federal and state requirements regarding the security and privacy of CONTRACTOR Data that is within the STATE's custody, including the requirements of HIPAA and State Technology Law.

XIX. RECORDS MAINTENANCE / EXAMINATION AND AUDIT

A. Maintenance of Contractor Records

1. The CONTRACTOR must preserve and retain all records relating to CONTRACTOR performance under this Agreement in readily accessible form

during the term of this Agreement and for a period of ten (10) years thereafter except that the CONTRACTOR shall retain Enrollees' Medical Records that are in the custody of the CONTRACTOR for ten (10) years after the date of service rendered to the Enrollee or cessation of CONTRACTOR operation, and in the case of a minor, for ten (10) years after majority. The CONTRACTOR shall require and make reasonable efforts to assure that Enrollees' Medical Records are retained by providers for ten (10) years after the date of service rendered to the Enrollee or cessation of CONTRACTOR operation, and in the case of a minor, for ten (10) years after majority.

2. All provisions of this Agreement relating to record maintenance and audit access must survive the termination of this Agreement and shall bind the CONTRACTOR until the expiration of a period of ten (10) years commencing with termination of this Agreement or if an audit is commenced, until the completion of the audit, whichever occurs later. If the CONTRACTOR becomes aware of any litigation, claim, financial management review or audit relating to the fulfillment of the terms of this Agreement that is started before the expiration of the ten (10) year period, the records shall be retained until all litigation, claims, financial management reviews or audit findings involved in the record have been resolved and final action taken.

B. Access to Contractor Records

1. CONTRACTOR must subject itself to audits/reviews by the STATE or its designee, as the Parties deem necessary to determine the accuracy of Enrollee Premium payments if applicable. CONTRACTOR also agrees to audit by the STATE on reasonable and customary terms, subject to applicable State and federal law regarding the confidentiality of and release of confidential Protected Health Information of Enrollees.

2. CONTRACTOR acknowledges and agrees that the STATE must, subject to applicable State and federal law regarding the confidentiality and release of confidential Protected Health Information of Enrollees, have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. CONTRACTOR agrees to maintain such records for possible audit for a minimum of ten (10) years, unless a longer period of records retention is agreed to. CONTRACTOR agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, CONTRACTOR agrees to include a similar right of the STATE to audit records and interview staff in any subcontract related to performance of this Agreement.

C. Contractor Audits or Reviews

1. CONTRACTOR must promptly submit to the STATE the results of final financial, market conduct, or special audits/reviews performed by the US Department of Health and Human Services, and/or any other State regulatory entity that has jurisdiction with respect to the services provided by CONTRACTOR to Enrollees.

2. CONTRACTOR must promptly notify the STATE in writing of any inquiry, audit, investigation, litigation, claim, examination or other proceeding involving CONTRACTOR, or any CONTRACTOR personnel, Participating Provider or other authorized subcontractor that is threatened or commenced by any regulatory agency or other party that a reasonable person might believe could materially affect the ability to perform in accordance with the terms set forth in this Agreement. Such notice shall be provided by CONTRACTOR to the STATE within ten (10) days of CONTRACTOR's receipt of notice regarding such action. CONTRACTOR must comply with the STATE's reasonable requests for information relating to the inquiry; provided, however than any such exchange of information shall be subject to compliance with law and shall not occur to the extent prohibited by order of the court, administrative agency, or other tribunal or regulatory authority having jurisdiction over the matter or by the laws and regulations governing the action. This section shall not be required with respect to disputes relating to claims and other matters noticed to the STATE in the ordinary course of business pursuant to other terms set forth in this Agreement or required by law.

XX. COMPENSATION

A. Capitation Payments

1. After enrollment is effectuated for an Enrollee(s):

   a. STATE shall provide CONTRACTOR with a monthly Capitation Payment for each Enrollee that has enrolled in its Essential Plans. Capitation Rates are based on county in accordance with the rating regions established by STATE. Capitation Payments made to CONTRACTOR must be used in accordance with federal and state laws and regulations, including 42 CFR Part 600 and the 1332 STC.

   b. The monthly Capitation Rates are attached hereto as Appendix J and shall be deemed incorporated into this Agreement without further action by the Parties.

   c. CONTRACTOR shall invoice and collect Premium, if applicable, and Cost-Sharing payments directly from Enrollees and/or third-party entities on behalf of the Enrollee. Such third-party entities may include the Ryan

White HIV / AIDS Programs under Title XXVI of the Public Health Service Act, Indian tribes, tribal organizations or urban Indian organizations, and State and federal government programs.

d. The monthly Capitation Payments to CONTRACTOR shall constitute full and complete payment to the CONTRACTOR for all services that the CONTRACTOR provides, except for the Premium, if applicable, and Cost-Sharing payments due to CONTRACTOR from individual Enrollees and/or third parties on behalf of the Enrollee.

B. Modification of Rates During Contract Period

1. Any technical modification to Capitation Rates during the term of the Contract as agreed to by CONTRACTOR, including but not limited to changes in premium groups, if applicable, eligible populations, or benefit package, shall be deemed incorporated into this Agreement without further action by the Parties upon approval of such modifications by the STATE.

2. Any other modification to Capitation Rates, as agreed to by the STATE and the CONTRACTOR during the term of this Agreement shall be deemed incorporated into this Agreement without further action by the Parties upon approval of such modifications by the STATE and the NY State Division of the Budget as of the effective date of the modified Capitation Rates as established by the STATE and the NY State Division of the Budget.

3. In the event that the STATE and CONTRACTOR fail to reach agreement on modifications to the monthly Capitation Rates, the STATE shall provide formal written notice to the CONTRACTOR of the amount and effective date of the modified Capitation Rates approved by STATE. CONTRACTOR shall have the option of terminating this Agreement in its entirety with respect to specific Essential Plans in a county or counties of CONTRACTOR's service area, if such approved modified Capitation Rates are not acceptable. In such case, the CONTRACTOR shall give written notice to the STATE, or entity designated by the STATE, within thirty (30) days of the date of the formal written notice from the STATE of the modified Capitation Rates; specifying the reasons for and effective date of termination. CONTRACTOR must work in conjunction with the STATE to develop a plan to phase-out its Essential Plan(s) and transition Enrollees to another Contractor in Enrollee's service area. This plan must include notifying Enrollees of other available health plan options at least one hundred and eighty days (180) prior to termination and providing follow-up letters to remind Enrollees to enroll with another health plan, in addition to any other requirement under New York State law. As a result, the effective date of termination shall be no less than one hundred and eighty (180) days from the date of the CONTRACTOR's written notice, unless the STATE determines that

an orderly transfer to another Essential Plan may be accomplished in fewer days. The terms and conditions in the CONTRACTOR's phase-out plan must be accomplished prior to termination. During the period commencing with the effective date of the STATE's modified Capitation Rates through the effective date of termination of the Agreement, the CONTRACTOR shall have the option of continuing to receive Capitation Payments at the expired Capitation Rate or at the modified Capitation Rates approved by the STATE and the NY State Division of the Budget for the rate period.

4. If the CONTRACTOR fails to exercise its right to terminate in accordance with this section, then the modified Capitation Rates approved by the STATE and the NY State Division of the Budget shall be deemed incorporated into this Agreement without further action by the Parties as of the effective date of the modified Capitation Rates as established by the STATE and the NY State Division of the Budget.

C. Rate-Setting Methodology

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

2. Notwithstanding the provisions set forth in section C(1) above, the STATE reserves the right to terminate this Agreement in its entirety upon determination by the STATE that the aggregate monthly Capitation Rates are not cost effective pursuant to section 369-gg(2) or 369-ii(1) of the NY State Social Services.

D. Payment of Capitation Rate

1. The monthly Capitation Rate for each Enrollee is due to the CONTRACTOR from the effective date of Enrollment until the Effective Date of Disenrollment of the Enrollee, or termination of this Agreement, whichever occurs first.

2. The CONTRACTOR shall receive a full month's Capitation Rate for the month in which Disenrollment occurs.

3. The 834 transactions (benefit enrollment and maintenance for qualified individuals enrolling in coverage) that are generated by STATE and transmitted to CONTRACTOR, and successfully processed by CONTRACTOR as set forth in the 820 Transactions (payment order / remittance advice) that are returned to the STATE by the CONTRACTOR to acknowledge receipt, shall be the enrollment lists for purposes of eMedNY or any successor claims payment system's premium billing and payment, subject to the ongoing eligibility of enrollees as of the first (1st) day of the enrollment month.

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

E. Denial of Payment of Capitation Rate

In the event that CMS denies payment for new or existing Enrollees based upon a determination that the CONTRACTOR failed to comply with federal statutes and regulatory requirements, the STATE will deny payment of the Capitation Rate to the CONTRACTOR for the same Enrollees for the period of time for which CMS denies payment.

F. State Right to Recover Capitation Payments

1. The Parties acknowledge and agree that the STATE has a right to recover Capitation Payments made to CONTRACTOR for Enrollees who are later determined, for the entire applicable payment month, to have been ineligible for an Essential Plan. Reasons that an Enrollee may be determined ineligible include but are not limited to death, incarceration, or having moved out of the CONTRACTOR's service area. The STATE has the right to recover Capitation Payments from the CONTRACTOR in instances where the Enrollee was inappropriately enrolled into an Essential Plan with a retroactive effective date, or when the enrollment period was retroactively deleted. STATE may only recover Capitation Payments made for Enrollees if it is determined by the STATE that the CONTRACTOR was not at risk for provision of health care services for any portion of the payment period. Notwithstanding the foregoing, the STATE always has the right to recover duplicate Capitation Payments paid for individual Enrollees inadvertently enrolled in multiple health plans whether or not the CONTRACTOR has made payments to providers. All recoveries will be made pursuant to guidelines developed by STATE.

2. The Parties acknowledge and agree that the STATE has the right to recover Capitation Payments paid to CONTRACTOR for Enrollees where the CONTRACTOR has failed to initiate disenrollment in accordance with the timeframes and requirements contained in this Agreement, pursuant to applicable law and regulation. The STATE may recover the Capitation Payment effective on the first day of the month following the month in which the CONTRACTOR was required to initiate the disenrollment.

G. Other Insurance and Settlements

CONTRACTOR is not allowed to pursue cost recovery against personal injury awards or settlements an Enrollee has received. Any recovery against these resources is to be pursued by the STATE, and the CONTRACTOR cannot take

action to collect these funds. Pursuit of Worker's Compensation benefits and No-fault insurance by the CONTRACTOR is authorized, to the extent that they cover expenses incurred by CONTRACTOR.

H. Contractor Financial Liability

CONTRACTOR shall not be financially liable for any services rendered to an Enrollee prior to his or her effective date of enrollment or subsequent to disenrollment.

I. No Recourse Against Enrollees

1. With the exception of the Premium, if applicable, and applicable Essential Plan cost-sharing provided for in this Agreement, the CONTRACTOR hereby agrees that in no event, including but not limited to non-payment by the STATE, insolvency of the CONTRACTOR, loss of funding for this program, or breach of this Agreement, shall the CONTRACTOR or a subcontractor bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Enrollee or person acting on his or her behalf for coverage provided in accordance with this Agreement.

2. This subsection shall not prohibit the CONTRACTOR or the subcontractors as specified in their agreements from billing for and collecting any applicable worker's compensation benefits or no-fault insurance. This subsection supersedes any oral or written contrary agreement now existing or hereinafter entered into between the CONTRACTOR and any Enrollee or persons acting on his behalf. This provision shall survive termination of this Agreement for any reason.

Appendix C-1

Marketplace Facilitated Enrollment (FE) Program

For CONTRACTOR that authorizes employees or representatives to provide application assistance to individuals enrolling in Qualified Health Plans (QHPs) and insurance affordability programs (IAPs) through NY State of Health, The Official Health Plan Marketplace (Marketplace), who are referred to as Marketplace Facilitated Enrollers

I. Background

1. The ACA establishes a streamlined enrollment system for QHPs and all insurance affordability programs (IAPs). The NY State of Health, The Official Health Plan Marketplace (Marketplace) of the New York State Department of Health ("STATE") has developed an integrated application allowing consumers to enroll in any IAP [Medicaid, Child Health Plus, Advance Premium Tax Credits, Cost-Sharing Reductions, and the Essential Plan (1332 State Innovation Waiver or Basic Health Program)] and QHPs through the Marketplace application. To ensure that consumers have as many opportunities as possible to apply through the Marketplace, STATE is expanding its successful Medicaid and Child Health Plus Health Plan Facilitated Enrollment Program to include QHPs and the Essential Plan.

2. CONTRACTOR's employees and representatives may provide application assistance to individuals applying for coverage through the Marketplace provided that: (i) each individual is trained and authorized as a Marketplace Facilitated Enroller ("Marketplace FE" or "MFE") prior to providing such assistance, and (ii) such authorized Marketplace FEs abide by the requirements outlined below.

II. Obligation of CONTRACTOR

1. CONTRACTOR must ensure that its employees and representatives complete the Marketplace approved training program regarding QHP options, IAPs, eligibility and benefits rules and regulations governing all IAPs operated in the State, pass an examination to assure successful completion of the training, and are authorized by the Marketplace.

2. CONTRACTOR must ensure its employees and representatives complete any subsequent training required by the Marketplace, which includes successfully completing annual recertification training.

3. CONTRACTOR must establish procedures to ensure that its Marketplace FEs:

    i. Inform applicants of the functions and responsibilities of Marketplace FEs;

    ii. Disclose to potential applicants any relationships the Marketplace FE has with QHPs or IAPs or other potential conflicts of interest;

    iii. Obtain authorization from the applicant prior to obtaining access to an applicant's Personally Identifiable Information (PII) and maintain a record of the authorization in a form and manner determined by the Marketplace; and

    iv. Inform the applicant that he or she may revoke the authorization at any time.

4. CONTRACTOR must establish procedures to ensure that its Marketplace FEs:

    i. Provide information to individual applicants about the full range of QHP options and IAPs for which they are eligible, which includes providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process;

    ii. Assist individual and employee applicants in applying for coverage in a QHP and for IAPs;

    iii. Help facilitate enrollment of eligible individuals in QHPs and IAPs;

    iv. Act in the best interest of the applicant assisted; and

    v. Do not misrepresent the options available to the applicant.

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

6. CONTRACTOR shall ensure that only authorized MFEs submit applications to the Marketplace using their individual identification number. Use of an MFE

identification number by any individual other than the authorized MFE is strictly prohibited.

7. CONTRACTOR must either directly or through an appropriate referral to an Navigator or non-Navigator assistance personnel or to NY State of Health Customer Service Center, provide or have its staff members and volunteers provide information in a manner that is accessible to individuals with disabilities as defined by the Americans with Disabilities Act, as amended, 42 U.S.C. 12101 et. seq. and section 504 of the Rehabilitation Act, as amended, 29.U.S.C. 794.

8. CONTRACTOR and its Marketplace FEs are prohibited from:

    i. imposing any charge on applicants for application or other assistance related to the Marketplace;

    ii. providing gifts to applicants or enrollees, including gift cards or cash, unless they are of nominal value, as an inducement for enrollment. Gifts, gift cards, or cash may exceed nominal value for the purpose of providing reimbursement for legitimate expenses incurred by a consumer in effort to receive NY State of Health application assistance, such as, but not limited to, travel or postage expenses;

    iii. soliciting any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including "cold calling" inquiries or solicitation. "Cold calling" does not include outreach to individuals enrolled in other products or plans offered by CONTRACTOR or to individuals formerly enrolled in products or plans offered by CONTRACTOR; or

    iv. initiating any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where CONTRACTOR has a relationship with the consumer and so long as other applicable State and Federal laws are otherwise complied with.

9. Compensation for Marketplace FEs:

    i. "Compensation" shall mean any remuneration required to be reported as income or compensation for federal tax purposes.

    ii. CONTRACTOR shall not pay commissions or provide Compensation to Marketplace FEs for new enrollment or the renewal of existing enrollments in Essential Plan and may not provide Compensation based on volume of enrollment or number of applications submitted.

iii. CONTRACTOR shall not offer Compensation to Marketplace FEs, including salary increases or bonuses, based solely on the number of individuals they enroll in Essential Plan or the number of individuals they enroll in particular IAPs. However, CONTRACTOR may base Compensation of Marketplace FEs on periodic performance evaluations that consider enrollment productivity as one of several performance factors during a performance period, subject to the following requirements:

a. CONTRACTOR may not award bonuses or any additional Compensation more frequently than quarterly, or for an annual amount that exceeds ten percent (10%) of a Marketplace FE's total annual Compensation;

b. Sign-on bonuses for Marketplace FEs are prohibited;

c. Where productivity is a factor in the bonus determination, bonuses must be structured in such a way that productivity carries a weight of no more than thirty percent (30%) of the total bonus and that application quality/accuracy must carry a weight equal to or greater than the productivity component;

d. CONTRACTOR must limit salary adjustments for Marketplace FEs to annual adjustments except where the adjustment occurs during the first year of employment after a traditional trainee/probationary period or in the event of a company-wide adjustment;

e. CONTRACTOR is prohibited from reducing base salaries for Marketplace FEs for failure to meet targets related to the volume of applications or enrollments;

f. CONTRACTOR is prohibited from offering non-monetary Compensation to Marketplace FEs, such as gifts or trips, based on the volume of enrollment or number of applications submitted.

iv. CONTRACTOR shall have human resources policies and procedures for the earning and payment of overtime and must be able to provide documentation (such as time sheets) to support overtime Compensation.

v. CONTRACTOR shall keep written documentation, including performance evaluation tools, of the basis it uses for awarding bonuses or increasing the salary of Marketplace FEs and employees involved in the facilitated enrollment program and make such documentation available for

inspection by STATE.

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

11. CONTRACTOR must:

    i. Provide its Marketplace FEs with the equipment necessary to provide in-person application assistance. Except in extraordinary circumstances, applications must be submitted on-line through the Marketplace on-line web portal. Computers must be connected to the internet using the most up-to-date versions of Chrome, Safari, or Firefox. All computers used by Marketplace FEs must have supported Operating Systems and the latest security patches installed.

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

    iii. Identity proof the Marketplace FE using instructions provided by STATE if the Marketplace FE fails the on-line identity proofing process used for the Marketplace.

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

12. CONTRACTOR shall implement plans of correction for Marketplace FEs who are not adequately performing their duties under the Marketplace FE program and shall rescind authorization to act as a Marketplace FE from all employees and representatives who are not adequately performing their duties in accordance with the requirements set forth in this appendix or who are out of compliance with the requirements of the program.

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

14. CONTRACTOR and its Marketplace FEs must refer to the employees and representatives authorized under this appendix only as Marketplace Facilitated Enrollers or Marketplace FEs.

III. Obligations of STATE

1. Provide or approve a comprehensive training program and any subsequent training updates for Marketplace FEs. Training may be delivered by STATE or its designated contractor in person or through on-line training programs.

2. Provide CONTRACTOR with or approve a training curriculum, including a facilitator guide, for use in training its staff members and volunteers.

3. Provide or approve any forms, applications, brochures or other materials needed to provide application assistance and information about the programs available through the Marketplace.

4. Collect information from CONTRACTOR regarding employees or representatives trained and authorized to provide application assistance so that a unique identifier can be created for each Marketplace FE.

5. Provide CONTRACTOR with or approve a form for Marketplace FEs to disclose conflicts of interest.

6. Provide data and reports to CONTRACTOR for use in monitoring Marketplace FE productivity until such time that the organization can generate this information through the Marketplace.

7. Update the list of trained and authorized Marketplace FEs based on information provided by CONTRACTOR, including terminating Marketplace FE accounts when necessary.

Invitation and Requirements for Insurer Certification and Recertification for Participation in 2026

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

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2026 Schedule of Key Events

EVENT	DUE DATE	QHP	SADP	EP
Invitation Released	May 5, 2025	X	X	X
Dental Forms and Rate Filings Due to DFS in SERFFF	May 9, 2025		X	
Letters of Interest Due to NYSoH	May 12, 2025	X	X	X
Medical Rate Filings Due to DFS in SERFF	May 15, 2025	X		
Written Questions Accepted by NYSoH	May 5 - May 27, 2025	X	X	X
Medical Policy Form Filings Due to DFS in SERFF	May 22, 2025	X		
Dental on Exchange Binders Due in SERFF	May 23, 2025		X	
Participation Proposals Due to NYSoH	May 27, 2025	X	X	X
Medical On Exchange Binders are Due in SERFF	June 13, 2025	X		
Provider Network Submission Due to NYSoH	July 23, 2025	X	X	X
Essential Plan Templates Due to NYSoH	July 25, 2025			X
DFS Rate Decision Due Date	August 4, 2025	X	X	
Essential Plan Subscriber Agreements Due to NYSoH	September 5, 2025			X
Plans Must Complete Approval of Information in Issuer Portal	September 12, 2025	X	X	X
Certification of Plans by NYSoH	September 19, 2025	X	X	X

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



Section I: Introduction and Overview

A. Issuing Office and Purpose

This Invitation is issued by the New York State Department of Health ("DOH") to invite:

i. Insurers offering Qualified Health Plans ("QHPs"), Stand-Alone Dental Plans ("SADPs") and Essential Plans ("EPs"), through NY State of Health, the Official Health Plan Marketplace ("Marketplace"), in 2025, to apply for recertification for 2026; and

ii. Other insurers that are licensed or certified in New York State to apply for certain health insurance plans to be certified as QHPs, SADPs, and EPs to be offered on the Marketplace in calendar year of 2026.

Following the submission and review of the information required by this Invitation, the DOH will review whether Applicants and their proposed products meet all federal minimum participation standards and other State requirements necessary for certification as a QHP, SADP or an EP. Applicants and individual plans found by DOH to satisfy all minimum standards and requirements, and in the case of Applicants applying for the first time, Applicants who sign a new Agreement with the DOH, will have products certified as QHPs, SADPs, or EPs available through the Marketplace. This will be the only opportunity for insurers to apply for certification or recertification of products to be offered on the Marketplace in 2026.

The DOH reserves the right to negotiate with Applicants in the best interest of the Marketplace and its consumers, including, but not limited to, ensuring choice for consumers and small businesses, and to provide continuity of coverage for consumers transitioning between Insurance Affordability Programs (Medicaid, EP, Child Health Plus, and QHPs).

NOTICE REGARDING ESSENTIAL PLAN CERTIFICATION:

As explained below, the U.S. Departments of Health and Human Services and Treasury approved DOH's a 1332 State Innovation Waiver application, which changes the authority of the Essential Plan program from section 1331 of the Affordable Care Act to section 1332. From a consumer and insurer perspective, the program will continue under Essential Plan branding even as the legal authority for the program has changed. Unless DOH otherwise provides notice, DOH will approve insurers' EP certifications or recertifications under the 1332 State Innovation Waiver program instead of the 1331 Basic Health Program.

B. Background

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

NY State of Health, the official health plan Marketplace of New York State, is authorized by the Federal Patient Protection and Affordable Care Act of 2010 (the "ACA") and the NY Public Health Law. The NY State of Health Marketplace has successfully increased the affordability and accessibility of health insurance coverage in New York.

As of February 1, 2025, nearly 4.3 million New Yorkers were enrolled in Medicaid through NY State of Health and over 2.4 million people enrolled in a non-Medicaid program through the Marketplace. This includes 221,534 people enrolled in a Qualified Health Plan, 598,812 enrolled in CHPlus, and 1,663,673 enrolled in the Essential Plan.

Between November 1, 2024, and February 1, 2025, nearly 2.4 million New Yorkers visited the NY State of Health website, Customer Service answered over 1.3 million telephone calls, and there were more than 8,365 certified enrollment experts, including navigators, certified application counselors, health plan-based facilitated enrollers ("Marketplace Facilitated Enrollers") and health insurance brokers who worked with NY State of Health consumers. Enrollment assistors helped more than three- quarters (83 percent) of enrollees complete their Marketplace applications during the 2025 Open Enrollment Period. Through its website, NY State of Health makes available to consumers an easy-to-use plan preview, or anonymous shopping tool, which allows individuals to shop for a health plan and to also receive a personalized premium estimate before starting an application. NY State of Health continues to promote the availability of affordable, comprehensive coverage through a multi-channel and multi-lingual statewide paid advertising campaign.

a. 1332 State Innovation Waiver

New York's Section 1332 State Innovation Waiver to expand Essential Plan eligibility to New Yorkers with incomes up to 250 percent of the Federal Poverty Line (FPL) was approved by the U.S. Department of Health and Human Services and U.S. Department of Treasury on March 1, 2024, for a period of five years, and with a subsequent amendment approved in September 2024, the term of the waiver now runs through December 31, 2029. The approved waiver has enabled New York to implement innovative strategies to expand access to high-quality affordable health insurance for New Yorkers. Through this State Innovation Waiver, the Essential Plan has expanded eligibility to New Yorkers with incomes up to 250 percent of the FPL ($39,125 annual income for an individual), and has made high-quality, affordable health coverage available to an additional 400,000 New Yorkers.

Access to coverage through EP is estimated to save New Yorkers between 200 and 250 percent of FPL an average of $6,100 per year, compared to what they would have spent on health coverage through QHP.

On September 25, 2024, NY State of Health received approval of an amendment to the waiver, which provides authority for the Marketplace to implement cost-sharing reductions for consumers enrolled in Qualified Health Plans beginning January 1, 2025.
All QHP and EP enrollees now have $0 out-of-pocket costs for certain services for diabetes and prenatal/postpartum care. In addition, Silver Plan enrollees with incomes up to 400% of the Federal Poverty Level ($60,240 for individuals, $124,800 for families of four) are eligible for additional cost-sharing reductions.

The waiver also established a framework for NY State of Health to develop new approaches to address social determinants of health and add additional services for Essential Plan enrollees.

- Under the 1332 Waiver, NY State of Health will operate the Essential Plan Cooling Program, which will pay for the purchase, delivery, and installation of air conditioners for Essential Plan members with persistent asthma. The program will open in Spring 2025. This initiative is intended to help medically vulnerable individuals cope with public health risks of rising temperatures due to climate change.

- The Office of Drug User Health and NY State of Health are partnering to pilot a behavioral health program at two sites in New York State. Essential Plan members who are at risk for, or have experienced, an overdose will be engaged in a contingency management model of care with the goal of retaining members in care, limiting emergency room visits, and reducing overall costs associated with each member.

b. Expanding Access to Cost-Sharing Reductions in Qualified Health Plans

DOH expanded eligibility for existing Cost-Sharing Reduction (CSR) plans to individuals with higher incomes in order to increase the affordability of QHP coverage starting January 1, 2025. Individuals with incomes up to 350% of FPL who are Advance Premium Tax Credit (APTC)-eligible are eligible for Silver CSR 87 plans, and individuals with incomes above 350% up to 400% of FPL who are APTC eligible are eligible for Silver CSR 73 plans. These CSR plans have significantly lower cost sharing than Standard Silver or Bronze plans.

To offset potential premium impacts in the individual market, DOH will use surplus federal 1332 passthrough funding to reimburse insurers' claims demonstrating the cost-sharing offset between the CSR Silver plans and the standard Silver plans for the newly eligible population, following a similar methodology used for federal cost-sharing reduction payments prior to 2017. The state has begun to make payments to issuers in 2025 with reconciliation to be completed in early 2026.

c. Eliminating Essential Plan and Qualified Health Plan Cost-Sharing for Individuals with Diabetes

Effective January 1, 2025, and continuing in 2026, DOH reduced cost-sharing for non-hospital-based preventive diabetes-related services, supplies and prescription drugs, for QHP and Essential Plan enrollees. The cost-sharing waiver applies to specific items and services and includes medical care, prescription drugs, supplies, and diagnostics, related to the primary diagnosis of diabetes.

Additional specific details and information regarding this initiative can be found in Attachment "U".

Qualified Health Plan

QHP enrollees have $0 out-of-pocket costs for certain diabetes-related services, as outlined in Attachment "U". This cost-sharing reduction is available to QHP enrollees in an on exchange, standard and/or nonstandard plan in all metal levels, except for catastrophic plans. Consumers can remain in the plan of their choice. Specific rules apply to High Deductible Health Plans.

To offset potential premium impacts in the individual market, DOH will use 1332 passthrough funding to reimburse insurers for the cost-sharing they would have otherwise received from QHP consumers for these diabetes-related services. There has been no change to plan premiums, benefits, or actuarial values.

Essential Plan

Essential Plan enrollees also have $0 out-of-pocket costs for certain diabetes-related services, as outlined in Attachment "U". This program is available to enrollees in all Essential Plan variants, including Essential Plan 1-4 and 200 – 250.

DOH will use 1332 passthrough funding to cover cost-sharing for these services for EP enrollees with diabetes.

d. Eliminating Cost-Sharing for Prenatal and Postpartum Services for Individuals in the Essential Plan

Effective April 1, 2024, and continuing in 2026, as part of New York's 1332 Waiver, individuals in the Essential Plan who reported becoming pregnant will remain in the Essential Plan rather than move to Medicaid for their pregnancy and 12 months postpartum. There will be parity in coverage and benefits between Essential Plan and Medicaid individuals. Consistent with Medicaid, copays are to be waived for pregnant individuals and postpartum individuals up to one year. Finally, prior authorization will not be permitted for blood pressure monitors.

e. Eliminating Cost-Sharing for Prenatal and Postpartum Services for Individuals in a Qualified Health Plan

Effective January 1, 2025, and continuing in 2026, DOH eliminated cost-sharing for certain services for pregnant and postpartum enrollees in Qualified Health Plans (QHPs), including (where applicable) deductibles, co-insurance, and co-payments for most services. Removing cost-sharing barriers for this population allows individuals to obtain needed care enabling them to access medical services, lab/x-ray services and supplies, and prenatal testing.

This initiative will apply to on exchange, standard and/or nonstandard plans, except for catastrophic plans.

High-deductible health plans are subject to specific rules. For a high-deductible health plan, consumers must pay the cost-sharing until they have met the minimum deductible amount required for high deductible plans under the Internal Revenue Code, with the exception of certain preventive services. Due to the Affordable Care Act's requirements for coverage of preventive health services, many maternal health services are currently covered without cost- sharing. The United States Preventive Services Task Force (USPSTF) and Health Resources & Services Administration (HRSA) broadly define services that are covered without cost-sharing, which include office visits, prenatal vitamins, and breast pumps and supplies.

Prior to the changes described here, cost-sharing had applied to certain maternal health services, including prescription drugs, mental health/substance use benefits, primary care provider (PCP) and specialist visits to treat co-existing health conditions such as hypertension, asthma, and urinary tract infections.

This initiative eliminates cost-sharing for all *diagnoses and services* for individuals through 12 months postpartum, except for the services outlined in the table below.

There are no required changes to plans' utilization management or prior authorization processes under this initiative, with the exception of blood pressure monitors. Plans must cover blood pressure monitors, including automatic blood pressure monitors, without a prior authorization requirement.

Cost-sharing still applies to physician, nurse practitioner and midwife services for delivery as well as, inpatient hospital and birthing center services for delivery. To offset potential premium impacts in the individual market, DOH will use 1332 passthrough funding to reimburse insurers for the cost-sharing they would have otherwise received from their consumers. Note, cost-sharing would continue to apply for delivery and hospital stays. Details regarding this initiative can be found in Attachment "U".

Cost-Sharing *Will* Apply to the Following Services
Ambulance Services
All Inpatient Services (hospital, rehabilitation, mental health/SUD, hospice)
Emergency Care in a Hospital
Physician, Nurse Practitioner and Midwife services for Delivery
Inpatient Hospital and Birthing Center services for Delivery
Pediatric Vision & Dental



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

A. Participation Requirements

1. Licensure and Solvency

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

Be licensed as an insurer under Articles 42 or 43 of NY Insurance Law or certified under Article 44 of NY Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or

Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to September 1, 2025, and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by September 1, 2025.

2. Choice of Participation

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

3. Service Area

Applicants must apply to participate in their entire service area, as approved by the Department of Financial Services ("DFS") or the DOH, at the time of application, provided all requirements of this Invitation are met. Applicants may apply to the DOH for an exception to this requirement by submitting a written request to the DOH explaining the facts that justify the exception.

The DOH reserves the right to grant exceptions to this requirement on a case-by-case basis when it determines that granting such exception is necessary, non-discriminatory and in the best interest of the Marketplace and consumers. Pursuant to 45 CFR § 155.1055, Applicants seeking participation must cover geographic areas that are established without regard to racial, ethnic, language, or health status- related factors, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

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

4. Public Health Emergencies

In response to a public health emergency, in order to maintain and ensure access to health coverage, the State reserves the right to waive the following provisions, including retroactively:

Eligibility:

- Annual Re-certification: The state shall temporarily waive requirements related to the timely processing of annual recertifications.

Grace Periods:

- The State reserves the right to extend grace periods, as permitted by federal law and/or regulation, for payment of enrollee premium in order to avoid termination or cancellations for non-payment of premium, if applicable, to ensure access to health care services.

5. QHP Applicant Product Offerings

a. Essential Health Benefits

Applicants must agree to provide the Essential Health Benefits ("EHBs") specified by the DOH for calendar year 2026, delineated in Attachment "A." The EHBs must be included in the calculation of the actuarial values of the products.

b. Metal Levels

All products in each metal level must meet the following specified actuarial value ("AV") levels based on the cost-sharing features of the product and determined using the U.S. Department of Health and Human Services ("HHS") AV calculator.

Bronze	• 60% AV
Silver	• 70% AV
Silver CSR *	• 73% AV (350 - 400% FPL)
Silver CSR *	• 87% AV (150 - 350% FPL)
Silver CSR *	• 94% AV (100 - 150% FPL)
Gold	• 80% AV
Platinum	• 90% AV

*Please note only individuals who are not eligible for EP or Medicare can enroll in a CSR product if they have an income below 250% of FPL.

The following de minimis variations from AV are permissible:

Bronze	• -4%/+2% if no major service is covered before deductible • -4%/+5% if one major service is covered before the deductible or is HSA-qualified
Silver	• Individual 0%/+2% • Small Group -4%/+2%
Silver CSR	• 0%/+1%
Gold	• -4%/+2%
Platinum	• -4%/+2%

Note that the minimum AV differential between the Silver plan (70%) AV and the Silver CSR (73%) is 2%.

c. Standard Products

QHP applicants must offer one (1) standard product in each metal level and in every county of its Marketplace service area. The standard product offered by QHP Applicants must include the benefits and visit limits as delineated in Attachment "A," and the cost-sharing limitations delineated in Attachment "B," with the exception that the wellness benefit may be substituted for (a) different wellness benefit(s) in accordance with federal and state regulation and guidance, as well as DFS review and approval.

This requirement applies to the individual market; there is no requirement to offer standard products for the small business marketplace. The standard products for 2026 are provided in Attachment "B."

d. Standard Products with Visit(s) Pre-Deductible

The 2026 standard bronze product includes 3 visits to a primary care provider (PCP) or specialist that are not subject to the deductible; copayments are applicable for these visits.

The 2026 standard silver plan, silver 73 and 87 CSR plans include 1 visit to a primary care provider (PCP) or specialist not subject to the deductible; copayments are applicable for these visits.

e. Child-Only Offerings

In accordance with federal regulation, QHP Applicants must agree to offer a child-only product at each metal level in the individual market. The child- only product must conform to the benefits and visit limits delineated in Attachment "A" and the same cost-sharing limitations delineated in Attachment "B." Only one child-only product is required per metal level. Please note that a QHP Applicant's participation in the State's Child Health Plus program does not satisfy this requirement.

f. Catastrophic Products

QHP Applicants must agree to offer at least one standard catastrophic product in each county of the Applicant's service area in the individual market. The standard catastrophic product can be found in Attachment "B." As part of the Participation Proposal, which is Attachment "F1," the DOH will require QHP Applicant's affirmative intent to offer, or continue to offer, a catastrophic product.

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

An Applicant's decision not to offer catastrophic coverage will be for the entire plan year of 2026.

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

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

g. Out-of-Network Products

An "out-of-network" product is a product that provides coverage for services rendered by health care providers that are not in the health plan issuer's network. QHP Applicants that offer an out-of-network product outside the Marketplace must offer the out-of-network product on the Marketplace, at the silver and platinum levels. This requirement applies to the individual market only.

QHP Applicants that do not offer an out-of-network product outside the Marketplace are strongly encouraged to offer a QHP on the Marketplace with an out-of-network benefit, so consumers have an option to purchase such a product should they chose to do so. An Applicant may use an additional or different license to offer an out-of-network QHP, provided the different or additional license is for an entity within the same family of companies.

h. Non-Standard Products

QHP Applicants may opt to offer up to two (2) "non-standard" products per metal level, as described below, in all or part of its service area, if the partial service area is approved by DOH and DFS in accordance with the requirements stated below, and any applicable DFS instruction or guidance. This non-standard product limit only applies to the individual market; there will be no limit on the number of products offered by an insurer on the small business marketplace.

Non-standard products offered on the Marketplace must have "meaningful differences" from each other and from the standard QHPs. Non-standard QHPs are considered meaningfully different when additional benefits, not included in the Essential Health Benefits are covered (e.g., adult vision, acupuncture).

Non-standard products must allow consumers to easily identify the differences between non-standard products and standard products, so that consumers can determine which plan provides the highest value at the lowest cost to address their needs

All non-standard products must comply with federal and state laws, regulations and guidance and shall be subject to DFS and Marketplace review and approval. Non-standard silver level products, if offered by the issuers, must have an actuarial value of 70%, with a permissible *de minimis* variation of 0/+2% AV.

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

Examples of permissible and non-permissible combinations:

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

QHP Applicants that offered a Bronze QHP that was HSA eligible in 2025, will be permitted to offer the HSA Compliant Bronze set forth in Attachment "B" in 2026, to ensure the HSA can carry over for their respective enrollees.

Child-only products, catastrophic products, out-of-network products, and the HSA Compliant Bronze product set forth in Attachment "B" will not be counted towards the two (2) non- standard product maximum.

i. Prescription Drug Coverage

As required under the federal rules, prescription drug coverage must cover at least the greater of:

(1) One drug in every United States Pharmacopeia ("USP") category and class; or
(2) The same number of prescription drugs in each category and class of the benchmark plan chosen by the state.

All prescription drug information must be submitted to DFS for review. This requirement is not intended to limit the number of drugs that the QHP Applicant may cover in a drug category or class. QHP Applicants are encouraged to develop formularies that exceed the federal requirements when it is determined to be in the best interest of their members.

j. Dental Coverage

Federal law requires coverage for pediatric dental services and permits such services to be covered by health insurers or stand-alone dental carriers. QHP Applicants have the option of embedding pediatric dental coverage within their QHPs, offering QHPs without pediatric dental coverage, or both.

In the event the DOH determines that there is no pediatric stand-alone coverage available in a county, all QHP Applicants in that county will be obligated to offer a QHP with embedded pediatric dental coverage.

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

QHP Applicant's product descriptions must include a plain language description of what services are included within "Basic" and "Major" dental services and must include information about any waiting periods, benefit maximums, any limits on services and benefits that do not count toward the max-of-pocket limit.

As described below in Section 7, SADP Applicants will be required to offer a Standard individual Adult Dental plan, starting January 1, 2026, but will still have the option to offer up to 2 non-standard products.

k. QHP and SADP Naming Conventions

To assist consumers in identifying products and differences between products, QHP and SADP Applicants must use the following naming conventions to identify all QHPs and SADPs offered on the Marketplace, in the order as presented below. Insurers will be required to add the network name associated with each product in the naming convention to assist consumers in identifying the specific network associated with the product. Please note that the absence of field name indicates the product DOES NOT include such coverage.

Individual Market

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	This should be the same product name the Applicant uses to market the product. ***For SADP issuers offering the individual market adult standard dental product (new for 2026), include "Adult Standard" in your product name.***
Metal Tier	Bronze, Silver, Gold, Platinum, Child- Only, Catastrophic	Indicate metal tier using entire the word for metal level.
Standard/ Non-Standard	ST or NS	Indicate standard or non- standard by using "ST" for standard and "NS" for non- standard. ST or NS must immediately follow the Metal Tier.
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of- network coverage.
Network Name	To be assigned by Applicant	Indicate the network name associated with each Product
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29.
Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, Other Significant Details	List the general categories of benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Specify the type of dental coverage embedded in the QHP. If none, leave blank
Dental Coverage Waiting Period	WP	Include "WP" to indicate any waiting periods for adult dental services.

Examples of permissible QHP Individual Market names are shown below:

- ABC Product, Platinum, ST, INN, 123 Network, Dep25,
- ABC Product, Gold, ST, INN, XYZ Network, Dep29
- ABC Product, Silver, NS, OON, Main St Network, Dep29, Family Vision, Family Dental, WP

Small Business Marketplace

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	This should be the same product name the Applicant uses to market the product.
Metal Tier	Bronze, Silver, Gold, Platinum,	Indicate metal tier using the entire word for metal level.
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Network Name	To be assigned by Applicant	Indicate the network name associated with each Product
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29.
Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, Other Significant Details	List the general categories of benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Specify the type of dental coverage embedded in the QHP. If none, leave blank.
Dental Coverage Waiting Period	WP	Include "WP" to indicate any waiting periods for adult dental services.
Domestic Partner	DP	Include only if domestic partners are eligible for coverage.
Family Planning	FP	Include only if the family planning benefit is covered.
Healthy NY	HNY	Include if the product is a Healthy NY product.

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

- ABC product, Platinum, ST, INN, 123 Network, Dep25
- ABC product, Gold, NS, OON, Adult Dental, XYZ Network, Dep29, DP, FP
- ABC product, Silver, OON, Main ST Network, Dep25
- ABC product, Gold, ST, INN, EFG Network, Dep 25, HNY

l. Effective Dates

All certified and recertified products offered through the Marketplace will have effective dates of January 1, 2026, in the individual market. Small group coverage runs on a plan year.

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

QHP Applicants, however, will not be able to establish and offer new products at any time during the year. Products to be offered during calendar year 2026 must be established and submitted to DOH and DFS through this Invitation.

6. Stand-Alone Dental Applicant Product Offerings

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

Effective January 1, 2025, and continuing in 2026, waiting periods will not be permitted for any adult dental services, other than up to 12 months for orthodontics for on exchange individual stand-alone dental plans.

SADP Applicants' product descriptions must include a plain language description of what services are included within "Basic" and "Major" dental services and must include information about waiting periods that apply to covered orthodontia, benefit maximums, any limits on services, benefits that do not count toward the max-of-pocket limit and whether a deductible is applicable for adult dental care benefits.

a. Essential Health Benefits

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

b. The Standard Product

The SADP Applicant must offer one standard pediatric stand-alone dental product in every county of its service area. The standard product offered by the SADP Applicant must include the same pediatric benefits as delineated in Attachment "A." The standard product must comply with federal regulation and DFS guidance. This requirement applies to the individual market.

Beginning January 1, 2026, SADP Applicants must offer a standard individual adult standalone dental plan on the Marketplace.

This standard SADP plan is comprised of 285 CDT (current dental terminology) codes defined in 9

benefit categories. This standard plan will have a $50 individual/$150 family embedded, combined in-network and out-of-network deductible per plan year. The standard plan will have a per individual combined in- and out-of-network annual benefit maximum of $1,500 per plan year.

More information regarding additional details of this standard adult dental plan can be found in the DFS Standard Adult Dental model language and the schedule of benefits., see links below:

- Standard Adult Dental Care Benefit Language
- Dental Cost-Sharing Expenses and Allowed Amount
- Standard Individual Adult Dental Schedule of Benefits

All 2026 SADP Applicants must offer:

- (1) Standard Adult/Family Dental Plan
- (1) Standard Pediatric Only Dental Plan

c. Non-Standard Products

New for 2026, the SADP Applicant may opt to continue to offer up to two (2) non-standard products for the individual market. The SADP Applicant may opt to offer unlimited non- standard products for the small business marketplace.

Non-standard SADP products offered on the Marketplace must have “meaningful differences” from each other and from the standard adult dental plan. Non-standard SADPs are considered meaningfully different when additional benefits are covered.

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

7. Small Business Marketplace

In addition to the above participation requirements, Applicants seeking to participate in the small business marketplace agree to adhere to the following requirements:

a. Definition of a Small Group

Small group is a group that meets the definition of “small group” in the NY Insurance Law and regulations, which is currently defined as a group of one hundred (100) or fewer full time equivalent employees (“FTEs”) over the prior calendar year with at least one common law employee enrolled as defined by federal regulation, (see 26 CFR § 31.3121(d)-1(c)). An employee does not include a sole proprietor or the sole proprietor’s spouse. The small business marketplace will determine the size of the employer by following the definitions set forth by the Department of Financial Services, which can be found on their website at: FAQs: Small Group Expansion to 1-100 Employees | Department of Financial Services

b. Employer Choice

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

c. Product Offerings

Issuers proposing to no longer offer products in 2026 that were certified in 2025 on the small business marketplace, must inform the NY State of Health by the date Medical Policy Forms and Rates are due to DFS as indicated in the 2026 Schedule of Key Events, explaining the reason for the removal.

There will be no designation of "standard" and "non-standard" products in the small business marketplace. That is, Applicants applying for the small business marketplace in 2026 are not required to offer the standard benefits shown in Attachment "B." Applicants must, however, adhere to metal level actuarial value requirements and must agree to offer at least one product at each metal level on the small business marketplace.

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

For Plan Year 2026, Healthy NY (HNY) issuers will continue to have the option of seeking SHOP-certification. This will allow HNY employers to access the Federal small business health care tax credit, if otherwise eligible.

d. Minimum Participation

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

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

e. Health Savings Accounts and Health Reimbursement Accounts

Health Savings Accounts ("HSAs") and Health Reimbursement Accounts ("HRAs") are financial mechanisms created under law and regulated by the Internal Revenue Service ("IRS") that provide individuals with tax advantages to offset healthcare costs. HSAs are accounts held by a trustee or custodian (i.e., a bank) on behalf of individuals. HRAs are accounts held solely by an employer on behalf of an employee. For more information, please visit: https://www.irs.gov/forms-pubs/about-publication-969.

Applicants will be permitted to offer high deductible health plans that meet the IRS requirements and may arrange for the applicable HSA and HRA, if requested by the consumer and/or employer.

f. Non-Discrimination

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

B. Premium Rates and Policy Form Filings

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

Pursuant to Sections 3201, 3231, 4235, and 4308 of the NY Insurance Law, the New York State Department of Financial Services ("DFS") is authorized and directed to review and approve policy forms and premium rates before such policy forms may be issued or delivered. HHS has determined that New York State has an effective rate review mechanism and, as such, New York State is authorized to conduct rate review pursuant to state standards. Accordingly, pursuant to the requirements of the NY Insurance Law, Applicants must file with DFS proposed policy forms and premium rates for Marketplace products and obtain the Superintendent's approval of such policy forms and premium rates prior to issuing or delivering such contracts and prior to QHP certification or recertification.

2. Policy Form Filings

All policy forms for QHP products and SADPs shall be submitted to DFS by the date shown in the 2026 Schedule of Key Events, for approval through the System for Electronic Rate and Form Filing ("SERFF") in accordance with instructions established by DFS and HHS.

DFS will update a checklist and instructions for policy form filings, which will be available on the DFS website. Applicants should use the checklist and instructions to ensure that all policy form submissions are complete.

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

3. Rate Filings

All premium rate applications for Marketplace products must be received by DFS on or before the due date shown in the 2026 Schedule of Key Events for SADP Applicants and QHP Applicants.

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

DFS will develop a checklist and instructions for premium rate filings, which will be available on the DFS website. Applicants should use the checklist and instructions to ensure that all rate application submissions are complete.

QHP Applicants must use the updated federal AV calculator when determining whether the Marketplace products meet the actuarial values required for the respective products. HHS has updated the AV calculator, so Applicants must rerun their products through the updated AV calculator to ensure that all proposed products meet the required AV levels. To the extent the AV calculator is not built into the rate templates, Applicants must include in the rate application, a printout from the AV calculator for each Marketplace product submitted and a clear benefit description for each product submitted. The federal AV calculator can be found at https://www.cms.gov/cciio/resources/regulations-and-guidance/index#plan- management.

4. Provisions Applicable to QHP Applicants

a. Rating Tiers

Individual and small group products in New York State are community rated in accordance with state law, regulations, and guidance. QHP Applicants cannot consider age, sex, health status, occupation or tobacco use when establishing premium rates.

All products shall be initially priced to reflect five tiers, with the following relativities:

Tier	Relativities
Single person	1.00
Single + spouse	2.00
Single + child(ren)	1.70
Single + spouse + child(ren)	2.85
Child only	0.412

These relativities shall apply to 2026 rates in the individual market and the small business

marketplace. The Superintendent of DFS will review and may adjust the relativities for subsequent years.

b. Child-Only Products

QHP Applicants must offer child-only products in conjunction with the standard product designs. Only one child-only product is required per metal level. Separate policy forms must be created and provided to enrollees of child-only products. The Superintendent of DFS will review this requirement and may adjust the factor for subsequent years.

c. Federal Risk Adjustment

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

d. Single Risk Pool Inside and Outside of the Marketplace

Under the ACA and applicable regulations, QHP Applicants must consider all of the enrollees in all non-grandfathered products offered by the Applicant to be members of a single risk pool in the individual market and the small business marketplace, respectively. This requirement applies to products offered both inside and outside of the Marketplace, for each market.

Consequently, if the QHP Applicant offers a small group or individual product on the Marketplace, it should submit one rate adjustment filing per market containing the non- grandfathered products offered inside and outside the Marketplace. DFS will issue instructions as to how to submit the rate adjustment filings. Catastrophic products will have their own risk pool.

e. Premium Rate Periods

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

   For example, if the employer's plan year begins April 1, 2026, the rate provided to that employer will be guaranteed for all employees through March 31, 2027, as well as new employees or special enrollments that occur during the plan year, through March 31, 2027.

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

f. Rating Regions

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

5. Role of Brokers and Agents

To maximize access to health insurance coverage for residents of New York State, brokers, and agents (collectively, "Producers") will be permitted to assist both small groups and individuals in purchasing coverage through the Marketplace.

a. Producer Certification

Producers who have successfully completed the training certification program for each applicable market and entered into an agreement with the Marketplace, will be deemed certified to conduct business in the Marketplace. Such agreements will require Producers to be licensed and in good standing with the DFS.

b. Producer Compliance

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

If a Producer is suspected of unauthorized enrollment, their Marketplace account credentials will be immediately suspended while we investigate the allegations. If unauthorized enrollment is confirmed we will terminate the producer from our system and would refer the case to the appropriate authority including but not limited to law enforcement, the NYS Office of the Medicaid Inspector General (OMIG), and the New York Department of Financial Services, which is the State agency that licenses producers in New York. NYSOH reserves the sole right to allow and terminate access to Producers ability to conduct business through the Marketplace.

c. Producer Compensation

QHP

All QHP Applicants must comply with all applicable provisions of Federal and State law with respect to agent and broker ("Producer") compensation and fees.

Compensation arrangements with Producers with respect to enrollment in QHPs must be the same for products sold inside and outside of the Marketplace. The maximum commission or fee that can be paid to a Producer for enrollment is Four Percent (4%) of premium. "Bonus" payments are not permitted. "Bonus" payments are any additional remuneration to a Producer based on factors such as volume of enrollments or type of enrollments in QHP's.

Please see section III for Producer Compensation in Essential Plan.



Section III: Essential Plans

A. Essential Plan Participation Requirements

On March 1, 2024, the U.S. Department of Health and Human Services and U.S. Department of Treasury ("Departments") approved New York's Section 1332 State Innovation Waiver ("1332 Waiver" or "Waiver") to expand Essential Plan eligibility to New Yorkers with incomes up to 250 percent of the Federal Poverty Line. The waiver was initially approved for five years, from April 1, 2024, through 2028. Subsequently, New York amended the waiver to include cost-sharing initiatives, and the Departments approved to extend the waiver through 2029. The 1332 Waiver and NY Social Services law section 369-ii replace the Basic Health Program ("BHP") and NY Social Services Law 369-gg as the authority for Essential Plan. As of April 1, 2024, New York has suspended its BHP for the Waiver's duration.

The transition to 1332 Waiver authority permits NY State of Health to extend eligibility for the Essential Plan to individuals with incomes up to 250 percent of FPL, as outlined below. This transition was seamless to consumers in 2024, as there were no changes to benefits and costs for eligible individuals below 200 percent of FPL under the 1332 State Innovation waiver and the program will continue to be branded as the "Essential Plan."

If New York's 1332 State Innovation Waiver is suspended or terminated, insurers' Essential Plans will be certified or recertified pursuant to the Basic Health Program.

Essential Plan Applicants must agree to adhere to Essential Plan guidance issued by the DOH, including Essential Plan Guidance 3.1, attached to this Invitation in Attachment "V", and any successor guidance.

Essential Plan Applicants must demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by September 1, 2025, for Plan Year 2026.

1. Choice of Participation

Notwithstanding issues related to non-renewal in Section IV. I. 3., applicants who apply to participate in the Essential Plan may also apply to participate in both the QHP individual market and the QHP small business marketplace but are not required to participate in either. EP Applicants may participate in the Medicaid or Child Health Plus programs but are not required to participate in either program.

2. Service Area

EP Applicants must apply to participate in their entire service area as approved by the DOH at the time of application, provided all requirements of this Invitation are met. EP Applicants may apply to the DOH for an exception to this requirement by submitting a written request to the DOH explaining the facts that justify the exception. The DOH reserves the right to grant exceptions to this requirement on a case-by- case basis, when it determines that granting such exception is necessary,

non-discriminatory and in the best interest of the Marketplace. EP Applicants seeking participation must cover geographic areas that are established without regard to racial, ethnic, language, or health status-related factors, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

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

DOH reserves the right to negotiate service area with EP Applicants, to ensure choice of EP insurer in each county of the state, consistent with federal requirements.

3. Public Health Emergencies

In response to a public health emergency, to maintain and ensure access to health coverage, the State reserves the right to waive requirements related to timely processing of eligibility re-certifications, including retroactively.

4. Benefits, Cost-Sharing and Individual Premium Contributions

a. Standard Essential Plans

EP Applicants must agree to offer all five variations of EP product, which are based on enrollee income as a percentage of FPL and other factors as described below (the "Standard EP"). All Standard EPs below are based on the essential health benefits benchmark plan specified by DOH for calendar year 2026, with the following exceptions: pediatric services will not be included in the benefit, the wellness benefit may be substituted for a different wellness benefit or benefits in accordance with federal and state regulations, guidance and DOH review and approval. DOH will continue to communicate details of benefits changes and rate impact as needed.

The Standard EPs shall include adult vision and dental benefits as part of the health care services with no premium or cost-sharing. EP 1, EP 2, EP 200-250, EP 3 and 4 shall include the adult dental and vision benefits equivalent to those provided under NY Medicaid. For individuals who are pregnant or postpartum, all Standard EPs shall offer coverage equivalent to what is provided to the same population in NY Medicaid, including the expanded doula benefit.[1]

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

[1] EP individuals are eligible for doula services during pregnancy and up to 12 months after the end of a pregnancy, regardless of the pregnancy outcome. Additional information regarding this benefit can be found in the EP model language posted on the NYSOH website.

i. For individuals with incomes greater than 200% and less than or equal to 250% of FPL ("Essential Plan 200-250" in Attachment "G"), EP Applicants must provide the Standard EP. Individual enrollees will have no monthly premium for Essential Plan 200-250 coverage. EP Applicants must also offer a version of this product for the American Indian/Alaska Native ("AI/AN") population with no cost-sharing for any services.

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

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

iv. For individuals with incomes greater than 100% and less than or equal to 138% of FPL, who are not eligible for Federal Medicaid due to immigration status ("Essential Plan 3" in Attachment "G"), EP Applicants must provide the Standard EP.

Pursuant to Section 369-ii and 366(1)(g)(ii) of the NY Social Services Law, in order to maintain coverage for certain non-citizens who have an income at or below 138% of the federal poverty level, and who previously would have qualified for NY Medicaid benefits, EP Applicants must include benefits equivalent to those provided under NY Medicaid, as may be modified from time to time, which include but are not limited to the following additional benefits: non-prescription drugs, orthotic devices, orthopedic footwear, and adult vision and dental services equivalent to the NY Medicaid benefit.

Non-emergency transportation will be covered but administered by DOH. Enrollees will have no monthly premium for Essential Plan 3 coverage.

v. For individuals with incomes at or below 100% of FPL, who are not eligible for Federal Medicaid due to immigration status ("Essential Plan 4", in Attachment "G"), EP Applicants must provide the Standard EP.

Pursuant to Section 369-ii and 366(1)(g)(ii) of the NY Social Services Law, in order to maintain coverage for certain non- citizens who have an income at or below 100% of the federal poverty level, and who would have previously qualified for NY Medicaid benefits, EP Applicants must include benefits equivalent to those provided under NY Medicaid, as may be modified from time to time, which include but are not limited to the following additional benefits: non- prescription drugs, orthotic devices, orthopedic footwear, and

adult vision and dental services equivalent to the NY Medicaid benefit.

Non- emergency transportation will be covered but administered by DOH. Enrollees will have no monthly premium for Essential Plan 4 coverage and will have no cost-sharing on benefits.

b. Standard Essential Plan Plus Adult/Vision/Dental Benefits

Adult vision and dental benefits are included in the health care services in the Standard EP.

c. Additional Features of Essential Plans

Under section III(B)(7) of Appendix C-2023 of the agreement between EP Applicants and the State of New York, EP Applicants must include in the Standard EP, the following features:

i. Care coordination and care management for enrollees, with a focus on enrollees with chronic health conditions;

ii. Foster patient involvement in their health care decision-making, including the use of incentives for appropriate health care utilization and patient choice of provider;

iii. Incentives for the use of preventive services. Incentives may not be in the form of cash or instruments convertible to cash (e.g., checks, money orders, or debit cards) and must be related to the delivery of preventive care services to the Enrollee or the Enrollee achieving a health goal. The value of such incentives must be proportional to the preventive care service or health-related activity completed by the Enrollee. EP Applicants shall not offer an incentive or incentive program to an Enrollee that has not been approved by the Marketplace.

d. Essential Plan Naming Conventions

To assist consumers in easily identifying the EP Plans, all EP Applicants must use the same names for their products, and the Marketplace will attach the insurer logo and/or company name on its website to identify the insurer. The EPs must be labeled as follows:

i. Essential Plan 200 - 250
ii. Essential Plan 1
iii. Essential Plan 2
iv. Essential Plan 3
v. Essential Plan 4

e. Effective Dates

Individuals who are determined eligible to enroll in the Essential Plan offered through the Marketplace shall have a coverage effective date of the first of the month in which an Essential Plan is selected. Plan selection may occur manually, or via auto-assignment. For example, an individual who selects an Essential Plan on February 20, 2026, will have coverage in the Essential Plan starting February 1, 2026.

Individuals who enroll in any variant of the Essential Plan will have the following effective dates:

i. For all EP 3 and EP 4 individuals and newly enrolling EP 1, EP 2, and EP 200-250 individuals, the effective date of Essential Plan coverage will be the first of the month in which they select an EP plan. For example, an individual who enrolls in an Essential Plan on February 15, 2026, will have coverage starting February 1, 2026.

ii. For all EP renewals, the effective date will be the first of the following month.

Note that EP enrollees who renew coverage after the fifteenth of the month in their last month of coverage will have no gap in coverage. Coverage will begin the first of the following month and they will be enrolled into their same plan. Consumers who change plans at renewal and renew after the fifteenth of the month will be enrolled into their same plan the first of the following month and then transitioned to their new plan the first of the next month. For example, an enrollee whose coverage ends December 31, 2025, returns on December 25, 2025, and completes necessary updates and remains eligible for the Essential Plan will be enrolled in their same plan beginning January 1, 2026. If the enrollee is changing plans, coverage in their new plan will begin February 1, 2026.

Additionally, EP members who fail to renew before their eligibility end date, but who then complete a late renewal the following month and remain eligible for the same program and health plan, will have their enrollment backdated so there are no gaps in coverage.

For example, a consumer fails to complete their EP renewal, and their EP enrollment is terminated June 30, 2026. They return on July 12, 2026, renew, and re-enroll with the same EP Issuer; they will be given a July 1, 2026, enrollment start date.

Of note, EP enrollee's plan year runs for a 12-month period beginning on the effective date of the coverage or on any anniversary date thereafter.

Example – Enrollee has an effective date of April 1, 2025. Their plan year would begin on April 1, 2025, and the enrollee's out-of-pocket expenses would accumulate from April 1, 2025, through March 31, 2026, restarting again on April 1, 2026.

f. Compensation

EP Applicants who contract with the DOH to offer the Essential Plan on the NY State of Health Marketplace will receive from DOH, a monthly capitation payment for each member that has enrolled in its EP. The capitation payments made to the issuer must be used in accordance with federal and state laws and regulations, including New York's approved 1332 Waiver State Innovation Waiver plan. EP Applicants will be informed of their monthly capitation payment amount upon availability.

EP Issuers are subject to the Medical Loss Ratio (MLR) of at least eighty-six percent (86%) and to rebating provisions. (*See* ACA § 1331(b)(3); 45 CFR § 158.210(c), 45 CFR § 158.240(b)). The EP Applicant will have ten (10) business days following the determination of its capitation rate to notify the DOH of its final determination on whether to participate in the Essential Plan in 2026.

g. Assistor Compensation

Starting January 1, 2026, EP Issuers must not pay commissions to Producers for new EP enrollment or the renewal of existing EP enrollments; and may not provide remuneration based on the volume of enrollment or number of NYSOH applications submitted. Starting January 1, 2026, for licensed or unlicensed Marketplace Facilitated Enrollers, including any "in-house" personnel of EP Issuers who are licensed brokers, EP Issuers must not:

(i) award bonuses or any additional compensation more frequently than quarterly, or for an annual amount that exceeds ten percent (10%) of annual compensation;

(ii) provide sign-on bonuses. Where productivity is a factor in the bonus determination, bonuses must be structured in such a way that productivity carries a weight of no more than 30 percent of the total bonus and that application quality/accuracy must carry a weight equal to or greater than the productivity component;

(iii) provide non-monetary compensation or bonuses, such as gifts or trips, based on volume of enrollment;

(iv) Reduce base salaries for failure to meet targets related to the volume of applications or enrollments. EP Issuers may base compensation on periodic performance evaluations that consider enrollment productivity and/or retention as one of several performance factors during a performance period.

For licensed or unlicensed Marketplace Facilitated Enrollers and "in-house" personnel who are licensed brokers, EP Issuers must limit salary adjustments to annual adjustments except where the adjustment occurs during the first year of employment after a traditional trainee/probationary period or in the event of a company-wide adjustment.

EP Issuers shall have human resources policies and procedures for the earning and payment of

overtime and must be able to provide documentation (such as time sheets) to support overtime compensation. EP issuers shall keep written documentation, including performance evaluation tools, of the basis it uses for awarding bonuses or increasing the salary of personnel engaged in enrollment assistance for the EP program and make such documentation available for inspection by NY State of Health.

h. Rating Regions and Risk Adjustment

Capitation payments will be made to EP Applicant on a county basis and in accordance with the nine rating regions set forth in Attachments "H" and "I" to this Invitation. The DOH currently risk adjusts for all rating groups within the EP rating structure except for the new 200% - 250% FPL EP applicants.

i. Subscriber Agreements and Template Submissions

EP Applicants must use the subscriber agreements that will be provided to applicants shortly after the release of this Invitation. Revisions to the model language contained in the subscriber agreements will be limited to the bracketed sections of the subscriber agreements. EP Applicants can include their logos and numerical contract-identifying information on agreements. The subscriber agreements must be submitted to the DOH by the due date shown in the 2026 Schedule of Key Events.

EP Applicants must submit the required EP templates to DOH that provide prescription drug information, links to plan information, service area information, plan rates and contact information. The templates must be submitted to DOH by the due date shown in the 2026 Schedule of Key Events.

j. Non-Discrimination

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

k. Summary of Benefit and Coverage

EP Applicants must provide to DOH their Summary of Benefits and Coverage (SBC) for each EP tier for plan year 2026. SBCs should conform to standards set by CMS, available here. Additionally, DOH will provide draft templates to EP Applicants on or before July 1, 2025, which contain special drafting instructions approved by CMS to designate EP as minimum essential coverage. (Draft templates are available in Attachment "S"). EP Applicants must submit the required EP SBCs for 2026 to their assigned plan managers on or before August 31, 2025.



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

A. Administrative Requirements

1. Enrollment and Member Services

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

QHP Applicants and SADP Applicants must adhere to the open enrollment periods and special enrollment periods established under applicable law and guidance. Enrollment is not effectuated until receipt of initial payment of premium from the prospective enrollee.

However, once payment is received, the Applicant must adhere to the grace period standards set forth in federal regulation and DFS guidance for those enrollees receiving advance premium tax credit assistance. For enrollees in the individual market that do not receive advance premium tax credit assistance, once the initial premium is paid, the Applicant must provide a thirty (30) day grace period to pay premiums in accordance with DFS guidance.

b. Enrollment Period for the Essential Plan

The enrollment period in the Essential Plan will be open all year. Eligibility for the Essential Plan will be redetermined every twelve (12) months, unless, as discussed below, an enrollee becomes pregnant. If the enrollee is redetermined EP eligible, a new 12-month enrollment will begin.

If an enrollee becomes pregnant and decides to remain in Essential Plan during the plan year, the enrollee will have coverage for the duration of the pregnancy, along with one (1) year of postpartum coverage. The 12-month postpartum coverage will start on the last day of pregnancy and end on the last day of the 12th month. If the enrollee is then redetermined EP eligible, a new 12-month enrollment will begin.

c. Enrollment/Disenrollment Transactions

Applicants must be able to send and receive HIPAA Compliant 834 and 999 transactions in accordance with the 834 and 999 Companion Guide, developed by the DOH and CMS pursuant to law, regulation, and guidance. In addition, the NYSOH provides these transactions to insurers on a daily basis and Applicants must process these transactions regularly, and more specifically in accordance with the following timeframes:

i. Transaction files, including maintenance and termination transactions, must be picked up daily;

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

iii. Effectuation transactions, which are the basis of Federal Advance Premium Tax

Credit (APTC) payments to issuers, must be sent within five (5) business days of receipt of payment, and must include the insurer-assigned member identification number;

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

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

d. Member Services General Functions

The Applicant must agree to operate a Member Services Department during regular business hours, which must be accessible to Marketplace enrollees via a toll-free telephone line.

Personnel must also be available via a toll-free telephone line (which can be the member services toll-free line or separate toll-free lines), not less than during regular business hours, to address complaints and utilization review inquiries.

In addition, the Applicant must have a telephone system capable of accepting, recording, or providing instruction in response to incoming calls regarding complaints and utilization review during other than normal business hours and measures in place to ensure a response to those calls the next business day after the call was received.

Beginning in 2026 DOH is requiring all Applicants to submit call center performance reports on a quarterly basis. A call center performance template has been included as Attachment "T". These reports will be due from the Applicants to their assigned plan manager on the following dates: April 10th, July 10th, October 10th of 2026, with the final report due on January 10th, 2027.

The Marketplace is requiring Applicants to meet at minimum a 30 second Average Speed to Answer (ASA)and a less than 5% abandonment rate for their incoming calls. These call performance reports should include the following: calls offered, calls answered and the average handle time for calls received related to the Marketplace.

The call performance reporting must indicate if the calls reported are member, provider or a combination of both. The report should outline if the data is specific to EP and QHP or if it includes other Marketplace programs. If the Applicant utilizes a behavioral health vendor for member care, call center reporting from the vendors is required in the same format and timeframe outlined above.

Applicants must be prepared to adjust member services staff to meet expected performance levels on peak Marketplace volume days.

If the Applicant fails to achieve the 30 second ASA or less than 5% abandonment rate DOH will

require an explanation detailing the root cause of the issue. A corrective action plan will be required if there are continued occurrences of failure to meet the thresholds.

DOH will analyze call performance reports throughout 2026 and may update these requirements in future plan invitations.

e. Subscriber Contracts

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

f. Accessibility

Information must be provided to prospective enrollees and enrollees in plain language and in a manner that is accessible and timely to individuals with limited English proficiency ("LEP") and individuals with disabilities, including accessible websites and the provision of auxiliary aids and services at no cost to the individual, in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

The Applicant and its contractors must:

i. Provide written materials in a prose that is understood by an eighth grade reading level and must be printed in at least ten (10) point font type;

ii. Make available written materials and other informational materials in a language other than English, whenever at least five (5%) of the applicants and/or enrollees of the issuer in any county of the service area speak that particular language and do not speak English as a first language; or, alternatively, in any county of the service area where the applicants and/or enrollees of the issuer speak a common non- English language, the issuer must provide taglines in those languages indicating the availability of written translation of materials in any language the prospective or current enrollees peaks;

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

iv. Make verbal interpretation services available in any language to current or potential enrollees who speak a language other than English as a primary language. Interpreter

services must be offered in person, where practical, but otherwise may be offered by telephone;

v. Have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include assistive technologies for the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies; and

vi. To the extent HHS establishes standards on written materials and/or verbal materials for the Marketplace that provides greater protections than the standards set forth above, Applicant shall adhere to such HHS standards.

g. Consumer Complaints

Consumer complaints received through the Marketplace and sent to the Applicant require a response from the Applicant no later than three (3) business days from the day the Marketplace sends the complaint.

If the matter involves an urgent coverage issue, the Applicant must respond and act upon the complaint within twenty-four (24) hours of issuance by the Marketplace.

These timeframes apply regardless of whether the complaint is generated as a result of technical problems with the Applicant's system or technical problems with the Marketplace system.

In the event the complaint involves a technical error by the Marketplace, or the Applicant needs a technical transaction to resolve the complaint, the Applicant will work cooperatively and diligently with the Marketplace to ensure the consumer's coverage is not delayed in any way as a result of waiting for the technical issues to be resolved.

B. Marketing Standards

1. NY State of Health Marketing and Outreach

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

2. QHP and EP Applicant Responsibilities

Applicants are encouraged to conduct advertising campaigns, including but not limited to television, radio, digital, billboards, subway, and bus posters. The Applicants are encouraged to distribute

marketing materials in local community centers, health fairs and other areas where potential enrollees are likely to gather.

The Applicant shall use the NY State of Health logo and branding designated by the DOH in referring to Marketplace products in marketing and outreach activities including any printed materials. Such materials must prominently display the Marketplace website and toll-free telephone number. Applicant will cooperate in good faith with DOH's marketing and outreach activities, including the development of advertising materials and descriptive literature for its Marketplace products.

Applicant may not employ marketing practices that will have the effect of discouraging the enrollment of individuals or small businesses with significant health needs in their Marketplace products.

The Applicant shall comply with all provisions of federal and state law regulating advertising material and marketing practices. The Applicant's advertising materials must accurately reflect general information that would be applicable to a Marketplace enrollee. Materials must not contain false or misleading information. Applicants may not offer incentives to potential enrollees to enroll in a Marketplace product or renew their coverage.

The Applicant may not require participating providers to distribute Applicant-prepared communications to their patients.

Marketing may not take place in patient rooms or treatment areas.

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

C. Network Adequacy

Applicants will establish and maintain a network of participating providers that is consistent with 45 CFR § 156.230 and existing DOH managed care network adequacy standards.

DOH and NY State of Health will continue monitoring issuers' networks to ensure consumers enrolling through the Marketplace have access to the healthcare providers they need. In addition, as previously shared in the 2024 Essential Plan Quality Incentive Program Letter (sent January 7, 2025), NY State of Health will produce Statements of Deficiency for requirements not met by insurers, including plan network and provider directory data accuracy, and will deduct points from insurer EP Quality Incentive Program scores for lack of compliance (failing to meet the 75% accuracy threshold) starting with Measurement Year 2024.

Specifically, Applicants must adhere to the following:

1. General Standards

In establishing the network, the Applicant must consider the following: anticipated enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services covered in each product, the number of providers who are not accepting new patients and the geographic location of the providers and enrollees.

To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the enrollee population and to assure that all services will be accessible without undue delay. This includes being geographically accessible (i.e., meeting time/distance standards) and being accessible for people with disabilities.

2. Specific Standards for QHP Applicants and EP Applicants

a. Network Composition

The QHP Applicant's and EP Applicant's network must contain all of the provider types necessary to furnish the Marketplace products, including but not limited to hospitals, physicians (primary care and specialists), mental health and substance use providers, allied health professionals, ancillary providers, durable medical equipment ("DME") providers, home health providers, and pharmacies. Specifically, the Applicant's network must meet the following minimum standards:

Each county network must include at least one (1) hospital; however, for the following counties and boroughs, the network must include at least three (3) hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, Manhattan, and Queens;

i. Each county network must include the core provider and service types established in the Data Dictionary through the Provider Network Data System ("PNDS") website;
ii. Provide a choice of three (3) primary care physicians ("PCPs") in each county, but more may be required based on enrollment and geographic accessibility;
iii. Include at least two (2) of each required specialist provider types in each county, but more may be required based on enrollment and geographic accessibility;
iv. Meet the following time and distance standards:

Primary Care Providers

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

Dental Providers

- In metropolitan areas – 30 minutes by public transportation or by car;
- In nonmetropolitan areas – 30 minutes or 30 miles by public transportation or car; and

- A time and distance standard of 45 minutes/45 miles may be used in the following rural counties and provider types, where a lack of providers has been demonstrated to DFS:
    - Pedodontics: Allegany, Cayuga, Chemung, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence, Steuben and Tompkins.
    - Oral Surgeons: Essex, Franklin, Lewis, Schoharie and Steuben.
    - Orthodontics: Broome, Cayuga, Chemung, Clinton, Essex, Franklin, Jefferson, Lewis, Madison, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence and Tompkins.

Other Provider Types

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

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

ii. QHP Applicants and EP Applicants are required to have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in QHP Applicants' and EP Applicants' service area;

iii. The QHP Applicant and EP Applicant must make every good faith effort to include in its network the essential community providers defined under federal regulation, and at a minimum, must include in each county network a federally qualified health center and a tribal operated health clinic, to the extent such providers are available;

iv. Qualified Health Plans and Essential Plans are required under State law to contract with National Cancer Institute (NCI) designated cancer centers, licensed by the department within the health plan's service area that are willing to agree to provide cancer-related inpatient, outpatient, and medical services to the plan's enrollees.

Such contract would be under the prevailing terms and conditions that the plan requires of other similar providers included in the plan's provider network but must include reimbursement of at least the fee for service Medicaid rate and methodology applicable to the center's inpatient and outpatient services. (See, Chapter 57 of the Laws of 2022).

Additional information regarding NCI-Designated Cancer Centers can be found here: https://www.cancer.gov/research/infrastructure/cancer-centers/find

v. QHP Applicants and EP Applicants are required to include individual providers, outpatient facilities, residential treatment facilities, and inpatient facilities in its behavioral health network. The network must include facilities that provide inpatient, and outpatient mental health and inpatient and outpatient alcohol and substance use services. Facilities providing inpatient alcohol and substance use services must be capable of providing detoxification and rehabilitation services.

Pursuant to applicable law, QHP Applicants and EP Applicants are required to notify enrollees of significant changes in their networks which will be effective in the 2026 plan year. Applicants are required to submit disruption analysis reports to the NY State of Health, when a network is scheduled to have a hospital disenroll, an IPA or major medical group, or is scheduled to lose or change their pharmacy carrier.

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

b. Specific Standards for Dental Benefits and Stand-Alone Dental Carriers

The Applicant's dental network shall include geographically accessible general dentists sufficient to offer each enrollee a choice of two (2) primary dentists in their service area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 enrollees. Networks must also include at least two (2) orthodontists, one (1) pediatric dentist and at least one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders ("TMD") and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral.

The network must include dentists with expertise serving special needs populations (e.g., HIV+ and developmentally disabled patients).

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

3. Sanctioned Providers Applicable to All Applicants

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

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

ii. Had their license suspended by the New York State Education Department or the

Office of Professional Medical Conduct.

4. Method of Review

Network adequacy shall be reviewed by the DOH on a county-by-county basis. For some network adequacy purposes, however, the county may be extended by the DOH in the event the Applicant demonstrates a lack of health care resources or demonstrates that utilization patterns of consumers typically reside outside the county. In such cases, and for rural areas, Applicants may contract with providers in adjacent counties to fulfill the network adequacy requirements, as determined by the DOH.

5. Frequency of Review

The DOH shall review the adequacy of an Applicant's network upon submission of the application, and on a quarterly basis thereafter. Pursuant to NY Insurance Law § 3217-1(a)17, NY Insurance Law §4324(a)(17) and NY Public Health Law § 4408(r), Applicants must update their online directory, as well as their PNDS submission(s) within fifteen (15) days of becoming aware of the addition or termination of a provider from its network, or a change in a physician's hospital affiliation.

6. Submission of the Network

The Applicant shall submit its network through the Provider Network Data System, https://pnds.health.ny.gov , in accordance with instructions issued by the DOH and the Provider Network Submission Instructions set forth in Attachment "P". Submissions must include out-of-state providers within the Applicant's network and must include arrangements with specialty centers and centers of excellence. The DOH reserves the right to ask for further explanations and/or details in the event the system is not able to capture or accurately identify particular service providers.

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

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

D. Enhancements to Network Information

In addition to the Network Adequacy requirements set forth in Section IV(C), all Applicants shall adhere to the following, unless otherwise specified:

1. Provider Directories

The Applicant shall maintain an up-to-date listing of providers, including facilities and specialty providers, participating in the products offered through the Marketplace (the "Marketplace Provider Directory"). The Marketplace Provider Directory must include names, office addresses, telephone numbers, board certification for physicians, any affiliations with participating hospitals, information on language capabilities and wheelchair accessibility of participating providers. The Marketplace Provider Directory should also identify providers that are considered Primary Care Physicians and identify providers that are not accepting new patients. Consistent with NY Insurance Law § 3217- 1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), such directories shall be updated within fifteen (15) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

The Applicant must make available to DOH, a URL link that provides access to the Applicant's Marketplace Provider Directory. The directory must clearly identify the network of providers participating in the Marketplace QHPs, SADPs or EPs.

If multiple network configurations are offered by the Applicant, the directories must clearly identify the network(s) for the particular Marketplace product(s). For example, if one network is used for an Applicant's standard QHP products, but a different network is used for one particular non-standard QHP product, the provider directory for the standard product and non- standard product must be distinct and identifiable to a consumer. The directories must distinguish individual network(s) offered by the Applicant so a consumer using the directory can clearly and easily access the correct network via the URL link provided to the Marketplace. For tiered networks, the directory must clearly identify the tier in which the provider participates. Applicants should include the word 'NYSOH Marketplace' on their internal provider directory websites to assist consumers with identifying which networks belong to Marketplace products.

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

2. Verification of Networks and Appointment Availability Standards/Monitoring

- The Applicant shall provide their process to periodically verify the accuracy of its reported Marketplace provider network(s). Such process may include, but not be limited to, direct outreach to providers listed by the Applicant as participating in Marketplace networks. The Applicant shall provide to the DOH, the method and frequency with which it will carry out such verifications and report to the DOH the results of such verification efforts within a timeframe specified by DOH. The goals of such processes are to validate participation by providers and to make sure providers are aware of their participation in Marketplace networks.

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

- DOH will periodically perform Access and Appointment Availability Surveys to assess accuracy of provider network information and appointment scheduling timeframes and request corrective action plans as appropriate.

- DOH reserves the right to publicly post the results of these Access and Appointment surveys by issuer on the NY State of Health website. The 2024 survey results can be found here: https://info.nystateofhealth.ny.gov/provider-access-and-availability-survey-results"

- DOH and NY State of Health will continue monitoring issuers' networks to ensure consumers enrolling through the Marketplace have access to the healthcare providers they need. In addition, as previously shared in the 2024 Essential Plan Quality Incentive Program Letter (sent January 7, 2025), NY State of Health will produce Statements of Deficiency for requirements not met by insurers, including plan network and provider directory data accuracy, and will deduct points from insurer EP Quality Incentive Program scores for lack of compliance (failing to meet the 75% accuracy threshold) starting with Measurement Year 2024.

3. Addressing Provider Directory Disputes

Applicants must develop and implement protocols to effectively address inquiries and complaints concerning provider directories. Applicants shall provide to the DOH the protocols developed within a timeframe specified by DOH.

4. Treatment Cost Calculators for Participating Providers

The QHP Applicant and EP Applicant must have in place a treatment cost calculator available through an internet website and such other means for individuals without access to the internet. Such treatment cost calculators must be able to demonstrate enrollee cost-sharing using current price data under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual.

E. Consumer Network Protections

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

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

i. QHP Applicants and EP Applicants must hold its members harmless from liability for all out-of-network emergency ("ER") bills. In addition, QHP Applicants and EP Applicants must hold their member harmless from liability for non- emergency ("non-ER") surprise out-of-network bills: (a) for services rendered by a non- participating physician at a participating hospital or ambulatory surgical center where an in-network provider is unavailable, or a non- participating physician renders services without a member's knowledge, or unforeseen medical circumstances arise (unless a participating physician is available and the member chose to obtain services from a non-participating physician); or (b) whenever a participating physician refers a member to an out-of-network provider without the member's written consent.

ii. QHP Applicants and EP Applicants shall allow their members to request a referral to an out-of-network provider or request prior authorization to have a service provided by an out-of-network provider, when there is not an appropriate in- network provider available to the member.

iii. QHP Applicants and EP Applicants must allow members to request:

- A standing referral to a specialist provider when the enrollee's condition requires ongoing care from the specialist provider;
- A referral to a specialist responsible for providing or coordinating the member's care when the member has a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which may require specialized medical care for a prolonged period of time; and
- Direct access to primary care services and preventive obstetric and gynecologic services within the network of providers without having to obtain a referral.

iv. QHP Applicants and EP Applicants will provide its members with all grievance, utilization review and external appeal rights, including the ability to appeal a denial for an out-of-network referral and external appeal rights to denials for an out-of-network referral.

v. QHP Applicants and EP Applicants will provide to its members and to DOH, information on cost-sharing and payments to providers with respect to any out-of- network coverage pursuant to 45 CFR § 156.220(a)(7) and consistent with Part H of Chapter 60 of the Laws of 2014 (the "Out-of-Network Law").

vi. QHP Applicant and EP Applicant may use a treatment cost calculator to provide estimates of out-of- pocket expenses for receiving services at an out-of-network provider, provided such calculators provide the information required by the Out- of-Network Law. Upon request, QHP Applicant and EP Applicant will provide a URL link to its

out-of-network treatment cost calculator.

F. Prescription Drug Benefits

1. Formulary Requirements

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

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

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

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

QHP Applicants and EP Applicants must comply with NY Public Health Law § 4406-c, and NY Insurance Law § 3216(i)(27), (28), § 3221(a)(16), § 3221 (l) (18), and § 4303(jj), (kk). Formularies will be reviewed to ensure the intent of the state law is being followed. QHP Applicants and EP Applicants should not place all prescription drugs to treat a specific condition on the highest tier or should provide information to DOH or DFS to demonstrate that they are otherwise in compliance with 45 CFR §156.125 which prohibits discriminatory benefit designs.

2. Pharmacy and Therapeutics Committee

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

3. Pharmacy Rules

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

4. Prescription Drug Co-payments

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

Insurance Law § 4325(h) and NY Public Health Law § 280-a, NY Public Health Law § 4406-c(6) or NY Education Law § 6826- a.

G. Quality and Enrollee Satisfaction

1. QHP Applicant Requirements

a. Quality Rating System

New York will use U.S. Centers for Medicare and Medicaid Services ("CMS") generated quality ratings in 2025, which is based upon data provided to CMS by health insurers in 2024. Each rated health plan has an "overall" quality rating, ranging from 1 to 5 stars, which accounts for member experience, medical care and health plan administration.

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

b. Quality Improvement Strategy ("QIS") or Quality Strategy("QS")

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

We strongly recommend Applicants post the content of their QIS and QS information on their public website in a form that is appropriate for the public to review.

c. Quality Improvement Strategy ("QIS")

QHP Applicants that offered QHP coverage through the Marketplace in 2023 and 2024, and continues operating in the Marketplace through 2025, and had more than 500 QHP enrollees in a "product" (defined by CMS for this purpose as insurer model, including HMO, EPO, PPO, POS, etc.) as of July 1, 2024, must submit at least one QIS Implementation Plan form. When a QHP Applicant is continuing a QIS, the applicant must submit a QIS Progress Report Form for the 2026 Plan Year.

QHP Applicants that meet the eligibility criteria to submit a QIS are required to use the QIS Implementation Plan form for the 2026 Plan Year if: implementing a QIS for the first time; discontinuing a current QIS and implementing a new QIS; or if implementing an additional QIS. Beginning with the 2025 Plan Year QHP applicants who want to make changes to their QIS but have already submitted two Modification Summary Supplement forms to change the same QIS must submit a Progress Report Closeout form to discontinue that QIS and submit a new Implementation Plan form to create a new QIS For the 2026 Plan Year.

The QIS Progress Report Form for the 2026 Plan Year should be submitted for: QHP Applicants who are continuing their current QIS, with or without modifications; and QHP Applicants who are

discontinuing their current QIS and implementing a new QIS.

The Modification Summary Supplement for the 2026 Plan Year should be submitted for QHP Applicants to indicate any modifications to an existing QIS Implementation Plan for the upcoming Plan Year (making changes to goals activities, measures, performance targets, and/or the product types). Beginning with the 2025 Plan Year QHP applicants who want to make changes to their QIS but have already submitted two Modification Summary Supplement forms to change the same QIS must submit a Progress Report Closeout form to discontinue that QIS and submit a new Implementation Plan form to create a new QIS.

In addition, Applicants are required to use the Quality Improvement Strategy Technical Guidance and User Guide for the 2026 Plan Year resource for completion of the applicable forms.

These resources are available at: https://www.cms.gov/Medicare/Quality-Initiatives- Patient-Assessment- Instruments/QualityInitiativesGenInfo/ACA-MQI/Quality- Improvement-Strategy/QIS-General. This website contains the 2026 Plan Year QIS forms and instructional documents regarding QIS implementation and reporting.

Applicants that submitted a new QIS Implementation Plan Form in Plan Year 2025 and have not made any changes to the QIS do not need to resubmit the QIS Implementation Plan Form for the 2026 Plan Year. The Applicant would be required to submit a QIS Progress Report Form for the 2026 Plan Year and if applicable a Modification Summary Supplement for the 2026 Plan Year.

Applicants must:

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

ii. Implement a QIS that includes at least one of the following:
- Activities for improving health outcomes;
- Activities to prevent hospital readmissions;
- Activities to improve patient safety and reduce medical errors;
- Activities for wellness and health promotion; and/or

iii. Implement at least one QIS that includes activities to reduce health and health care disparities.

iv. Adhere to guidelines, including the QIS Technical Guidance and QIS User Guide established by Health and Human Services ("HHS"), in consultation with experts in health care quality and interested parties.

v. Report on progress implementing the QIS to the DOH on a periodic basis.

QHP Applicants must submit the required QIS information as part of their participation proposal for the 2026 coverage year by completing the required parts of the 2026 Plan Year applicable forms including: the QIS Implementation Plan Form, the QIS Progress Report Form and the QIS Modification Summary Supplement.

The submitted QIS appropriate forms for the 2026 plan year will be evaluated by the NY State Department of Health (Department) Office of Health Services Quality and Analytics, in consultation with the NY State of Health. Based upon the results of the QIS evaluation, an overall outcome of "meets" or "does not meet" will be assigned to the QIS submission. QHP Applicants will be notified in writing regarding any corrective actions required.

d. Quality Strategy ("QS")

QHP Applicants that did not offer QHP coverage through the Marketplace in 2023 and 2024 or did not have more than 500 enrollees enrolled in a product as of July 1, 2024, must develop a Quality Strategy ("QS") that encompasses all the requirements set forth in 1311 (g) of the Affordable Care Act ("ACA"). This strategy must be implemented and updated annually with progress reported to the designated office of the DOH. The quality strategy should describe how the Applicant will address the following:

- The implementation of quality improvement activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication, and care compliance initiatives, including through the use the medical home model, for treatment or services under the plan or coverage;

- The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post discharge reinforcement by an appropriate health care professional;

- The implementation of activities to improve health outcomes, and patient safety, as well as to reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage;

- The implementation of wellness and health promotion activities;

- The implementation of activities to reduce health and health care disparities, including the use of language services, community outreach, social determinants of health, and cultural competency trainings; and including evaluation of such activities.

- A description of any current or proposed innovative programs to expand access to mental health services including, but not limited to, telepsychiatry or consultative services for co- management of common behavioral health conditions in children and adults.

e. Quality Reporting System ("QRS")

QHP Applicants must submit quality data collected as part of the Quality Reporting System ("QRS") and QHP enrollee survey requirements to NYS DOH. QHP Applicants should follow the 2025 Quality Rating System Measure Set Technical Specifications. These quality indicators are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance's ("NCQA") Health Care Effectiveness Date and Information Set ("HEDIS").

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

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

To reduce inequities across patient groups, health plans must first understand where inequities exist, the magnitude of the inequities, and why these inequities are occurring within their member population. As a first step towards stratification of quality data by patient race, ethnicity, language spoken, and other demographic variables health plans will need to increase reporting of data by race and ethnicity.

The enrollment transactions that NY State of Health provides to health plans include self- reported race and ethnicity information that consumers provide as part of the NY State of Health application. All plans must provide this data as part of the patient record with their QARR submissions.

f. Enrollee Satisfaction Survey

QHP Applicants must annually survey a sample of their Marketplace eligible members to allow the DOH to assess members' experience of care, including their access to care as well as their interactions with their providers and health plan. This information will be collected through the enrollee satisfaction survey under CMS guidelines. The NYS DOH will use the experience of care

information to identify any opportunities for improvement and the analyses of this data may require some plans to develop and implement quality improvement strategies.

2. EP Applicant Requirements

a. Quality Strategy ("QS")

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

EP Applicants must participate in an annual quality improvement activity. The New York State Department of Health (Department) will distribute quality performance matrix reports for the Essential Plans in July of 2025. A response to these reports is required and the requirements will be outlined in future communications.

b. Quality Reporting

EP Applicants will be required to participate in the NYS DOH Quality Assurance Reporting Requirements ("QARR"). The quality indicators in QARR are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance ("NCQA") and the Health Care Effectiveness Data and Information Set ("HEDIS") with New York State specific measures added to address health issues of importance to the state.

QARR Technical specifications are released annually during the Spring of the measurement year, with reporting of QARR data due on or about the following June 15.

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

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

To reduce inequities across patient groups, health plans must first understand where disparities exist, the magnitude of the inequities, and why these inequities are occurring within their member population. As a first step towards stratification of quality data by patient race, ethnicity, language spoken, and other demographic variables health plans will need to increase reporting of data by race and ethnicity.

The enrollment transactions that NY State of Health provides to health plans include self- reported race and ethnicity information that consumers provide as part of the NY State of Health application. All plans must report this data with their QARR submissions. Essential Plan Applicants are expected to submit at least 80% of their memberships race and ethnicity data for members who qualify for a quality measure on the patient level detail file as outlined by annual Quality Assurance Reporting Requirements.

c. Screening for Social Determinants of Health

EP Applicants will be required to screen 85% of their members for social determinants of health in their preferred language at enrollment or re-enrollment. The data will be collected via the Social Needs Screening-Electronic HEDIS measure which is required for aggregate and patient level detail reporting in NYS' QARR 2025 specifications.

It is highly encouraged that the EP Applicants use the Centers for Medicaid and Medicare (CMS)'s Accountable Health Communities Health Related Social Needs Screening Tool to align with current screening for Health Home members and potential future screening requirements for Medicaid members.

EP Applicants may use health care providers or other tools to help complete screenings but will be responsible for submission as outlined by the HEDIS specification for the measure. This limits the provision of data to members continuously enrolled as defined by the measure. Screened for social determinants of health is defined as that a screening for food, housing, and transportation was conducted and that a positive or negative finding of the screen was captured.

The NY State Department of Health has established an EP Quality Incentive Pool which shall provide incentive payments to health plans that achieve specified levels of performance on quality and consumer satisfaction measures and such other factors, including but not limited to reducing health care inequities, compliance measures related to quality reporting, plan network, and provider directories, as determined by the NYS DOH.

d. Satisfaction Survey ("CAHPS")

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

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

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

e. Accreditation

The DOH will not require Applicants to be accredited as a condition of participation in 2026.

3. Principles for Usage of Artificial Intelligence (AI)

In recognition of the vital role insurers play in the health care system, and to ensure that emerging technologies are harnessed to improve health equity and quality, Applicants are required to develop, implement, and maintain written policies that address, document, and manage Artificial Intelligence (AI) risks and potential negative impacts and center a health equity-focused review. Such policies would be for the responsible use of systems that use AI involved in areas including, but not limited to, delivering care, utilization management, risk adjustment, and claims adjudication. This request is consistent with the final rule issued in April 2024 under Section 1557 of the Affordable Care Act, which clarifies that nondiscrimination in health programs and activities apply to the use of AI, clinical algorithms, predictive analytics and other tools. These policies should be submitted to the Applicants assigned Plan Manager by June 30, 2025.

DOH will conduct a review of the submitted policies to ensure that they are in accordance with the intent of the above rule. This area will be subject to ongoing evaluation in future years.

H. Reporting

1. General

The Applicant will maintain a health information system that collects, analyzes, and reports data. The system must be able to report on utilization, claims payment policies and practices, periodic financial disclosures, enrollment and disenrollment information, the number of claims that are denied, customer service information, rating of provider practices, information on cost- sharing and payments with respect to any out-of-network coverage, prescription drug distribution and cost reporting, quality and customer satisfaction reporting pursuant to the DOH reporting requirements, and any other information requested by the DOH and/or required under applicable federal and state laws or regulations.

2. Timing and Instructions for Reporting

The Applicant must submit required reports to the DOH in a manner consistent with federal requirements under Section 45 CFR Part 156, or as otherwise instructed by the DOH.

3. Encounter Data

Applicants will be required to submit encounter data for all contracted services obtained by each of their members. Encounters are records of each face-to-face interaction a member has with the

health care system and includes outpatient visits, inpatients admissions, dental care, emergency room and urgent care visits. Encounters for ordered services, such as pharmacy and labs, shall also be submitted. An encounter is comprised of the procedure(s) or service(s) rendered during the contact and includes information on the site of service and may also include diagnosis information. Each encounter must be recorded in an information system as each unique occurrence between recipient and provider. Encounters must be submitted on at least a monthly or more frequent basis through the DOH designated vendor in a format and manner to be prescribed by the DOH.

4. Financial Reporting

Applicant shall submit financial reports, including certified annual financial statements, and make available documents relevant to its financial condition to the DOH and DFS in a timely manner as required by state and federal laws and regulations. Applicant must also agree to also submit separate premium and expenditure reports, and any additional relevant financial reports and documents related to its financial condition, in a manner and form required by the DOH.

I. Certification, Recertification and Decertification Processes

1. Certification

The Marketplace will grant certification through SERFF and/or email notice. All Applicants that meet the requirements set forth in this Invitation, will have their health plans certified to be offered through the Marketplace.

2. Decertification

A plan issuer certified by the Marketplace may be decertified if it fails to adhere to the certification standards set forth in this application, fails to resolve state agency sanctions, fails to comply with any applicable corrective action plan, or fails to recertify, and for any other reason set forth in the Agreement between DOH and applicable law. Decertification of individual products shall occur in accordance with all applicable laws and regulations governing the removal of a product from the market, including notification to enrollees.

3. Non-Renewal

Plan issuers may opt not to renew participation or products in the Marketplace. The issuer must notify DOH of its decision not to renew, no later than thirty (30) days prior to the start of Open Enrollment. The Issuer shall cooperate with DOH in the development of a plan to facilitate the orderly transition of its members, including, but not limited to, notification to consumers and providing DOH with member specific information to the extent permitted by law. In addition, per Executive Order 167, an issuer that withdraws from the Qualified Health Plan market cannot participate in Medicaid, Child Health Plus or the Essential Plan. [2]

[2] Executive Order No. 167, issued June 9, 2017 [9 NYCRR 8.167], and continued through Executive Order [Hochul] No. 6 [9 NYCRR 9.6].

4. Suspension

The DOH may suspend enrollment in a health plan in the event a state agency requires suspension, or in the event the DOH determines it is in the best interest of the public. Notification of such suspension shall occur in accordance with applicable laws and regulations.

J. Federal and State Laws and Regulations

1. Federal Laws, Regulation and Guidance

The Applicant shall always strictly adhere to all applicable federal laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted, including the following:

- The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, as amended. The two laws are collectively referred to as the Affordable Care Act ("ACA");
- American Rescue Plan Act of 2021
- Inflation Reduction Act of 2022
- 45 C.F.R. Parts 155 and 156 Marketplace Establishment Standards and Other Related Standards Under the Affordable Care Act, Insurance Standards Under the Affordable Care Act, Including Standards Related to Exchanges;
- Health Information Technology for Economic and Clinical Health Act of 2009;
- Health Insurance Portability and Accountability Act of 1996;
- The Privacy Act of 1974; and
- If New York is operating a BHP, 42 CFR Part 600 and other related guidance and instructions; and
- The ACA Section 1332 State Innovation Waiver Specific Terms and Conditions.

2. State Laws and Regulations

The Applicant shall always strictly adhere to all applicable state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted. Applicant acknowledges that such laws include, but are not limited to the following:

a. Contracts/Insurance Companies and Non-Profit Medical and Dental Indemnity Corporations

- N.Y. Insurance Law § 3201, 11 N.Y.C.R.R. 52.1, et. seq. (Approval of Policy Forms);
- N.Y. Insurance Law § 3231 (Rating of Individual and Small Group Health Insurance Policies; Approval of Superintendent);

- N.Y. Insurance Law § 4308 (Supervision of Superintendent);
- N.Y. Insurance Law § 4235, 11 N.Y.C.R.R. 52.2 (Group Accident and Health Insurance);
- Executive Order No. 167, issued June 9, 2017 [9 NYCRR 8.167], and continued through Executive Order [Hochul] No. 6 [9 NYCRR 9.6].

b. Access to Care

- N.Y. Public Health Law § 4403(5)(a), 10 N.Y.C.R.R. 98-1.13(b) (Health Maintenance Organizations, Network Adequacy);
- N.Y. Public Health Law § 4403(6)(a), 10 N.Y.C.R.R. 98-1.13(a) (Health Maintenance Organizations, Access to Appropriate Providers);
- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.13(j) (Health Maintenance Organizations, Emergency Health Services);
- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.6, 10 N.Y.C.R.R. 98-1.12 (Health Maintenance Organizations, Quality Management Program);
- N.Y. Insurance Law § 4325 (Prohibitions);
- N.Y. Insurance Law § 3224-a (Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments of Health Care Services);
- The Out-of-Network Law, Chapter 60 of the Laws of 2014;
- Health Insurance Coverage for the Treatment of Gender Dysphoria, DFS Insurance Circular - Letter No. 7 (2014) (found here: http://www.dfs.ny.gov/insurance/circltr/2014/cl2014_07.pdf);
- Changes in Utilization Review Standards for Substance Use Disorder Treatment Pursuant to Chapter 41 of the Laws of 2014;
- Updated FAQs Regarding 18 Approved Forms of Contraception Issued by CMS May 11, 2015 (found here: http://www.dol.gov/ebsa/faqs/faq-aca26.html);
- Discrimination Based on Sexual Orientation, Gender Identity and/or Gender Dysphoria, DFS Insurance Circular Letter No. 9 (2018), June 25, 2018

c. Access to Information

- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.16 (Disclosure and Filing);
- N.Y. Public Health Law § 4405-b (Duty to Report);
- N.Y. Public Health Law § 4408 (Disclosure of Information);
- N.Y. Public Health Law § 4909 (Prescription Drug Formulary Changes);
- N.Y. Insurance Law § 4909 (Prescription Drug Formulary Changes);
- N.Y. Public Health Law § 4910 (Right to External Appeal);
- N.Y. Insurance Law § 4323 (Marketing Material); and
- N.Y. Insurance Law §§ 3217-a and 4324 (Disclosure of Information).

3. Medicaid and Child Health Plus Programs

Applicants that also participate in the Medicaid Managed Care Program and the Child Health Plus Program shall adhere to the requirements of the respective programs. Nothing contained herein shall be interpreted to supersede the laws, regulations, guidance or instructions issued under the Medicaid Managed Care Program and Child Health Plus Program.



Section V: Application Process

A. Issuing Agency

As stated in Section I (A), this Invitation is issued by the DOH. DOH is responsible for the requirements specified herein and for processing all Applications in partnership with the DFS. This Invitation has been posted on the DOH Marketplace informational website.

DOH shall review Applications in an objective, comprehensive manner designed to benefit both the Marketplace and Applicants. The DOH intends that all Applications will be reviewed uniformly and consistently. For the purpose of its review, the DOH may seek assistance from any person, other than one associated with an Applicant.

B. Letters of Interest

Applicants are requested to submit non-binding Letters of Interest as soon as possible, but no later than the date set forth in the 2026 Schedule of Key Events, via electronic or regular mail at the addresses set forth in paragraph "C" below. Submission of the Letter of Interest does **not** bind a prospective Applicant to submit an application.

If an Applicant would like to receive e-mail notification of updates/modifications to the Invitation, including the issuance of DOH responses to questions raised regarding the Invitation, the Applicant may include such request in their Letter of Interest.

A form Letter of Interest is attached to this Invitation as Attachment "E" for QHP Applicants, EP Applicants, SADP Applicants and Small Business Market (SHOP) Applicants. Please indicate which offerings you are interested in participating in for 2026.

C. Inquiries

All responses and requests for information concerning this Invitation by a prospective Applicant, or an Applicant, or a representative or agent of a prospective Applicant, or Applicant, should be directed to the contact listed below.

In order for DOH to address questions efficiently, prospective Applicants are requested to send their inquiry in writing by email to the address below.

Inquiries of a technical nature may result in either a written response or a referral to the appropriate individual for a verbal response. To the extent possible, written questions concerning a specific requirement of the Invitation should cite the relevant section of the Invitation for which clarification is sought.

Questions of this nature will be responded to by the DOH in writing and such questions and answers will be posted on the NY State of Health website (nystateofhealth.ny.gov), unless the party submitting a question demonstrates that the question/answer will contain confidential and/or

proprietary information.

NAME: Invitation Administrator

EMAIL: nyhxpm@health.ny.gov

ADDRESS
NY State of Health
NYS Department of Health
Corning Tower, Suite 2378
Albany, New York 12237

D. Changes to the Application

The DOH reserves the right to:

- Withdraw the Invitation at any time, at the DOH's sole discretion;
- Disqualify any Applicant whose conduct and/or Application fails to conform to the requirements of this Invitation;
- Seek clarifications and revisions of Applications. The DOH may require clarification from individual Applicants to assure a complete understanding of the Application and/or to assess the Applicant's compliance with the requirements in this Invitation; and
- At any time during the Invitation process, amend the Invitation to correct errors or omissions, and to supply additional information. Prospective Applicants are advised that at any time during the course of this application process, pertinent federal and state laws, regulations, and rules may change, and the protocol for using required systems such as SERFF and the PNDS website may change. In addition, scheduled dates may need to be adjusted. All Prospective Applicants and Applicants will be informed of such changes, and Applicants may be directed to supply additional information in response to such amendments.

E. Submission of the Application

1. Application Contents

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

For QHP Applicants and Stand-Alone Dental Plan Applicants:

i. Participation Proposal;
ii. Submission of Policy Form, Rates, and Binders to DFS for QHP and SAD Applicants;
iii. Submission of Provider Network Information, Verification of Networks and

Appointment Availability Standards/Monitoring;

iv. QIS Implementation Plan and Progress Report Form or Quality Strategy (QHP Applicants Only).

v. Submission of QDP Benefit Cost-sharing Template to DOH

For EP Applicants:

i. Participation Proposal;
ii. Submission of Subscriber Agreements to DOH for EP Applicants;
iii. Submission of EP Information Templates to DOH;
iv. Submission of Provider Network Information, Verification of Networks and Appointment Availability Standards/Monitoring and
v. Quality Strategy.

Each of the component parts must be received by the due dates set forth in the 2026 Schedule of Key Events, listed in this Invitation. Late submissions may not be accepted.

2. QHP, SADP, and EP Applicant Instructions

a. Participation Proposals

Applicants shall submit one electronic signed copy of the Participation Proposal to the email address noted in Section V (C). Participation Proposals will not be accepted by fax. The Participation Proposal must be signed and executed by an individual with legal authority to bind the Applicant to the authenticity of the information provided. The Participation Proposal Form to be completed and submitted by Applicants is attached to this Invitation as Attachment "F" (QHP Applicants and SADP Applicants) and Attachment "J1" (EP Applicants).

Applicants applying to offer both QHPs and EPs must complete **both** Attachments.

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

As set forth in Section II(B), Marketplace products, rates and policy forms must be submitted to DFS per DFS instruction, which will be available on the DFS website.

c. Submission of Subscriber Agreements and Templates to DOH for EP Applicants

As set forth in Section II (B), EP Applicants will be required to submit EP Subscriber Agreements to DOH. EP Applicants will also be required to submit plan information via DOH required templates. Policy forms and templates must be sent directly to the Applicant's assigned Plan Manager by the due date indicated in the 2026 Schedule of Key Events.

d. Submission of Provider Network Information

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

e. Submission of Quality Improvement Strategy or Quality Strategy

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

f. Vendor Responsibility

On or around the same time that Applicants submit forms and rates, Applicants will be notified of their responsibility to complete the New York State "vendor responsibility" process through the New York State VendRep System. The VendRep system instructions are available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at https://portal.osc.state.ny.us. For questions about the VendRep System contact 866-370-4672 or 518-408-4672 or ITServiceDesk@osc.state.ny.us

g. Submission of HHS Form 690, Assurance of Compliance

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

F. Public Information

Disclosure of information related to this Invitation process and resulting contracts shall be permitted consistent with the laws of the State of New York and specifically the Freedom of Information Law (FOIL) contained in Article 6 of the NY Public Officers Law. Information constituting trade secrets or information that if disclosed would cause substantial injury to the competitive position of the subject enterprise, for purposes of FOIL, shall be clearly marked and identified as such by the Applicant upon submission. Determinations regarding disclosure will be made when a request for such information is received by the DOH Records Access Office.

G. Agreement with DOH

Following completion of the activities outlined in this Invitation and having been determined to have met all the requirements, the DOH will provide Applicants with an Agreement. The Agreement resulting from this Invitation will be effective only upon approval by the New York State Office of the Attorney General (OAG) and the Comptroller of the State of New York (OSC). Applicants must enter

into an Agreement with the DOH for their products to be certified and offered through the Marketplace.



Section VI: Attachments

Attachment Designation	Attachment Name
Attachment "A"	QHP Essential Health Benefits 2026
Attachment "B"	Standard Schedule of Benefits Chart 2026
Attachment "C"	QHP and SADP Rating Regions by County 2026
Attachment "D"	QHP and SADP Rating Regions Map 2026
Attachment "E"	Letter of Interest 2026
Attachment "F (1)"	QHP and SADP Participation Proposal 2026
Attachment "F (2)"	QHP Products Offered by County and Market 2026
Attachment "F (3)"	SADP Products Offered by County and Market 2026
Attachment "F (4)"	QHP & SADP Product Offerings & Discontinuances 2026
Attachment "G"	EP Benefits and Cost-Sharing Chart 2026
Attachment "H"	EP Rating Regions 2026
Attachment "I"	EP Rating Regions Map 2026
Attachment "J (1)"	EP Participation Proposal 2026
Attachment "J (2)"	EP Products Offered by County 2026
Attachment "K"	EP Template Instructions 2026
Attachment "L"	EP Admin Template 2026
Attachment "M"	EP Plans Template 2026
Attachment "N"	EP Rates Template 2026
Attachment "O"	EP Service Area Template 2026
Attachment "P"	Provider Network Submission Instructions 2026
Attachment "Q"	URL Template Instructions 2026
Attachment "R"	URL Template 2026
Attachment "S"	SBC Templates All EP Tiers 2026
Attachment "T"	Call Performance Reporting Template 2026
Attachment "U"	Cost-Sharing Reduction Initiatives 2026
Attachment "V"	Essential Plan (EP) Guidance 3.1 2026



Section VII: Definitions

For purposes of this Invitation:

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

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

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

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

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

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

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

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

"Marketplace" shall mean NY State of Health, The Official Health Plan Marketplace (formerly known as the New York Health Benefit Exchange or Exchange) established within the New York State Department of Health pursuant to Executive Order Number 42 on April 12, 2012 and codified in the NY Public Health Law in 2019.

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

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

"Personally Identifiable Information" ("PII") shall mean information that can be used to distinguish or trace a person's identity, such as their name, social security number, etc., alone or when combined with other personal or identifying information that is linked or linkable to a particular individual.

"Protected Health Information" ("PHI") shall refer to individually identifiable health information as defined in 45 CFR 164.402.

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

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

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

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

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

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

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

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

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

"Special Enrollment Periods" shall, as described in 45 C.F.R. § 155.420, and applicable law and guidance, mean the periods during which a qualified individual or enrollee who experiences certain qualifying events as set forth in federal regulation, may enroll in, or change enrollment in, a QHP through the Marketplace outside of the annual open enrollment periods.

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



ATTACHMENT J (1)

2026 PARTICIPATION PROPOSAL
ESSENTIAL PLAN

All Applicants must submit the following information to the e-mail address set forth in Section V (C) of the Invitation. Answers should be completed within this Participation Proposal Form, unless otherwise directed. Completion of this Participation Proposal does not bind the Applicant to participate in the Essential Plan (EP). Applicant will have ten (10) business days following the determination of its capitation rate to notify the DOH of its final determination to participate in EP.

1. Participation.

Indicate below whether Applicant is also participating in the Individual Marketplace, Small Business Marketplace or both, and the type of Applicant. If the Applicant is applying as both a Health Insurer Applicant and an EP Applicant, two separate participation proposals must be sent to DOH.

PARTICIPANT TYPE		EXCHANGE	
■	Health Insurer Applicant	■	Individual
☐	SHOP		

2. Organization

a) Identify below the legal entity that will be responsible for offering products in each Exchange and its current license or certification. If Applicant anticipates licensure prior to September 1, 2025, identify what type of licensure is anticipated.

Healthfirst PHSP, Inc. which is licensed as a prepaid health services plan pursuant to Article 44 of the NYS Public Health Law.

b) Identify whether the same legal entity currently contracts with the State Department of Health for the Child Health Plus and/or Medicaid Program, and if so, identify the program(s).

Healthfirst PHSP, Inc. contracts with the State Department of Health for Medicaid and Child Health Plus.

c) Identify any entities that will be involved in the administration of the EP and briefly describe the roles of such entities. Include in this section any entity the Applicant is using to satisfy coverage of the EP benefits (e.g., adult vision), and any entity the Applicant is using to accept and transmit enrollment information.

- **HF Management Services, which provides administrative and management services;**
- **American Specialty Health (ASH), which provides: utilization management, network management and claims payment administration for chiropractic benefits; and manages the fitness incentive program;**
- **eviCore, which provides utilization management for radiology, radiation therapy, genetic lab, and oncology;**
- **CVS Caremark, which administers pharmacy benefits;**
- **EyeMed, which provides utilization management for routine vision and medical optometry;**
- **DentaQuest, which provides utilization management, network management and claims payment administration for dental services;**
- **Teladoc, which provides telemedicine services for general medicine, behavioral health, and dermatology; and**
- **OrthoNet, which provides utilization management for physical therapy, occupational therapy, and speech therapy, podiatry, vascular and back pain management.**

3. Identification of Service Area

a) Identify whether EP Applicant will be using its Commercial Service Area or its Medicaid Service Area.

☐ Commercial Service Area ■ Medicaid Service Area

b) Provide the following information on ***Attachment J (2)*** - For the Essential Plan, provide the Name of the Applicant and place an x in each box indicating each county that the product will be offered.

4. Quality Strategy

- Attach to this proposal the EP Applicant's Quality Strategy.

5. URL links

Provide URL links for the following areas:

- Plan Brochures/QHP Descriptions (if applicable)

  Product descriptions can be found at: https://healthfirst.org/essential-plans.

- Summary(ies) of Benefits

  Summaries of Benefits & Coverage (SBC) can be found at: http://healthfirst.org/healthfirst-summary-of-benefits/.

- Provider Directory

  The provider directory can be accessed at http://hfdocfinder.org/

- Pharmacy Formulary

  The Pharmacy Formulary can be accessed at www.healthfirst.org/formulary.

- Treatment Cost Calculator

  The Treatment Cost Calculator can be accessed at http://hfcostlookup.org/

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6. Plan Contacts

Provide a contact who will be responsible for each of the areas identified below. Include their name, title, telephone number and email address:

- Product/form submissions
  Shawn Nowicki
  Director, Regulatory Affairs
  (212) 801-6210
  snowicki@healthfirst.org

- Network adequacy
  Shpresa Basha
  Manager, Provider Data Reporting
  (212) 401-8457
  sbasha@healthfirst.org

- Provider Directories
  Felechia Pope
  Vice President, Delivery System Operations
  (212) 519-8194
  Fpope@Healthfirst.org

- Quality submissions
  Laisha Washington
  Vice President, Clinical Quality
  (212) 801-6186
  LaWashington@HealthFirst.org

- Customer Service/Call Center Issues
  Kimberly O'Connor
  VP, Call Center Operations & Member Services
  (212) 801-1639
  koconnor@healthfirst.org

- Pharmacy submissions
  Bhavesh Modi
  VP, Pharmacy

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(212) 209-6442
BModi@Healthfirst.org

- Enrollment Transactions
  Rachel Sylvester
  VP, Enrollment & Billing
  (212) 453-7772
  RSylvester@Healthfirst.org

- Billing issues
  Rachel Sylvester
  VP, Enrollment & Billing
  (212) 453-7772
  RSylvester@Healthfirst.org

- Encounter submissions
  Uday Joshi
  VP, Encounters & DA
  (212) 823-2419
  ujoshi@healthfirst.org

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ATTESTATION TO PARTICIPATION PROPOSAL

The following must be signed and executed by an individual with the capacity and legal authority to bind the Applicant to the authenticity of the information provided.

I, _____Pat Wang_____, hereby attest that I have been duly authorized to execute this Participation Proposal on behalf of Applicant, and to the best of my knowledge, the information and data provided by Applicant in response to the Invitation and Requirements for Participation in the NY State of Health, the Official Health Plan Marketplace (the "Invitation") is accurate, true, and complete. I understand that the NY State of Health will rely on my statements above in reviewing the Participation Proposal and the related information and data submitted in response to the Invitation. In completing the certification process set forth in the Invitation, Applicant shall, always, strictly adhere to all applicable federal and state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted.

__Pat Wang_____
Print Name

__President & CEO_____
Print Title

Signed by:
Pat Wang
9BA62409E905473...
Signature

5/20/2025 | 12:33:22 PM EDT
Date

nystateofhealth
The Official Health Plan Marketplace

ATTACHMENT J (2)
2026 EP Products by County

Applicant Name: Healthfirst PHSP, Inc.

Instructions: Place an x in each box indicating which counties you will offer EP Standard. If you are proposing to enter a new county in 2025, highlight the cell in yellow indicating the new county. If you are proposing to leave a county in 2025, highlight the cell in red, indicating a product removal.

County	EP Standard
Albany	
Allegany	
Bronx	X
Broome	
Cattaraugus	
Cayuga	
Chautauqua	
Chemung	
Chenango	
Clinton	
Columbia	
Cortland	
Delaware	
Dutchess	
Erie	
Essex	
Franklin	
Fulton	
Genesee	
Greene	

Hamilton	
Herkimer	
Jefferson	
Kings	X
Lewis	
Livingston	
Madison	
Manhattan	X
Monroe	
Montgomery	
Nassau	X
Niagara	
Oneida	
Onondaga	
Ontario	
Orange	X
Orleans	
Oswego	
Otsego	
Putnam	
Queens	X
Rensselaer	
Richmond	X
Rockland	X
St. Lawrence	
Saratoga	
Schenectady	
Schoharie	
Schuyler	
Seneca	
Steuben	
Suffolk	X

Sullivan	X
Tioga	
Tompkins	
Ulster	
Warren	
Washington	
Wayne	
Westchester	X
Wyoming	
Yates	

APPENDIX I

TRADING PARTNER AGREEMENT

All trading partners who will be participating in electronic transactions with the NY State of Health, The Official Health Plan Marketplace must first have a fully executed Trading Partner Agreement (TPA) with the NY State of Health of the New York State Department of Health (STATE). The TPA form is available on the following pages.

APPENDIX I

TRADING PARTNER AGREEMENT

This Trading Partner Agreement ("Agreement") is made and entered into on this __12th__day of _November___, 2025 (the "Effective Date"), by and between _Healthfirst PHSP, Inc._____ ("Trading Partner"), and the NY State of Health of the New York State Department of Health ("STATE").

WITNESSETH

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

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

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

such other healthcare transactions that may be necessary pursuant to agreement by and between STATE and Trading Partner; and

WHEREAS, STATE and Trading Partner seek to address certain requirements that are applicable to the parties under regulations issued pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (as the same may be amended from time to time, "*HIPAA*") including, without limitation, the Standards for Electronic Transactions, which were issued in their final form on August 17, 2002 (as the same may be amended from time to time, the "*Transaction Regulations*"), and the Security Standards, which were issued in their final form on February 20, 2003 (as the same may be amended from time to time, the *"Security Standards"*); and

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants and agreements herein contained, Trading Partner and STATE agree to the foregoing and as follows:

1. General Obligations.

1.1 Compliance With Transaction Regulations. Each party shall, and shall cause its applicable subcontractors and agents to, comply with the applicable requirements of the Transaction Regulations and any applicable Implementation Specifications issued therein. STATE shall provide, and shall update from time to time as applicable, a HIPAA compliant (i) Trading Partner Information Companion Guide (the "TPI Guide"), (ii) an 834 Companion Guide; (iii) an 820 Companion Guide; (iv) an 837 Post Adjudicated Claims Data Reporting (PACDR) Companion Guide; (v) an Interface Control Document for Group Set Up File, and such other guides that may be necessary to provide specific instructions, where applicable, to assist Trading Partners in appropriately filling out their transactions for STATE (collectively referred to herein as "Trading Partner Guides"). These Trading Partner Guides will be distributed by the NYSOH's Plan Management department.

1.2 No Changes. With respect to each transaction, each party agrees that it will not change any definition, data condition or use of a data element or segment as proscribed in the Transaction Regulations and/or the applicable Implementation Specifications. Further, neither party will take any action to change the meaning or intent of the Implementation Specifications.

APPENDIX I

1.3 No Additions. With respect to each transaction, each party agrees that it will not add any data elements or segments to the maximum defined data set as proscribed in the Transaction Regulations and/or the applicable Implementation Specifications.

1.4 No Use. With respect to each transaction, each party agrees that it will not use any code or data elements that either are marked "not used" or are not in the Transaction Regulations and/or the applicable Implementation Specifications.

1.5 Testing Requirements. The Trading Partner Guides set forth the testing requirements that Trading Partner and/or its contractors and/or agents must implement and/or complete prior to submitting any live, production transactions to STATE or its fiscal agent. Trading Partner agrees to satisfy these requirements.

1.6 Communications. The Trading Partner Guides set forth specifications for establishing connectivity with, and transmitting transactions to STATE or its fiscal agent. Trading Partner agrees to satisfy these requirements.

1.7 Supplementary Specifications. The Trading Partner Guides set forth the current supplementary specifications ("*Supplementary Specifications*") of STATE with respect to the Transaction Regulations and any applicable Implementation Specifications. STATE shall have the right to amend the Supplementary Specifications and/or to provide additional supplementary specifications to Trading Partner from time to time (all of which shall constitute Supplementary Specifications for purposes of this Agreement). Trading Partner will be expected to implement such amendments and additions within sixty (60) calendar days following STATE publication of same, unless a shorter period is necessary to conform to applicable laws and/or regulations or otherwise required by STATE to ensure effective transactions.

1.8 Security Requirements.
(a) Each party will take reasonable care to ensure that the information submitted in each transaction is timely, complete, accurate and secure, and will take reasonable precautions to prevent unauthorized access to: (i) its own and the other party's transmission and processing systems; (ii) the transmissions themselves; and (iii) the control structure applied to transmissions between them.

(b) Each party is solely responsible for the preservation, privacy and security of data in its possession, including data in transmissions received from the other party and other persons. If either party receives from the other data not intended for it, the receiving party will immediately notify the sender to arrange for its return, re-transmission, or destruction, as the other party directs.

(c) Under the final HIPAA Security Regulations, parties entering into a Business Associate agreement relating to the electronic exchange of data will implement additional requirements as specified in the Security Regulations including, without limitation, requirements relating to encryption, Public Key Infrastructure (PKI) and other similar technologies

(d) Each party and its Business Associates shall be prohibited from: (i) transmitting healthcare transactions covered under this Agreement directly to STATE from outside of the U.S. or its territories, and (ii) from providing IP addresses or other information to STATE that would allow for transmission of healthcare transactions covered under this Agreement directly from STATE to a location outside the U.S. or its territories.

2. Costs and Expenses. Each party shall be responsible for any and all costs and expenses related to such party's compliance with the Transaction Regulations, any applicable Implementation Specifications and the terms of this Agreement. Further, each party shall be responsible for all costs, charges and fees it may incur in connection with transmitting and receiving transactions.

APPENDIX I

3. Term and Termination.

3.1 Term; Effect of Termination. This Agreement shall remain in effect until one party provides written notice of termination to the other, which termination shall be effective thirty (30) days following the other party's receipt of the notice. Termination or expiration of this Agreement or any other contract between the parties does not relieve either party of its obligations under this Agreement and under federal and State laws and regulations pertaining to the privacy and security of Individually Identifiable Health Information nor its obligations regarding the confidentiality of proprietary information.

4. Miscellaneous.

4.1 Defined Terms. Capitalized terms used in this Agreement but not defined herein shall have the meanings ascribed to them in the Transaction Regulations and/or in HIPAA.

4.2 Interpretation. Any ambiguity in any term or condition of this Agreement shall be resolved in favor of a meaning that permits the parties to comply with HIPAA.

4.3 ***Standard Clauses.*** Appendix A, Standard Clauses for New York State Contracts, June, 2023, is incorporated into this Trading Partner Agreement by reference.

IN WITNESS WHEREOF, STATE and Trading Partner have caused this Agreement to be signed and delivered by their duly authorized representatives as of the date set forth above.

On behalf of STATE and Trading Partner:

NEW YORK STATE DEPARTMENT OF HEALTH

By: Danielle Holahan

Print Name: Danielle Holahan

Title: Executive Director

TRADING PARTNER

By: Kathryn A Howell

Print Name: Kathryn A. Howell

Title: Chief Legal Officer

C042073

Healthfirst PHSP, Inc.

Provider # 04151608

Essential Plan (EP) Premium Rate Sheets

Effective Date CY26

County Name	*Essential Plan 1*	*Essential Plan 2*	*Essential Plan 3*	*Essential Plan 4*	*Essential Plan 200-250*
Nassau	$675.97	$711.12	$614.26	$615.40	$658.32
NYC	$658.41	$698.11	$711.11	$712.43	$633.84
Orange	$538.28	$709.85	$399.79	$400.50	$609.75
Rockland	$656.28	$501.22	$864.26	$865.93	$644.00
Suffolk	$675.97	$711.12	$614.26	$615.40	$658.32
Sullivan	$538.28	$709.85	$399.79	$400.50	$609.75
Westchester	$656.28	$501.22	$864.26	$865.93	$644.00

EXHIBIT 4

Excerpts, 2021 Essential Plan

Model Contract between Healthfirst and New York State

MISCELLANEOUS/CONSULTANT SERVICES

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

NYS COMPTROLLER'S # C036146

ORIGINATING AGENCY GLBU: DOH01
DEPARTMENT ID: 3450000

CONTRACTOR (Name and Address):

Healthfirst PHSP, Inc.
100 Church Street
New York, NY 10007

TYPE OF PROGRAM(S):

Essential Health Plan [Basic Health Program, NY SSL § 369-gg]

CHARITIES REGISTRATION NUMBER:

05-41-57

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

FEDERAL TAX IDENTIFICATION NUMBER:
13-3783732

NYS VENDOR IDENTIFICATION NUMBER:
1000026827

MUNICIPALITY NO. (if applicable)

CONTRACT TERM

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

FUNDING AMOUNT FOR CONTRACT TERM: NOT TO EXCEED $5,066,292,723.17

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

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

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

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

APPENDICES ATTACHED AND PART OF THIS CONTRACT
Precedence shall be given to these documents in the order listed below.

-X- APPENDIX A Standard Clauses as Required by the Attorney General for all State Contracts.
-X- APPENDIX X Contract Amendment Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)
-X- APPENDIX Q Modification of Standard Department of Health Contract Language
-X- NEW YORK STATE DEPARTMENT OF HEALTH CONTRACT
-X- APPENDIX M Participation by Minority and Women-Owned Business Enterprises
-X- APPENDIX C Program Specific Requirements
-X- APPENDIX C-1 Marketplace Facilitated Enroller Program
-X- APPENDIX D NY State of Health Invitation and Requirements for Insurer Certification and Recertification for Participation in 2021, as amended by the Q and A posted on the NY State of Health Website
-X- APPENDIX D-1 Contractor's Proposal for certification to participate in Basic Health Program
-X- APPENDIX I Trading Partner Agreement
-X- APPENDIX J Capitation Rates

IN WITNESS THEREOF, the parties hereto have executed or approved this Contract on the dates below their signature.

CONTRACTOR

Healthfirst PHSP, Inc.

By: Pat Wang

Pat Wang
Printed Name

Title: President & CEO

Date: April 14, 2021

STATE AGENCY

New York State Department of Health

By: Donna Frescatore

Donna Frescatore
Printed Name

Title: Executive Director

Date: 4/30/21

State Agency Certification:
"In addition to the acceptance of this Contract, I also certify that original copies of this signature page will be attached to all other exact copies of this Contract."

STATE OF NEW YORK)
)SS.:
County of New York)

On the 14 day of April in the year 2021 before me, the undersigned, personally appeared Pat Wang, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Pearl Smith
(Signature and office of the individual taking acknowledgement)

PEARL SMITH
Notary Public - State of New York
NO. 01SM6175960
Qualified in New York County
My Commission Expires Nov 28, 2023

ATTORNEY GENERAL'S SIGNATURE

Title:

Date:

NYS COMPTROLLER'S SIGNATURE

Title:

Date:

APPROVED
DEPT. OF AUDIT & CONTROL
Jul 26 2021
James M. Iwaneczko
FOR THE STATE COMPTROLLER

"Non-Participating Provider" means a provider of Health Care Services with which the CONTRACTOR has no Provider Agreement.

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

"Personally Identifiable Information (PII)" means information that can be used to distinguish or trace a person's identity, such as their name, social security number, etc., alone or when combined with other personal or identifying information that is linked or linkable to a particular individual.

"Protected Health Information (PHI)" refers to individually identifiable health information as defined in 45 CFR 164.402.

"Premium" means the dollar amount payable by the Enrollee to the CONTRACTOR to effectuate and maintain coverage.

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

"Recertification" refers to the Marketplace's annual review and verification of an Essential Plan's compliance with the requirements for Certification and the provisions of applicable law regarding Essential Plans.

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

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

"Subscriber Contract" means the contract between CONTRACTOR and a Subscriber which is based on the model policy form created by the STATE and issued to each Enrollee by the CONTRACTOR at the time of Enrollment which details the provision of health care coverage under this Agreement.

"Summary of Benefits and Coverage (SBC)" refers to a document provided by CONTRACTOR to Enrollees describing simple and consistent information about plan benefits and coverage. The SBC helps Enrollees to better understand their coverage and compare coverage options.

2. In the event that the STATE determines decertification of an Essential Plan(s) is required pursuant to this Agreement and applicable law, the STATE will provide CONTRACTOR with written notice of this determination and the opportunity for a hearing prior to decertification. The hearing will be before the Commissioner of Health or his or her designee. Decertification must occur in accordance with all applicable laws and regulations governing the removal of an Essential Plan from the Marketplace, including notification to Enrollees.

3. During the Contract Term (excepting the Recertification process) CONTRACTOR must not change Essential Plan standardized benefits or cost-sharing features, including Essential Health Benefits, unless required pursuant to federal or state law.

4. CONTRACTOR may change or discontinue an Essential Plan only in accordance with this Agreement.

5. STATE may suspend enrollment in an Essential Plan if a state agency requires suspension, or in the event that the STATE determines that it is in the best interest of the public. Notification of such suspension must occur in accordance with applicable laws and regulations.

IV. PROVIDER NETWORKS

A. Network Adequacy Requirements

1. For Essential Plans offered through the Marketplace, CONTRACTOR will establish and maintain a network of Participating Providers that satisfies the access standards in 45 C.F.R. 156.230 and 156.235, the Invitation, existing STATE managed care network adequacy standards, and the requirements of this Agreement, together with instructions and guidance issued by the STATE. The network adequacy requirements and standards for Essential Plans must be consistent with the network adequacy requirements and standards that exist outside of the Marketplace pursuant to the NY State Public Health Law and regulation.

2. In establishing the network, CONTRACTOR must consider the following: anticipated enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services covered in each product, the number of providers who are not accepting new patients, and the geographic location of the providers and Enrollees.

3. To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population and to assure that Enrollees have access to all services without undue delay. This

includes geographic accessibility (i.e. meeting time / distance standards) and accessibility for people with disabilities.

4. STATE may, on a case-by-case basis, defer certain network adequacy requirements set forth in this Agreement if it determines there is sufficient access to services in a county. The STATE reserves the right to rescind the deferment at any time, upon thirty (30) days' notice to the CONTRACTOR, should circumstances in a county change.

5. CONTRACTOR must identify any existing network that it intends to use to satisfy network adequacy requirements for Essential Plan(s).

B. Network Composition

1. CONTRACTOR's network must contain all the provider types necessary to furnish the Essential Plan(s), including but not limited to hospitals, physicians (primary care and specialists), mental health and substance abuse providers, allied health professionals, ancillary providers, Durable Medical Equipment (DME) providers, home health providers, and pharmacies. Specifically, the CONTRACTOR's network must meet the following:

    a. Each county network must include at least one hospital; however, for the following counties, the network must include at least three (3) hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, New York, Queens;

    b. Hospitals that have 50 or more beds must meet the patient safety standards set forth in 45 CFR 156.1110, including a quality assessment and performance improvement program and discharge planning.

    c. Each county network must include the core provider types and ratios established through the Provider Network Data System ("PNDS");

    d. Provide a choice of three (3) primary care physicians ("PCPs") in each county, but more may be required based on enrollment and geographic accessibility;

    e. Include at least two (2) of each required specialist provider types in each county, but more may be required based on enrollment and geographic accessibility;

f. Time and distance standards:

i. Primary Care Providers: For Metropolitan areas, 30 minutes by public transportation. For non-Metropolitan areas, 30 minutes or 30 miles by public transportation or by car. In rural areas, transportation standards may exceed these thresholds if justified.

ii. Other Providers: CONTRACTOR will undertake its best efforts to meet the 30-minute / 30-mile standard.

2. In its behavioral health network, CONTRACTOR must include individual providers, outpatient facilities, residential treatment facilities, and inpatient facilities. The network must include facilities that provide inpatient and outpatient alcohol and substance use services. Facilities providing inpatient alcohol and substance use services must be capable of providing detoxification and rehabilitation services.

3. In its dental network, CONTRACTOR must include geographically accessible general dentists sufficient to offer each Enrollee a choice of two (2) primary care dentists in their service area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 Enrollees. In addition, dental networks must include at least one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders (TMD) and oral / maxiofacial prosthodontic must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral. The network must include dentists with expertise serving special needs populations (e.g. HIV-positive and developmentally disabled patients).

C. Essential Community Providers

1. CONTRACTOR must have a sufficient number and geographic distribution of Essential Community Providers, where available, to provide reasonable and timely access to such a broad range of such providers.

2. CONTRACTOR must include a federally qualified health center and a tribal operated health clinic in each county network, to the extent such providers are available.

D. Sanctioned Providers

1. CONTRACTOR must not include in its network any provider who:

a. Has, over the previous five (5) year period, been sanctioned or prohibited from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act and/or 18 NYCRR 515.3, and/or 18 NYCRR 515.7.

b. Has had his or her license suspended by the New York State Education Department or the State Office of Professional Medical Conduct.

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

E. Network Adequacy Review / Process

1. STATE:

a. Will review network adequacy on a county by county basis. For certain network adequacy purposes, the county may be extended by approximately ten (10) miles beyond the county line if CONTRACTOR demonstrates a lack of health care resources or demonstrates that utilization patterns of consumers typically reside outside of the county. In such cases, and in rural areas in particular, CONTRACTOR may contract with providers in adjacent counties to fulfill network adequacy requirements.

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

c. Will, in the event STATE identifies an insufficiency in CONTRACTOR's network, provide CONTRACTOR with written notice of such insufficiency and an opportunity to cure within the specific time period required by the STATE., The time period will be at least thirty (30) days. Failure to cure the insufficiency within the time period dictated by the STATE could result in a statement of deficiency, as applicable, or the suspension of the Essential Plan's authority to enroll new applicants in the county in which STATE finds the CONTRACTOR's network deficient. If STATE determines in its sole discretion that CONTRACTOR'S network fails to provide appropriate access to services covered by an Essential Plan, after the Essential Plan has had an opportunity to cure such deficiency and has failed to do so, the STATE may terminate this Agreement.

d. Reserves the right to update or modify the process for CONTRACTOR'S submission of its network for review and approval by the STATE, with at least sixty (60) days advance notice to CONTRACTOR.

2. CONTRACTOR:

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

   b. Must submit changes to its networks to STATE as soon as they occur (e.g. addition or termination of large hospital or physician's practice), but no later than fifteen (15) days from the date of the occurrence.

   c. Will submit its network through the Provider Network Data System (PNDS) in accordance with the instructions included in the Invitation, or as otherwise directed by the STATE. The network submission must include, as applicable, out-of-state providers within the CONTRACTOR's network and must include agreements with specialty centers and centers of excellence. The STATE reserves the right to request further explanation and/or details if the system is not able to capture or accurately identify particular providers;

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

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

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

V. POLICY FORM AND PREMIUM RATE FILING

A. Review of Rates and Forms

1. CONTRACTOR must use the model policy forms provided by STATE, with revisions to the model language limited to the bracketed sections of the model policy forms.

2. CONTRACTOR must accept the Capitation Rate approved by STATE, as further described in this Agreement, and apply the applicable cost-sharing.

a. As of the Coverage Effective Date, and until the Effective Date of Disenrollment, the CONTRACTOR is, pursuant to the terms and conditions of the Essential Plan, responsible for the coverage of all covered care and services provided under the Essential Plan's benefit package and delivered to Essential Plan Enrollees, with the exception of benefits provided through state fee for service programs.

3. CONTRACTOR will not be liable for the cost of any services rendered to an Enrollee prior to his or her Coverage Effective Date.

E. Process

1. CONTRACTOR must accept enrollments of Eligible Individuals in the order in which the enrollment information is received without regard to the Eligible Individual's sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, gender identity or type of illness or condition.

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

3. In accordance with federal regulation, CONTRACTOR must offer method of payment options to Enrollees that do not discriminate against individuals without bank accounts or credit cards.

VIII. ENROLLEE RIGHTS AND NOTIFICATION

A. Information Requirements

1. CONTRACTOR must provide all Enrollees an information package as required by 45 C.F.R. 156.265(e), including a Subscriber Contract and a Summary of Benefits and Coverage ("SBC").

2. The CONTRACTOR must issue such information to the Enrollee as soon as possible but no later than fourteen (14) days after the Coverage Effective Date.

3. The CONTRACTOR must provide Enrollees with an annual notice that the Subscriber Contract and SBC are available upon request.

4. The CONTRACTOR must make information available to prospective Enrollees and Enrollees (including information regarding internal and external appeals rights) in plain language and in a manner that is accessible and timely to individuals with disabilities, including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the

Americans with Disabilities Act and section 504 of the Rehabilitation Act. CONTRACTOR must:

a. Provide written materials in a prose that is understood by an eighth-grade reading level except as otherwise required by STATE and must be printed in at least 10-point type.

b. Make available written materials and other informational materials in a language other than English whenever at least five percent (5%) of the prospective Enrollees or Enrollees of the CONTRACTOR in any county of the service area speak that particular language and do not speak English as a first language; or, alternatively, provide taglines in common non-English languages indicating the availability of written translation materials in any language the prospective or current Enrollees speak.

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

d. Make available verbal interpretation services in any language to current or potential enrollees who speak a language other than English as a primary language to the extent reasonably practicable. Interpreter services must be offered in person where practical, but otherwise may be offered by telephone.

e. Have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include readers to assist the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies.

f. To the extent that HHS establishes standards on written materials and/or verbal information for the Marketplace that provid es greater protections than the standards set forth above, adhere to such standards.

5. CONTRACTOR must inform individuals of the services provided in paragraph "4" above and how to access such services and alternative mechanisms.

B. Provider Directories

1. The CONTRACTOR must maintain and update, and make publicly available, a listing by specialty of all Participating Providers, including facilities (the "Provider Directory"). Such Provider Directory shall include names, office addresses, telephone numbers, specialty, board certification for physicians, any affiliations with participating hospitals, information on language capabilities and wheelchair accessibility of Participating Providers. The Provider Directory should also identify providers that are considered Primary Care Physicians and providers that are not accepting new patients. Consistent with the 2014 Out-of-Network Law, electronic versions of such directories shall be updated within fifteen (15) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

2. CONTRACTOR must make available to the STATE a URL link that provides access to the CONTRACTOR's Provider Directory. The directory must clearly identify the network of providers participating in Essential Plans. If multiple network configurations are offered by the CONTRACTOR, the directories must clearly identify the network for the particular Essential Plan(s). The directory must clearly distinguish this network(s) from other networks offered by CONTRACTOR so that a consumer using the directory can clearly and easily access the correct directory via the URL link provided to the Marketplace.

3. CONTRACTOR must implement a system to periodically verify the accuracy of its reported Essential Plan provider network(s), to validate participation by individual providers and assure that individual providers are aware of their participation in the Essential Plan network(s). Such system may include, but not be limited to, direct outreach to providers listed by the CONTRACTOR as participating in the Essential Plan network(s). CONTRACTOR shall provide to STATE the method and frequency with which it shall carry out such verifications and report to the STATE the results of such verification efforts within a timeframe specified by STATE.

4. CONTRACTOR must develop and implement protocols to address inquiries and complaints concerning provider directories. CONTRACTOR shall provide to STATE the protocols developed within a timeframe specified by STATE.

5. CONTRACTOR must notify Enrollees in writing at least annually that updates to its provider directory are available online, and that updates and/or a copy of the directory may be provided in hardcopy upon request.

C. Treatment Cost Calculator for Services Rendered by a Participating Provider

CONTRACTOR must, in accordance with and to the extent required by federal regulations, have a treatment cost calculator available through an Internet Web site and by toll free telephone number for individuals without access to the Internet. Such treatment cost calculators must be able to demonstrate Enrollee cost sharing under the individual's plan, or coverage with respect to the furnishing of a specific item or service by a Participating Provider in a timely manner upon the request of the individual.

D. Member Identification Cards

1. CONTRACTOR must issue an identification card to Enrollees as soon as is possible but no later than seven (7) days following receipt of enrollment transaction from STATE. The identification card shall contain pertinent information including the CONTRACTOR's member services toll free telephone number.

2. If unforeseen circumstances prevent the CONTRACTOR from issuing the official identification card to new Enrollees within the above timeframe, the CONTRACTOR must implement an alternative method by which individuals may identify themselves as Enrollees prior to receiving the card or otherwise make the enrollment and cost-sharing information readily available to the Enrollees and Participating Providers.

E. Member Handbooks / Subscriber Contracts

The CONTRACTOR must issue to a new Enrollee as soon as possible but no later than fourteen (14) days after the Coverage Effective Date a Subscriber Contract or Member Handbook; and, at the option of CONTRACTOR, a Member Handbook.

IX. TERMINATION OF COVERAGE

A. Obligations of STATE

1. STATE must permit an Enrollee to terminate his or her coverage in an Essential Plan in the event of a qualifying event (including as a result of the Enrollee obtaining other minimum essential coverage), upon fourteen (14) days' notice to

The Applicant shall comply with all provisions of federal and state law regulating advertising material and marketing practices. The Applicant's advertising materials must accurately reflect general information that would be applicable to a Marketplace enrollee. Materials must not contain false or misleading information. Applicants may not offer incentives to potential enrollees to enroll in a Marketplace product or renew their coverage.

The Applicant is prohibited from door-to-door solicitations of potential enrollees or distribution of material and may not engage in "cold calling" inquiries or solicitation. The Applicant may not require participating providers to distribute Applicant-prepared communications to their patients. Marketing may not take place in patient rooms or treatment areas.

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

C. Network Adequacy

Applicants will establish and maintain a network of participating providers that is consistent with 45 CFR § 156.230 and existing DOH managed care network adequacy standards. Specifically, Applicants must adhere to the following:

a. General Standards

In establishing the network, the Applicant must consider the following: anticipated enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services covered in each product, the number of providers who are not accepting new patients and the geographic location of the providers and enrollees.

To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the enrollee population and to assure that all services will be accessible without undue delay. This includes being geographically accessible (i.e., meeting time/distance standards) and being accessible for people with disabilities.

b. Specific Standards for QHP Applicants and EP Applicants

a. Network Composition

The QHP Applicant's and EP Applicant's network must contain all of the provider types necessary to furnish the Marketplace products, including but not limited to: hospitals, physicians (primary care and specialists), mental health and substance use providers, allied health professionals, ancillary providers, durable medical equipment ("DME") providers, home health providers, and pharmacies. Specifically, the Applicant's network must meet the following minimum standards:

(i) Each county network must include at least one (1) hospital; however, for the following

counties and boroughs, the network must include at least three (3) hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, Manhattan and Queens;

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

(iii) Provide a choice of three (3) primary care physicians ("PCPs") in each county, but more may be required based on enrollment and geographic accessibility;

(iv) Include at least two (2) of each required specialist provider types in each county, but more may be required based on enrollment and geographic accessibility;

(v) Meet the following time and distance standards:

Primary Care Providers

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

Dental Providers

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

Other Provider Types

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

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

(vii) QHP Applicants and EP Applicants are required to have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically

underserved individuals in QHP Applicants' and EP Applicants' service area;

(viii) The QHP Applicant and EP Applicant must make every good faith effort to include in its network the essential community providers defined under federal regulation, and at a minimum, must include in each county network a federally qualified health center and a tribal operated health clinic, to the extent such providers are available;

(ix) QHP Applicants and EP Applicants are required to include individual providers, outpatient facilities, residential treatment facilities, and inpatient facilities in its behavioral health network. The network must include facilities that provide inpatient and outpatient mental health and inpatient and outpatient alcohol and substance use services. Facilities providing inpatient alcohol and substance use services must be capable of providing detoxification and rehabilitation services.

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

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

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b. Specific Standards for Dental Benefits and Stand-Alone Dental Carriers

The Applicant's dental network shall include geographically accessible general dentists sufficient to offer each enrollee a choice of two (2) primary dentists in their service area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 enrollees. Networks must also include at least two (2) orthodontists, one (1) pediatric dentist and at least one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders ("TMD") and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral.

The network must include dentists with expertise serving special needs populations (e.g. HIV+ and developmentally disabled patients).

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

c. Sanctioned Providers Applicable to All Applicants

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

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

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

d. Method of Review

Network adequacy shall be reviewed by the DOH on a county-by-county basis. For some network adequacy purposes, however, the county may be extended by the DOH in the event the Applicant demonstrates a lack of health care resources or demonstrates that utilization patterns of consumers typically reside outside the county. In such cases, and for rural areas, Applicants may contract with providers in adjacent counties to fulfill the network adequacy requirements, as determined by the DOH.

e. Frequency of Review

The DOH shall review the adequacy of an Applicant's network upon submission of the application, and on a quarterly basis thereafter. Pursuant to NY Insurance Law § 3217-1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), Applicants must update their online directory, as well as their PNDS submission(s) within fifteen (15) days of becoming aware of the addition or termination of a provider from its network, or a change in a physician's hospital affiliation.

f. Submission of the Network

The Applicant shall submit its network through the Provider Network Data System, https://pnds.health.ny.gov, in accordance with instructions issued by the DOH and the Provider Network Submission Instructions set forth in Attachment "Q". Submissions must include out-of-state providers within the Applicant's network and must include arrangements with specialty centers and centers of excellence. The DOH reserves the right to ask for further explanations and/or details in the event the system is not able to capture or accurately identify particular service providers.

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

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

D. Enhancements to Network Information.

In addition to the Network Adequacy requirements set forth in Section IV(C), all Applicants shall adhere to the following, unless otherwise specified:

a. Provider Directories

The Applicant shall maintain an up-to-date listing of providers, including facilities and specialty providers, participating in the products offered through the Marketplace (the "Marketplace Provider Directory"). The Marketplace Provider Directory must include names, office addresses, telephone numbers, board certification for physicians, any affiliations with participating hospitals, information on language capabilities and wheelchair accessibility of participating providers. The Marketplace Provider Directory should also identify providers that are considered Primary Care Physicians and identify providers that are not accepting new patients. Consistent with NY Insurance Law § 3217-1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), such directories shall be updated within fifteen (15) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

The Applicant must make available to DOH, a URL link that provides access to the Applicant's Marketplace Provider Directory. The directory must clearly identify the network of providers participating in the Marketplace QHPs, SADPs or EPs.

If multiple network configurations are offered by the Applicant, the directories must clearly identify the network(s) for the particular Marketplace product(s). For example, if one network is used for an Applicant's standard QHP products, but a different network is used for one particular non-standard QHP product, the provider directory for the standard product and non-standard product must be distinct and identifiable to a consumer. The directories must distinguish individual network(s) offered by the Applicant so a consumer using the directory can clearly and easily access the correct network via the URL link provided to the Marketplace. For tiered networks, the directory must clearly identify the tier in which the provider participates

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

b. Verification of Networks and Appointment AvailabilityStandards/Monitoring

1. The Applicant shall provide their process to periodically verify the accuracy of its reported Marketplace provider network(s). Such process may include, but not be limited to, direct outreach to providers listed by the Applicant as participating in Marketplace networks. The Applicant shall provide to the DOH, the method and frequency with which it will carry out such verifications and report to the DOH the results of such verification efforts within a timeframe specified by DOH. The goals of

EXHIBIT 5

2024 Essential Plan 200-250 Member Contract

healthfirst

This is Your

ESSENTIAL PLAN CONTRACT

Issued by

Healthfirst PHSP, Inc.

This is Your individual Contract for the Essential Plan coverage issued by Healthfirst PHSP, Inc. This Contract, together with the attached Schedule of Benefits, applications and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract.

Renewability. The renewal date for this Contract is twelve months from the effective date of coverage. This Contract will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Contract or by You upon 30 days' prior written notice to Us. If You become pregnant while covered under this Contract, You will have coverage for the duration of the pregnancy, along with one year of postpartum coverage. The 12-month postpartum coverage period will start on the last day of Your pregnancy and end on the last day of the 12th month.

In-Network Benefits. This Contract only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers. Except for care for an Emergency Condition described in the Emergency Services and Urgent Care section of this Contract, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

This Contract is governed by the laws of New York State.



Pat Wang
CEO & President

If You need foreign language assistance to understand this Contract, You may call Us at the number on Your ID card.

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SECTION I

Definitions

Defined terms will appear capitalized throughout this Contract.

Acute: The onset of disease or injury, or a change in the Subscriber's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Contract for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Contract: This Contract issued by Healthfirst PHSP, Inc., including the Schedule of Benefits and any attached riders.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Contract.

Doula: A trained person who provides continuous physical, emotional, and informational support to the pregnant person and pregnant person's family before, during, and for a reasonable time after childbirth. A Doula may provide services in hospitals, in birthing centers, at home deliveries, or in other community settings.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Federal Poverty Level (FPL): A measure of income level issued annually by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain program and benefits, including the Essential Plan, and are updated on an annual basis.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitation Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Contract.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to New York Public Health Law Article 40 or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Lawfully Present Immigrant: The term "lawfully present" includes immigrants who have:

- "Qualified non-citizen" immigration status without a waiting period
- Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)
- Valid non-immigration visas
- Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals). To see a full list of eligible immigration statuses, please visit the web site at http://www.healthcare.gov/immigrants/immigration-status/ or call the NY State of Health at 1-855-355-5777.

Medically Necessary: See the How Your Coverage Works section of this Contract for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Network: The Providers We have contracted with to provide health care services to You.

NY State of Health ("NYSOH"): The NY State of Health, the Official Health Plan Marketplace. The NYSOH is a marketplace for health insurance where individuals, families and small businesses can learn about their health insurance options; compare plans based on cost, benefits and other important features; apply for and receive financial help with premiums and cost-sharing based on income; choose a plan; and enroll in coverage. The NYSOH also helps eligible consumers enroll in other programs, including Medicaid, Child Health Plus, and the Essential Plan.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide health care services to You. The services of Non-Participating Providers are Covered only for Emergency Services or when authorized by Us.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide health care services to You. A list of Participating Providers and their locations is available on Our website at www.healthfirst.org or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Contract or any anniversary date thereafter, during which the Contract is in effect.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Contract.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating nurse practitioner or Physician who typically is an internal medicine or family practice Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are

Covered under this Contract that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for the Subscriber. Except as provided in the Access to Care and Transitional Care section of this Contract or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Contract that describes the Copayments, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, Referral requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of New York, Queens, Richmond, Bronx, Kings, Nassau, Suffolk, Orange, Sullivan, Rockland, and Westchester Counties.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Subscriber: The person to whom this Contract is issued. Whenever a Subscriber is required to provide a notice pursuant to a Grievance or Emergency Department admission or visit, “Subscriber” also means the Subscriber’s designee.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a participating Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility that provides Urgent Care.

Us, We, Our: Healthfirst PHSP, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Contract.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Subscriber.

SECTION II

How Your Coverage Works

A. Your Coverage Under this Contract.
You have been enrolled in an Essential Plan. We will provide the benefits described in this Contract to You. You should keep this Contract with Your other important papers so that it is available for Your future reference.

B. Covered Services.
You will receive Covered Services under the terms and conditions of this Contract only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Contract; and
- Received while Your Contract is in force.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

C. Participating Providers.
To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at www.healthfirst.org.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken;
- Whether the Participating Provider is accepting new patients.

You are only responsible for any Cost-Sharing that would apply to the Covered Services if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:

- The Provider is listed as a Participating Provider in Our online Provider directory;
- Our paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;
- We give You written notice that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider; or
- We do not provide You with a written notice within one (1) business day of Your telephone request for network status information.

In these situations, if a Provider bills You for more than Your Cost-Sharing and You pay the bill, You are entitled to a refund from the Provider, plus interest.

D. The Role of Primary Care Physicians.
This Contract does not have a gatekeeper, usually known as a Primary Care Physician ("PCP"). This Contract requires that You select a Primary Care Physician "PCP". Although You are encouraged to receive care from Your PCP, You do not need a Referral from a PCP before receiving Specialist care from a Participating Provider.

You may select any participating PCP who is available from the list of PCPs in the Essential Plan Network. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Contract for more information about designating a Specialist. To select a PCP, visit Our website at www.healthfirst.org and log into the member portal. If You do not select a PCP, We will assign one to You.

E. Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the PCP to make sure he or she is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a Healthfirst Essential Plan Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

You may change Your PCP by visiting Our website at www.healthfirst.org and logging into the member portal. This can be done once a week.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve an authorization to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

F. Out-of-Network Services.
The services of Non-Participating Providers are not Covered except Emergency Services and Pre-Hospital Emergency Medical Services to treat Your Emergency Condition, or unless specifically Covered in this Contract.

G. Services Subject to Preauthorization.
Our Preauthorization is required before You receive certain Covered Services. Your Participating Provider is responsible for requesting Preauthorization for in-network services listed in the Schedule of Benefits section of this Contract.

H. Preauthorization / Notification Procedure.
If You seek coverage for services that require Preauthorization or notification, Your Provider must call Us at the number on Your ID card.

Your Provider must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during

regular business hours prior to the admission.

- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.

- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:
- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

I. Medical Management.
The benefits available to You under this Contract are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

J. Medical Necessity.
We Cover benefits described in this Contract as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:
- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:
- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;

- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and External Appeal sections of this Contract for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

K. Protection from Surprise Bills.

1. **Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:
    - For services performed by a non-participating Provider at a participating Hospital or Ambulatory Surgical Center, when:
        - A participating Provider is unavailable at the time the health care services are performed;
        - A non-participating Provider performs services without Your knowledge; or
        - Unforeseen medical issues or services arise at the time the health care services are performed.

    A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

    - You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
        - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
        - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
        - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Contract.

    You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Cost-Sharing. The Non-Participating Provider may only bill You for Your Cost-Sharing. You can sign a form to notify Us and the Non-Participating Provider that You received a surprise bill.

    The Surprise Bill Certification Form is available at www.dfs.ny.gov or You can visit Our website at www.healthfirst.org/idr for a copy of the form. You need to mail a copy of the form to Us at the address for Surprise Bill Certification Form in the Important Telephone Numbers and Addresses paragraph below and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

L. Delivery of Covered Services Using Telehealth.

If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. We may subject the coverage of a service delivered via telehealth to co-payments and/or coinsurance provided that they are at least as favorable to You as those established for the same service when not delivered via telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Contract that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

M. Important Telephone Numbers and Addresses.

- **CLAIMS**
  212-801-3250

  Healthfirst, Inc.
  P.O. Box 5165
  New York, NY 10274-5165
  (Submit claim forms to this address)

  claimsubmission@healthfirst.org
  (Submit electronic claim forms to this e-mail address.)

  Pharmacy Claims:
  800-364-6331

  Claims: CVS Caremark
  P.O. Box 52136
  Phoenix, AZ 85072-2136
  (Submit pharmacy claim forms to this address.)

  www.caremark.com
  (Submit electronic claim forms to this website)

- **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**
  888-250-2220
  Expedited appeals: 877-779-2959

- **SURPRISE BILL CERTIFICATION FORM**
  Healthfirst, Inc.
  P.O. Box 5165
  New York, NY 10274-5165

(Submit surprise bill certification forms to this address.)

- **MEDICAL EMERGENCIES AND URGENT CARE**
  888-394-4327
  24 hours per day including evenings, weekends and holidays

- **MEMBER SERVICES**
  888-250-2220
  (Member Services Representatives are available Monday - Friday, 8:00 a.m. – 8:00 p.m.)

- **PREAUTHORIZATION**
  888-394-4327

- **BEHAVIORAL HEALTH SERVICES**
  888-250-2220

- **OUR WEBSITE**
  www.healthfirst.org

SECTION III

Access to Care and Transitional Care

A. Authorization to a Non-Participating Provider.
If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will not be Covered.

B. When a Specialist Can Be Your Primary Care Physician.
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCP. We will consult with the Specialist and Your PCP and decide whether the Specialist should be Your PCP. Any authorization will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. We will not approve a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing.

C. Standing Authorization to a Participating Specialist.
If You need ongoing specialty care, You may receive a “standing authorization” to a Specialist who is a Participating Provider. This means that You will not need a new authorization from Your PCP every time You need to see that Specialist. We will consult with the Specialist and Your PCP and decide whether You should have a standing authorization. Any authorization will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide Your PCP with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing authorization to a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a standing authorization to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

D. Specialty Care Center.
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may request an authorization to a specialty care center with expertise in treating Your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government or a national health organization as having special expertise to treat Your disease or condition. We will consult with Your PCP, Your Specialist, and the specialty care center to decide whether to approve such an authorization.

Any authorization will be pursuant to a treatment plan developed by the specialty care center, and approved by Us in consultation with Your PCP or Specialist and You. We will not approve an authorization to a non-participating specialty care center unless We determine that We do not have an appropriate specialty care center in Our network. If We approve an authorization to a non-participating specialty care center, Covered Services rendered by the non-participating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a participating specialty care center. You will be responsible only for any applicable in-network Cost-Sharing.

E. When Your Provider Leaves the Network.
If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care and obtaining Preauthorization, Referrals, and a treatment plan approved by Us. You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

F. New Members In a Course of Treatment.
If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Contract becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Contract. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Contract becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. Copayments.
Except where stated otherwise, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Contract for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

B. Coinsurance.
Except where stated otherwise, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as shown in the Schedule of Benefits section of this Contract.

C. Out-of-Pocket Limit.
When You have met Your Out-of-Pocket Limit in payment of Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Contract, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year.

Cost-Sharing for out-of-network services, except for Emergency Services and out-of-network services approved by Us as an in-network exception and out-of-network dialysis, does not apply toward Your Out-of-Pocket Limit. The Out-of-Pocket Limit runs on a Plan Year basis.

D. Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Contract, before any applicable Copayment or Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount will be the amount We have negotiated with the Participating Provider, or the Participating Provider's charge, if less.

Our payments to Participating Providers may include financial incentives to help improve the quality of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to You. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

See the Emergency Services and Urgent Care Section of this Contract for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Contract for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

SECTION V

Who is Covered

A. Who is Covered Under this Contract.
You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live or reside in Our Service Area to be covered under this Contract. You must have a household income above 138% through 250% of the Federal Poverty Level. If You are enrolled in Medicare or Medicaid or affordable Employer Sponsored Health Insurance, You are not eligible to purchase this Contract. Also, if Your income is above 138% of the Federal Poverty Level, You are not eligible to purchase this Contract if You are under 19 years old, or greater than 64 years old.

You must report changes that could affect your eligibility throughout the year, including whether You become pregnant. If You become pregnant while covered under this Contract, You may remain enrolled in accordance with section 369-ii of the New York Social Service Law. If you remain in Essential Plan, You will have coverage for the duration of the pregnancy, along with one year of postpartum coverage. The 12-month postpartum coverage period will start on the last day of Your pregnancy and end on the last day of the 12th month. You may also become eligible to obtain Medicaid if You have a household income below 223% of the Federal Poverty Level. If You want Medicaid coverage instead of Essential Plan, You should contact NYSOH.

B. Types of Coverage.
The only type of coverage offered under the Essential Plan is Individual coverage, which means only You are covered. If additional members of Your family are also covered under the Essential Plan, they will receive a separate Contract.

C. Enrollment.
You can enroll under this Contract during any time of the year. If You are a new applicant for coverage through the NYSOH, Your coverage will begin on the first of the month that Your plan selection is made. For example, if the NYSOH receives your Essential Plan selection on February 18, coverage under the plan will begin on February 1. Any services you received between February 1 and February 18 will be covered by Us. If you had coverage through the NYSOH under a different program or plan and switch to an Essential Plan, Your coverage will begin on the 1st of the month following your plan selection. For example, if You select an Essential Plan on February 19th, Your coverage would begin March 1st.

SECTION VI

Preventive Care

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care.
We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your ID card or visit Our website at www.healthfirst.org for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. **Adult Annual Physical Examinations.** We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

   Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website at www.healthfirst.org, or will be mailed to You upon request.

   You are eligible for a physical examination once every calendar year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

   This benefit is not subject to Copayments, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

B. **Adult Immunizations.** We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments or Coinsurance when provided in accordance with the recommendations of ACIP.

C. **Well-Woman Examinations.** We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at

www.healthfirst.org, or will be mailed to You upon request. This benefit is not subject to Copayments or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above.

D. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments or Coinsurance when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds, and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

E. Family Planning and Reproductive Health Services. We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of this Contract, patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments or Coinsurance when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

F. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Contract. Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or

- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices.

G. Screening for Prostate Cancer. We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

H. National Diabetes Prevention Program (NDPP). We cover diabetes prevention services provided by CDC-recognized programs for individuals at risk of developing Type 2 diabetes. The benefit covers 22 group training sessions over the course of 12 months. You may be eligible for NDPP services if you have a recommendation by a physician or other licensed practitioner and You are at least 18 years old, not currently pregnant, are overweight and have not been previously diagnosed with Type 1 or Type 2 Diabetes, AND You meet one of the following:

- You have had a blood test result in the prediabetes range within the past year, OR
- You have previously been diagnosed with gestational diabetes, OR
- You score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test

I. Colon Cancer Screening. We Cover colon cancer screening for Members age 45 through 65, including all colon cancer examinations and laboratory tests in accordance with the USPSTF for average risk individuals. This benefit includes an initial colonoscopy or other medical test for colon cancer screening and a follow-up colonoscopy performed because of a positive result from a non-colonoscopy preventive screening test.

SECTION VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. Pre-Hospital Emergency Medical Services

We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment or Coinsurance. In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the FAIR Health rate at the 80th percentile.

2. Emergency Ambulance Transportation. In addition to Pre-Hospital Emergency Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

B. Non-Emergency Ambulance Transportation.

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

D. Payments for Air Ambulance Services. We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the air ambulance service.

We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the air ambulance service, an amount We have determined is reasonable for the air ambulance service, or the Non-Participating Provider's charge for the air ambulance service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity (IDRE), We will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any Cost-Sharing for air ambulance services. The Non-Participating Provider may only bill You for Your Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your Cost-Sharing, You should contact Us.

SECTION VIII

Emergency Services and Urgent Care

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Emergency Services.
We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**. If You are uncertain whether a Hospital emergency department is the most appropriate place to receive care, You can call Us before You seek treatment.

   We do not Cover follow-up care or routine care provided in a Hospital emergency department. You should contact Us to make sure You receive the appropriate follow-up care.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number listed in this Contract and on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

   We Cover inpatient Hospital services following Emergency Department care at a non-participating Hospital at the in-network Cost-Sharing. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer.

3. **Payments Relating to Emergency Services.** We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the Emergency Services. We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the Emergency Service, an amount We have determined is reasonable for the Emergency Service, or the Non-Participating Provider's charge. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

   If a dispute involving a payment for Emergency Services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for the services.

   You are responsible for any Cost-Sharing. You will be held harmless for any Non-Participating Provider charges that exceed Your Cost-Sharing. The Non-Participating Provider may only bill You for Your Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your Cost-Sharing, You should contact Us.

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions, or visit an Urgent Care Center.

If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Urgent Care is Covered in Our Service Area,

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.

2. **Out-of-Network.** We do not Cover Urgent Care from non-participating Urgent Care Centers or Physicians.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

SECTION IX

Outpatient and Professional Services

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Advanced Imaging Services.
We Cover PET scans, MRI, nuclear medicine, and CAT scans.

B. Allergy Testing and Treatment.
We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

C. Ambulatory Surgical Center Services.
We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

D. Chemotherapy and Immunotherapy.
We Cover chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Contract.

E. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Contract.

F. Clinical Trials.
We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Contract.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Contract for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

G. Dialysis.
We Cover dialysis treatments of an Acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than 10 dialysis treatments by a Non-Participating Provider per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

H. Habilitation Services.
We Cover Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition, per plan year. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

I. Home Health Care.
We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 40 visits per Plan Year. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation Services or Habilitation Services received under this benefit will not

reduce the amount of services available under the Rehabilitation Services or Habilitation Services benefits.

J. Infertility Treatment.
We Cover services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Subscriber who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.

   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultra sound;
   - Hysterosalpingogram;
   - Sono-hystogram;
   - Testis biopsy;
   - Blood tests; and
   - Medically appropriate treatment of ovulatory dysfunction.

   Additional tests may be Covered if the tests are determined to be Medically Necessary.

2. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;
   - Pelvic ultra sound;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **Fertility Preservation Services.** We Cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova or sperm. "Iatrogenic

infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

4. **Exclusions and Limitations.** We do not Cover:
   - In vitro fertilization;
   - Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs associated with an ovum or sperm donor, including the donor's medical expenses;
   - Cryopreservation and storage of sperm and ova except when performed as fertility preservation services;
   - Cryopreservation and storage of embryos;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for and relating to surrogate motherhood that are not otherwise Covered Services under this Contract;
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

   All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

K. Infusion Therapy.
We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.

L. Interruption of Pregnancy.
We Cover abortion services. Coverage for abortion services includes any Prescription Drug prescribed for an abortion, including both Generic Drugs and Brand-Name Drugs, even if those Prescription Drugs have not been approved by the FDA for abortions, if the Prescription Drug is a recognized medication for abortions in one of the following reference compendia:
- The WHO Model Lists of Essential Medicines;
- The WHO Abortion Care Guidelines; or
- The National Academies of Science, Engineering and Medicine Consensus Study Report.

Abortion services are not subject to Cost-Sharing when provided by a Participating Provider.

M. Laboratory Procedures, Diagnostic Testing and Radiology Services.
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

N. Maternity and Newborn Care.

1. We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Contract for Coverage of inpatient maternity care.

   We Cover breastfeeding support, counseling and supplies, including the cost of the purchase of one (1) breast pump per pregnancy for the duration of breast feeding from a Participating Provider or designated vendor.

O. Office Visits.

We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

P. Outpatient Hospital Services.

We Cover Hospital services and supplies as described in the Inpatient Services section of this Contract that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

Q. Preadmission Testing.

We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

R. Prescription Drugs for Use in the Office.

We Cover Prescription Drugs (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Contract.

S. Rehabilitation Services.

We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition per plan year. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury;

- The therapy is ordered by a Physician; and
- You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond 365 days after such event.

T. Retail Health Clinics.

We Cover basic health care services provided to You on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered Services are typically provided by a physician's assistant or nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common illnesses. Retail health clinics are not a replacement for your PCP. Your PCP should be your first choice for care and for regular visits.

U. Second Opinions.

1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis when Your attending Physician provides a written Referral to a non-participating Specialist.

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
   - The second opinion must be given by a board certified Specialist who personally examines You.
   - If the first and second opinions do not agree, You may obtain a third opinion.

4. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

V. Surgical Services.

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

Sometimes two (2) or more surgical procedures can be performed during the same operation.

1. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest Allowed Amount

2. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
    - For the procedure with the highest Allowed Amount; and
    - 50% of the amount We would otherwise pay for the other procedures.

W. Oral Surgery.

We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

X. Reconstructive Breast Surgery.

We Cover breast or chest wall reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast or chest wall to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Chest wall reconstruction surgery includes aesthetic flat closure as defined by the National Cancer Institute. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

Y. Other Reconstructive and Corrective Surgery.

We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Z. Telemedicine Program

In addition to providing Covered Services via telehealth, We Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in Our telemedicine program. You can check Our Provider directory or contact Us for a listing of the Providers that participate in Our telemedicine program.

Healthfirst offers the telemedicine program through Teladoc. Teladoc will provide You with unlimited 24 hours per day/7 days-a-week toll-free access to Teladoc providers available through their telemedicine program. You can also access these Teledoc providers through the Teladoc mobile application. Teladoc will connect you with a state licensed physician associated with their program. Please note that Healthfirst does not distribute a directory of telemedicine program providers. To access the Teledoc telemedicine program, go to www.healthfirst.org.

The Teladoc telemedicine program is for non-emergent medical problems. If you are experiencing a medical emergency, call 911. Please note: cost-sharing for Covered Services are different between the Teledoc program and those provided via telehealth from our network of Participating Providers.

AA. Transplants.
We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Subscriber-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is covered by Us. We do not Cover the medical expenses of a non-covered individual acting as a donor for You if the non-covered individual's expenses will be Covered under another health plan or program.

We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

SECTION X

Additional Benefits, Equipment and Devices

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Diabetic Equipment, Supplies and Self-Management Education.
We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. **Equipment and Supplies.**
   We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:
   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - All insulin preparations
   - Automatic blood lance kit
   - Cartridges for the visually impaired
   - Diabetes data management systems
   - Disposable insulin and pen cartridges
   - Drawing-up devices for the visually impaired
   - Equipment for use of the pump
   - Glucagon for injection to increase blood glucose concentration
   - Glucose acetone reagent strips
   - Glucose kit
   - Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
   - Glucose reagent tape
   - Glucose test or reagent strips
   - Injection aides
   - Injector (Busher) Automatic
   - Insulin
   - Insulin cartridge delivery
   - Insulin infusion devices
   - Insulin pump
   - Lancets
   - Oral agents such as glucose tablets and gels
   - Oral anti-diabetic agents used to reduce blood sugar levels
   - Syringe with needle; sterile 1 cc box
   - Urine testing products for glucose and ketones
   - Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

2. Self-Management Education.
Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. Limitations.
The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or otherwise Medically Necessary.

Step Therapy for Diabetes Equipment and Supplies. Step therapy is a program that requires You to try one type of diabetic Prescription Drug, supply or equipment unless another Prescription Drug, supply or equipment is Medically Necessary. The diabetic Prescription Drugs, supplies and equipment that are subject to step therapy include:

- Diabetic glucose meters and test strips;
- Diabetic supplies (including but not limited to syringes, lancets, needles, pens);
- Insulin;
- Injectable anti-diabetic agents; and
- Oral anti-diabetic agents.

These items also require Preauthorization and will be reviewed for Medical Necessity. For diabetic Prescription Drugs, refer to the step therapy provisions in the Prescription Drug section and the Step Therapy Protocol Override Determination provisions in the Utilization Review section of this Contract.

B. Durable Medical Equipment and Braces.
We Cover the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.
Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such

equipment. We do not Cover over-the-counter durable medical equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. **Braces.**
We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

C. Hearing Aids.

1. **External Hearing Aids.**
We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years.

2. **Cochlear Implants.**
We Cover bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:
   - Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
   - Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Contract. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

D. Hospice.

Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located.

We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

E. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Contract. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Contract. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

F. Prosthetics.

1. External Prosthetic Devices.

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this section of the Contract and are only Covered under the Vision Care section of this Contract.

We do not Cover shoe inserts.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. Internal Prosthetic Devices.

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

SECTION XI

Inpatient Services

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Hospital Services.
We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Contract apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital that occur within a period of not more than 90 days for the same or related causes.

B. Observation Services.
We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Contract.

D. Inpatient Stay for Maternity Care.
We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include

parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Contract and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Contract that apply to home care benefits.

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

E. Inpatient Stay for Mastectomy Care.
We Cover inpatient services for Subscribers undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

F. Autologous Blood Banking Services.
We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Habilitation Services.
We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit limit applies to all therapies combined.

H. Rehabilitation Services.
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:
1. Such therapy is related to the treatment or diagnosis of Your illness or injury;
2. The therapy is ordered by a Physician; and
3. You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

I. Skilled Nursing Facility.
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Contract). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 200 days per Plan Year for non-custodial care.

J. End of Life Care.
If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Contract until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:
1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

K. Limitations/Terms of Coverage.
1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

SECTION XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Contract. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:
    - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
    - A state or local government run psychiatric inpatient Facility;
    - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
    - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

    and in other states, to similarly licensed or certified Facilities.

    We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. We Cover up to a total of 20 family counseling visits during a Plan Year. Family counseling includes family counseling visits with the enrollee present and family counseling visits without the enrollee present. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health, and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed nurse practitioner; a licensed mental health counsel; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice

corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us. Outpatient services also include nutritional counseling to treat a mental health condition.

3. **Autism Spectrum Disorder.** We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, or treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

   a. **Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

   b. **Assistive Communication Devices.** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop or tablet computers. We Cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

      We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We Cover one (1) repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

   c. **Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

d. **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

e. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Contract.

f. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Contract.

g. **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under New York Public Health Law Section 2545, an individualized education plan under New York Education Law Article 89, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Contract for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

   You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Contract for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Contract for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

B. Substance Use Services. We Cover the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes Coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Addiction Services and Supports ("OASAS"); and, in other states, to those Facilities that are licensed certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs.

   We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room

and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services, and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

SECTION XIII

Prescription Drug Coverage

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Prescription Drugs.
We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On Our Formulary; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders, include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Contract.
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier

Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.

- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription drugs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to prevent HIV infection.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification and maintenance treatment, all buprenorphine products, methadone, and long-acting injectable naltrexone, and opioid and overdose reversal medication, including when dispensed over-the-counter.
- Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider. You may request an exception by having Your attending Health Care Provider complete the Contraception Exception Form and sending it to Us. Visit Our website at www.healthfirst.org or call the number on Your ID card to get a copy of the form or to find out more about this exception process.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at www.healthfirst.org/formulary.html. You may inquire if a specific drug is Covered under this Contract by contacting Us at the number on Your ID card.

B. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail, mail order or Designated pharmacy as ordered by an authorized Provider. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Contract.

Emergency Refill During a State Disaster Emergency. If a state disaster emergency is declared, You, Your designee, or Your Health Care Provider on Your behalf, may immediately get a 30-day Refill of a Prescription Drug You are currently taking. You will pay the Cost-Sharing that applies to a 30-day Refill. Certain Prescription Drugs, as determined by the New York Commissioner of Health, are not eligible for this emergency Refill, including schedule II and III controlled substances.

C. Benefit and Payment Information.

1. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Contract when Covered Prescription Drugs are obtained from a retail, mail order, or Designated pharmacy.

   You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

   You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

   Coupons and Other Financial Assistance. We will apply any third-party payments, financial assistance, discounts, or other coupons that help You pay Your Cost-Sharing towards Your Out-of-Pocket Limit.

2. **Participating Pharmacies.** For Prescription Drugs purchased at a retail, mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing;
   - The Prescription Drug Cost for that Prescription Drug; or

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the number on Your ID card to request approval.

3. **Non-Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

4. **Designated Pharmacies.** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

   Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

   If You are directed to a Designated pharmacy and You choose not to obtain Your Prescription Drug from a Designated pharmacy, You will not have coverage for that Prescription Drug.

   Following are the therapeutic classes of Prescription Drugs or conditions that are included in this

program:

- Age related macular edema;
- Anemia, neutropenia, thrombocytopenia;
- Crohn's disease;
- Cystic fibrosis;
- Cytomegalovirus;
- Endocrine disorders/neurologic disorders such as infantile spasms;
- Enzyme deficiencies/liposomal storage disorders;
- Gaucher's disease;
- Growth hormone;
- Hemophilia;
- Hepatitis C;
- Hereditary angioedema;
- Immune deficiency;
- Immune modulator;
- Infertility;
- Iron overload;
- Iron toxicity;
- Multiple sclerosis;
- Oncology;
- Osteoarthritis;
- Osteoporosis;
- Pulmonary arterial hypertension;
- Respiratory condition;
- Rheumatologic and related conditions (rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis).

5. **Mail Order.** Certain Prescription Drugs may be ordered through Our mail order pharmacy. You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You may be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order supplier regardless of the number of days supply written on the Prescription Order or Refill.

   Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

   We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy, when that retail pharmacy has a participation agreement with Us or Our vendor in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

   You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.heatlhfirst.org or by calling the number on Your ID card.

6. **Tier Status.** The tier status of a Prescription Drug may change periodically, but no more than four (4) times per calendar year or when a Brand-Name Drug becomes available as a Generic Drug as described below, based on Our tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier or is being removed from Our Formulary We will notify You at least 30 days before the change is effective. When such changes occur, Your Cost-Sharing may change. You may also request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this Contract. You may access the most up to date tier status on Our website at www.healthfirst.org or by calling the number on Your ID card.

7. **When a Brand-Name Drug Becomes Available as a Generic Drug.** When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded or placed on a higher tier due to a Generic Drug becoming available, You will receive 30 days' advance written notice of the change before it is effective. You may request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this Contract.

8. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of this Contract. Visit Our website at www.healthfirst.org or call the number on Your ID card to find out more about this process.

   Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 72 hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

   Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 24 hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

9. **Supply Limits.** Except for contraceptive drugs, devices, or products. We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply. However, for maintenance drugs We will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for up to three (3) Cost-Sharing amounts for a 90-day supply at a retail pharmacy.

   You may have the entire supply (of up to 12 months) of a prescribed contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices or products are not subject to Cost-Sharing when provided by a Participating Pharmacy.

   Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of two and a half (2.5) Cost-Sharing amounts for a 90-day supply.

   Specialty Prescription Drugs may be limited to a 30-day supply when obtained at a retail or mail order pharmacy. You may access Our website at www.healthfirst.org or by calling the number on Your ID card for more information on supply limits for specialty Prescription Drugs.

   Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at www.healthfirst.org or by calling the number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Contract.

10. **Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be prorated. If You receive an additional supply of the Prescription Drug within the 30-day period in which You received the seven (7) day supply, Your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than Your Copayment for a 30-day supply.

11. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You the Cost-Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of this Contract.

D. Medical Management.

This Contract includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug.

Preauthorization is not required for Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.healthfirst.org or call the number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Contract. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one or more types of Prescription Drugs before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Contract.

E. Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

3. Compounded Prescription Drugs will be Covered only when they contain at least one (1) ingredient that is a Covered legend Prescription Drug, and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs over $250 require Your Provider to obtain Preauthorization.

4. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Contract.

6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the Outpatient and Professional Services section of this Contract.

7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Contract. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary, or as otherwise stated in this Contract. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.

8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Contract.

11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

F. General Conditions.

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

2. **Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage.

   We may also, from time to time, enter into agreements that result in Us receiving rebates or other

funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

G. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Contract).

1. **Brand-Name Drug:** A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.

2. **Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Contract. This list is subject to Our periodic review and modification (no more than four (4) times per calendar year or when a Brand-Name Drug becomes available as a Generic Drug). To determine which tier a particular Prescription Drug has been assigned, visit Our website at www.healthfirst.org/formulary.html or call the number on Your ID card.

4. **Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as "generic" by the manufacturer, pharmacy or Your Physician may not be classified as a Generic Drug by Us.

5. **Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.

6. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Subscribers. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

7. **Participating Pharmacy:** A pharmacy that has:
   - Entered into an agreement with Us or Our designee to provide Prescription Drugs to members;
   - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
   - Been designated by Us as a Participating Pharmacy.

   A Participating Pharmacy can be either a retail or mail-order pharmacy.

8. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self- administration or administration by a non-skilled caregiver.

9. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, as contracted between Us and Our pharmacy benefit manager for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Contract includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

10. **Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

11. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by New York Education Law Section 6826-a.

SECTION XIV

Wellness Benefits

A. Exercise Facility Reimbursement.
We will partially reimburse You for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities that We have an agreement with and which maintain equipment and programs that promote cardiovascular wellness.

Reimbursement is limited to actual workout visits. We do not reimburse:

- Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities;
- Lifetime memberships;
- Equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.);
- Services that are amenities, such as a gym, that are included in Your rent or homeowners association fees.

In order to be eligible for reimbursement, You must:

- Be an active member of the exercise facility or attend classes at the exercise facility, and
- Complete 50 visits in a six (6)-month period.

In order to obtain reimbursement, at the end of the six (6)-month period, You must submit:

- A completed reimbursement form. Each time You visit the exercise facility, a facility representative must sign and date the reimbursement form.
- A copy of Your current facility bill which shows the fee paid for Your membership.

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of $200 or the actual cost of the membership per six (6)-month period. Reimbursement must be requested within 120 days of the end of the six (6)-month period. Reimbursement will be issued only after You have completed each six (6)-month period even if 50 visits are completed sooner.

B. Wellness Program.

1. Purpose.
The purpose of the Healthfirst Member Rewards Program wellness program is to encourage You to actively engage in Your health and well-being.

2. Description.
We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities including, but not limited to:

- Preventive care, such as cancer screenings and flu shots;

- Care Related to Chronic Conditions such as eye exams for members with Diabetes and Controller Medication Fills for members with Asthma; and

- Health Engagement such as updating or verifying contact information that allows Healthfirst to communicate health plan benefits and services in support of member education and wellness programs.

You can view a full list of eligible activities for the Healthfirst Member Rewards Program at www.healthfirst.org.

3. Eligibility.
You, the Subscriber, can participate in the wellness program.

4. Participation.
You can participate in Our Healthfirst Member Rewards Program by:

- Completing and submitting a Reward form
  - Reward forms can be requested through Member Services at the number on Your ID card
  - Mail the form to:
    P.O. Box 5163
    New York, NY 10274-5163
  - Fax the form to:
    212-601-6944
- Calling Member Services at the number on Your ID card.
- Clicking the completed service(s) in the Healthfirst Mobile App.

5. Rewards
Rewards for participation in Our Healthfirst Member Rewards Program range between $5 - $25. The funds will be provided to You in the form of a prepaid Mastercard (option of physical card or virtual card). The card can be used to purchase products and services that promote a healthy lifestyle and good health.

SECTION XV

Vision Care

Please refer to the Schedule of Benefits section of this Contract for day or visit limits and any Preauthorization or Referral requirements that apply to these benefits.

A. Vision Care.
We Cover emergency, preventive and routine vision care.

B. Vision Examinations.
We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time per Plan Year, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

C. Prescribed Lenses and Frames.
We Cover standard prescription lenses or contact lenses one (1) time in any 12-month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic.

We also Cover standard frames adequate to hold lenses one (1) time in any 12-month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. If You choose a non-standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non-standard frame. The difference in cost does not apply toward Your Out-of-Pocket Limit.

SECTION XVI

Dental Care

Please refer to the Schedule of Benefits section of this Contract for day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following dental care services:

A. Emergency Dental Care. We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

B. Preventive Dental Care. We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:

- prophylaxis (scaling and polishing the teeth) at six (6) month intervals.

C. Routine Dental Care. We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-rays, full mouth x-rays or panoramic x-rays at 36-month intervals, bitewing Ix-rays at six (6) to 12-month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation; and
- Amalgam and composite restorations (fillings).

D. Crowns

We Cover crowns, including stainless steel crowns, when Medically Necessary. Preauthorization is required.

E. Endodontics. We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

We Cover root canal therapy when Medically Necessary.

F. Periodontics. We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics that are otherwise Covered under this Contract.

We Cover crown lengthening only when associated with Medically Necessary crown or root canal procedure. Preauthorization is required.

G. Prosthodontics. We Cover prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months follow-up care, when they are Medically Necessary, including when necessary to alleviate a serious condition or one that is determined to affect employability; and

- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate. Preauthorization is required.

Complete dentures and partial dentures, whether unserviceable, lost, stolen, or broken will not be replaced for a minimum of eight (8) years from initial placement except when determined to be Medically Necessary. Preauthorization requests for replacement dentures prior to eight (8) years must include a letter from Your dentist, explaining the specific circumstances that necessitates replacement of the denture. If replacement dentures are requested within the eight (8) year period after they have already been replaced once, then supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.

General Guidelines for All Removable Prosthesis:

Complete and/or partial dentures will be approved only when the existing prosthesis is not serviceable and cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be covered when such procedures are performed in addition to a new prosthesis for the same arch within six (6) months of the delivery of a new prosthesis. Only “tissue conditioning” is covered within six (6) months prior to the delivery of new prosthesis.

Cleaning of removable prosthesis or soft tissue not directly related to natural teeth or implants is not a covered service. Prophylaxis and/or scaling and root planning is only covered when performed on natural dentition.

“Immediate” prosthetic appliances are not a covered service.

Other Removable Prosthetic Services
“Tissue conditioning” for treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration is the **ONLY** type of reline covered within six (6) months prior to the delivery of a new prosthesis. Insertion of tissue conditioning liners in existing dentures is limited to once per denture unit.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

Dental Implant Services. We Cover dental implants, including single implants, and implant related services, when Medically Necessary. Preauthorization is required for implant services.

Preauthorization requests for implants must have supporting documentation from Your dentist. Your dentist’s office must document, among other things, Your medical history, current medical conditions being treated, list of all medications currently being taken, explaining why implants are Medically Necessary and why other covered functional alternatives for prosthetic replacement will not correct Your dental condition, and certifying that You are an appropriate candidate for implant placement. If Your dentist indicates that You are currently being treated for a serious medical

condition, documentation from Your treating physician may be required.

H. Oral Surgery. We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of, or leading to orthodontics that are otherwise Covered under this Contract.

I. Orthodontics. We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

SECTION XVII

Exclusions and Limitations

No coverage is available under this Contract for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Contract. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Contract unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services.
We do not Cover orthodontia services except as specifically stated in the Dental Care section of this Contract.

G. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Contract, or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Contract for non-investigational treatments. See the Utilization Review and External Appeal sections of this Contract for a further explanation of Your Appeal rights.

H. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

I. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law

K. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Contract.

L. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

M. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

N. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

O. Services Not Listed.

We do not Cover services that are not listed in this Contract as being Covered.

P. Services Provided by a Family Member.
We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

Q. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services with No Charge.
We do not Cover services for which no charge is normally made.

S. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

T. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION XVIII
Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Contract. Either You or the Provider must file a claim form with Us. If the Provider is not willing to file the claim form, You will need to file it with Us.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Contract. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Contract.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within 180 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 180-day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Contract.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Contract.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

   If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15

days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION XIX

Grievance Procedures

A. Grievances.
Our Grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.
You can contact Us by phone at the number on Your ID card, in person, or in writing to file a Grievance. You must use Our Grievance form for written Grievances. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

You may ask that We send You electronic notification of a Grievance determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card. You can opt out of electronic notifications at any time.

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A Claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service	In writing, within 30 calendar days of receipt of Your Grievance.

or treatment.)	

D. Assistance.
If You remain dissatisfied with Our Grievance determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Health at 1-800-206-8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
E-mail: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov

If You need assistance filing a Grievance, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XX

Utilization Review

A. Utilization Review.
We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

Initial determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) for mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. Appeal determinations that services are not Medically Necessary will be made by: 1) licensed Physicians who are board certified or board eligible in the same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review ; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) for mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

We have developed guidelines and protocols to assist Us in this process. We will use evidence-based and peer reviewed clinical review criteria tools that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card. You can opt out of electronic notifications at any time.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your

Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

4. **Inpatient Rehabilitation Services Reviews.** After receiving a Preauthorization request for coverage of inpatient rehabilitation services following an inpatient Hospital admission provided by a Hospital or skilled nursing facility, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information.

5. **Crisis Stabilization Centers.** Coverage for services provided at participating crisis stabilization centers licensed under New York Mental Hygiene Law section 36.01 is not subject to Preauthorization. We may review the treatment provided at crisis stabilization centers retrospectively to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS or approved by OMH. If any treatment at a participating crisis stabilization center is denied as not Medically Necessary, You are only responsible for any Cost-Sharing that would otherwise apply to Your treatment.

6. **Preauthorization for Rabies Treatment.** Post-exposure rabies treatment authorized by a county health authority is sufficient to be considered Preauthorized by Us.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day.

You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of Urgent Care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

5. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use the clinical review tool designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

6. **Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified Facility notifies Us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. Retrospective Reviews.
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Step Therapy Override Determinations.
You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

1. **Supporting Rationale and Documentation.** A step therapy protocol override determination request should include supporting rationale and documentation from a Health Care Professional, demonstrating that:
   - The required Prescription Drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;

- The required Prescription Drug is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;
- You have tried the required Prescription Drug while covered by Us or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- You are stable on a Prescription Drug selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB-rated generic equivalent; or
- The required Prescription Drug is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review.** We will make a step therapy protocol override determination within 72 hours of receipt of the supporting rationale and documentation.

3. **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or Your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours or one (1) business day of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 24 hours of Our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If We do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

G. Reconsideration.

If We did not attempt to consult with Your Provider who recommended the Covered Service before

making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

H. Utilization Review Internal Appeals.
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit
    - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
    - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
    - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
    - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

I. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 days of receipt of the Appeal. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

   Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

J. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

K. Appeal Assistance.

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance

Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XXI

External Appeal

A. Your Right to an External Appeal.
In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, or is an emergency service or a surprise bill (including whether the correct Cost-Sharing was applied) You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Contract; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.
If We have denied coverage on the basis that the service is not Medically Necessary You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.
If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure Covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or

3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your Right to Appeal a Determination that a Service is Out-of-Network.
If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.
If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. Your Right to Appeal a Formulary Exception Denial.
If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Contract for more information on the formulary exception process.

G. The External Appeal Process.
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 72 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 24 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a

determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Contract. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Contract for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

H. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XXII

Termination of Coverage

This Contract may be terminated as follows:

A. Automatic Termination of this Contract.
This Contract shall automatically terminate:

1. Upon Your death.

2. When You turn 65, Your coverage will end at the end of the month in which You turn 65 or become Medicare eligible, whichever is earlier.

3. When You become Medicaid eligible or enroll in the Medicaid Program, Your coverage will end at the end of the month in which you are determined to be Medicaid eligible. This Contract shall not automatically terminate if You become Medicaid eligible because You are pregnant or in Your 12-month postpartum coverage period. If You become pregnant, have a household income below 223% of the Federal Poverty Level, and would like to choose to enroll in Medicaid instead of Essential Plan, You should contact NYSOH.

4. When You have had a change in immigration status that makes you eligible for other coverage, including Medicaid, and Your coverage will end at the end of the month before you are determined to be Medicaid eligible.

5. When You have enrolled in a different program through the NY State of Health Marketplace.

6. When You have enrolled in affordable Employer Sponsored Health Insurance.

B. Termination by You.
You may terminate this Contract at any time by giving the NYSOH at least 14 days' prior written notice.

C. Termination by Us.
We may terminate this Contract with 30 days' written notice as follows:

1. Fraud or Intentional Misrepresentation of Material Fact.
   If You have performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on Your enrollment application, or in order to obtain coverage for a service, this Contract will terminate immediately upon a written notice to You from the NYSOH. However, if You make an intentional misrepresentation of material fact in writing on Your enrollment application, We will rescind this Contract if the facts misrepresented would have led Us to refuse to issue this Contract and the application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to the issuance of this Contract.

2. If You no longer live or reside in Our Service Area.

3. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide You with at least 90 days prior written notice.

4. The date the Contract is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this State. We will provide You with at least 180 days' prior written notice.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Conversion Right to a New Contract after Termination section of this Contract for Your right to conversion to another individual Contract.

SECTION XXIII

Temporary Suspension Rights for Armed Forces' Members

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than five (5) years of active duty.

You must make written request to Us to have Your coverage suspended during a period of active duty.

Upon completion of active duty, Your coverage may be resumed as long as You make written application to Us.

For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XXIV

General Provisions

1. Agreements Between Us and Participating Providers.
Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Contract does not require any Provider to accept a Subscriber as a patient. We do not guarantee a Subscriber's admission to any Participating Provider or any health benefits program.

2. Assignment.
You cannot assign any benefits under this Contract or legal claims based on a denial of benefits or request for plan documents to any person, corporation or other organization. Any assignment of benefits or legal claims based on a denial of benefits or request for plan documents by You will be void and unenforceable.

Assignment means the transfer to another person, corporation or other organization of Your right to the services provided under this Contract, or Your right to collect money from Us for those services, or Your right to sue based on a denial of benefits or request for plan documents. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes in this Contract.
We may unilaterally change this Contract upon renewal, if We give You 60 days' prior written notice.

4. Choice of Law.
This Contract shall be governed by the laws of the State of New York.

5. Clerical Error.
Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.
Any term of this Contract which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Contract may be limited to a specific number of visits. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, Your coverage terminates and you enroll in the product later in the year.

8. Entire Agreement.
This Contract, including any endorsements, riders and the attached applications, if any, constitutes the entire Contract.

9. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-

Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

10. Furnishing Information and Audit.
You will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

11. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Contract.

12. Incontestability.
No statement made by You in an application for coverage under this Contract shall avoid the Contract or be used in any legal proceeding unless the application or an exact copy is attached to this Contract.

13. Independent Contractors.
Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You while receiving care from any Participating Provider or in any Participating Provider's Facility.

14. Input in Developing Our Policies.
You may participate in the development of Our policies by contacting Us directly. If you have any ideas or suggestions, please let us know. You can write to us at Healthfirst, Member Services, 100 Church Street, New York, NY 10007. Or call Member Services at 888-250-2220. Our Senior Management will review all suggestions we receive.

15. Material Accessibility.
We will give You ID cards Contracts, riders and other necessary materials.

16. More Information about Your Health Plan.
You can request additional information about Your coverage under this Contract. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Subscriber information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Contract.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.

- A copy of Our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines,
  including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Contract.

17. Notice.
Any notice that We give You under this Contract will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: Member Services, Healthfirst Plans, 100 Church Street, New York, NY 10007.

18. Recovery of Overpayments.
On occasion, a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

19. Renewal Date.
The renewal date for this Contract is 12 months after the effective date of this Contract. This Contract will automatically renew each year on the renewal date, as long as you remain eligible under the Contract and unless otherwise terminated by Us as permitted by this Contract.

20. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Contract. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Contract. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Contract.

21. Right to Offset.
If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

22. Severability.
The unenforceability or invalidity of any provision of this Contract shall not affect the validity and enforceability of the remainder of this Contract.

23. Significant Change in Circumstances.
If We are unable to arrange for Covered Services as provided under this Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

24. Subrogation and Reimbursement.
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Contract. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law Section 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

25. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Contract and nothing in this Contract shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Contract. No other party can enforce this Contract's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Contract, or to bring an action or pursuit for the breach of any terms of this Contract.

26. Time to Sue.
No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Contract. You must start any lawsuit against Us under this Contract within two (2) years from the date the claim was required to be filed.

27. Translation Services.
Translation services are available free of charge under this Contract for non-English speaking Subscribers. Please contact Us at the number on Your ID card to access these services.

28. Venue for Legal Action.
If a dispute arises under this Contract, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

29. Waiver.
The waiver by any party of any breach of any provision of this Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

30. Who May Change this Contract.
This Contract may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Contract in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

31. Who Receives Payment under this Contract.
Payments under this Contract for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider. If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Contract for more information about surprise bills.

32. Workers' Compensation Not Affected.
The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

33. Your Medical Records and Reports.
In order to provide Your coverage under this Contract, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Contract, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us

permission to share Your information with the New York State Department of Health, and other authorized federal, state and local agencies with authority over the Essential Plan, quality oversight organizations, and third parties with which We contract to assist Us in administering this Contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements. If You want to take away any permissions you gave to release this information, you may call us at the number on Your ID card.

34. Your Rights.
You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

As a Member, You should also take an active role in Your care. We encourage You to:

- Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
- Follow the treatment plan that You have agreed on with Your doctors or Providers;
- Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Contract. This may include information about other health insurance benefits You have along with Your coverage with Us; and
- Inform Us if You have any changes to Your name, address or Dependents covered under Your Contract.

ESSENTIAL PLAN
SECTION XXV

HEALTHFIRST SCHEDULE OF BENEFITS
See Benefit Description in Contract for More Details

Non-Participating Provider services are not Covered for any services other than those related to emergency care and You pay the full cost for services performed by a non-participating provider except in cases related to emergency care.

COST-SHARING	**Essential Plan 200 – 250**
Deductible • Individual	$0
Out-of-Pocket Limit • Individual Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a Plan Year basis.	$2,000
OFFICE VISITS	
Primary Care Office Visits (or Home Visits)	$15 Copayment
Specialist Office Visits (or Home Visits)	$25 Copayment

PREVENTIVE CARE	
• Adult Annual Physical Examinations*	Covered in full
• Adult Immunizations*	Covered in full
• Routine Gynecological Services/Well Woman Exams*	Covered in full
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full
• Sterilization Procedures for Women*	Covered in full
• Vasectomy	See Surgical Services Section
• Bone Density Testing*	Covered in full
• Screening for Prostate Cancer	Covered in full
• Screening for Colon Cancer	Covered in full
• All other preventive services required by USPSTF and HRSA	Covered in full
• *When preventive services are not provided in	Use Cost-Sharing for appropriate service (Primary Care

accordance with the comprehensive guidelines supported by USPSTF and HRSA	Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
EMERGENCY CARE	
Pre-Hospital Emergency Medical Services (Ambulance Services)	$75 Copayment
Non-Emergency Ambulance Services	$75 Copayment **Preauthorization Required**
Emergency Department Copayment waived if admitted to Hospital	$75 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Copayment
Urgent Care Center	$25 Copayment
PROFESSIONAL SERVICES and OUTPATIENT CARE	
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	 $25 Copayment **Preauthorization Required** $25 Copayment **Preauthorization Required**
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 $15 Copayment $25 Copayment

Ambulatory Surgical Center Facility Fee	$50 Copayment **Preauthorization Required**
Anesthesia Services (all settings)	Covered in full **Preauthorization Required**
Cardiac and Pulmonary Rehabilitation	
• Performed in a Specialist Office	$25 Copayment **Preauthorization Required**
• Performed as Outpatient Hospital Services	$25 Copayment **Preauthorization Required**
• Performed as Inpatient Hospital Services	Included as part of inpatient Hospital service cost-sharing **Preauthorization Required**
Chemotherapy and Immunotherapy	
• Performed in a PCP Office	$15 Copayment **Preauthorization Required**
• Performed in a Specialist Office	$15 Copayment **Preauthorization Required**
• Performed as Outpatient Hospital Services	$15 Copayment **Preauthorization Required**
• Performed at Home	$15 Copayment **Preauthorization Required**
• Chemotherapy and Immunotherapy Medications	$15 Copayment **Preauthorization Required**

Chiropractic Services	$25 Copayment **Preauthorization Required**
Clinical Trials	Use Cost-Sharing for appropriate service **Preauthorization Required**
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment **Preauthorization Required** $25 Copayment **Preauthorization Required** $25 Copayment **Preauthorization Required**
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services • Performed at Home Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year. See benefit description for more information.	 $15 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required**

Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$15 Copayment **Preauthorization Required** 60 visits per condition, per Plan Year combined therapies
Home Health Care 40 visits Per Plan Year	$15 Copayment **Preauthorization Required**
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **Preauthorization Required**
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy (Home infusion counts toward home health care visit limits) • Infusion Therapy Medication	 $15 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required**
Inpatient Medical Visits	$0 per admission
Interruption of Pregnancy • Abortion Services	 Covered in Full

Laboratory Procedures	
• Performed in a PCP Office	$15 Copayment **Preauthorization Required**
• Performed in a Freestanding Laboratory Facility or Specialist Office	$25 Copayment **Preauthorization Required**
• Performed as Outpatient Hospital Services	$25 Copayment **Preauthorization Required**
Maternity and Newborn Care	
• Prenatal Care	$0 **Preauthorization Required**
• Inpatient Hospital Services and Birthing Center One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early	$0 **Preauthorization Required**
• Physician and Midwife Services for Delivery	$0 **Preauthorization Required**
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps Covered for duration of breast feeding	$0 **Preauthorization Required**
• Postnatal Care	Included in Physician and Midwife Services for Delivery Cost-Sharing

	Preauthorization Required
Outpatient Hospital Surgery Facility Charge	$50 Copayment **Preauthorization Required**
Preadmission Testing	$0 Copayment
Prescription Drugs Administered in Office	
• Performed in a PCP Office	Included as part of the PCP office visit Cost-Sharing **Preauthorization Required**
• Performed in Specialist Office	Included as part of the Specialist office visit Cost-Sharing **Preauthorization Required**
• Prescription Drug Cost-Sharing	$15 Copayment **Preauthorization Required**
Diagnostic Radiology Services	
• Performed in a PCP Office	$15 Copayment **Preauthorization Required**
• Performed in a Freestanding Radiology Facility or Specialist Office	$25 Copayment **Preauthorization Required**
• Performed as Outpatient Hospital Services	$25 Copayment **Preauthorization Required**

Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	 $15 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required** 60 visits per condition, per plan year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery
Retail Health Clinic Care	$25 Copayment
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$25 Copayment
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery and	

Transplants **All transplants must be performed at designated Facilities**	
• Inpatient Hospital Surgery	$50 Copayment **Preauthorization Required**
• Outpatient Hospital Surgery	$50 Copayment **Preauthorization Required**
• Surgery Performed at an Ambulatory Surgical Center	$50 Copayment **Preauthorization Required**
• Office Surgery	$15 Copayment (when performed at PCP office) **Preauthorization Required** $25 Copayment (when performed at specialist office) **Preauthorization Required**
Telemedicine Program (Teladoc)	$0 Copayment
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	
Diabetic Equipment, Supplies and Self-Management Education	
• Retail Diabetic Equipment, and Supplies and Insulin (30-day supply; Up to a 90-day supply)	$15 Copayment per month. Diabetic insulin cost-sharing is no more than $100 for a 30-day supply. **Preauthorization Required**
• Diabetic Education	$15 Copayment
Durable Medical Equipment and Braces	5% cost-sharing **Preauthorization Required**

External Hearing Aids • Prescription Hearing Aids **Single purchase one every three (3) years**	5% cost-sharing **Preauthorization Required**
Cochlear Implants **One (1) per ear per time Covered**	5% cost-sharing **Preauthorization Required**
Hospice Care • Inpatient • Outpatient 210 days per Plan Year Five (5) visits for family bereavement counseling	 $150 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required**
Medical Supplies	5% coinsurance **Preauthorization Required**
Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts • Internal	 5% coinsurance **Preauthorization Required** Included as part of Inpatient Hospital Cost-sharing **Preauthorization Required**

INPATIENT SERVICES and FACILITIES	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	$150 Copayment **Preauthorization Required. However, Preauthorization is not required for emergency admissions.**
Autologous Blood Banking	5% coinsurance **Preauthorization Required**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) 200 days per Plan Year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility	$150 Copayment **Preauthorization Required**
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	$150 Copayment **Preauthorization Required** 60 days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 60 days per Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery.	$150 Copayment **Preauthorization Required**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)	$150 Copayment **Preauthorization required. However, Preauthorization is not required for emergency admissions.**

Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	
• Office Visits	$15 Copayment **Preauthorization Required**
• All Other Outpatient Services • Outpatient Services provided in a Facility licensed, certified, or otherwise authorized by OMH	$15 Copayment **Preauthorization Required**
• All Other Outpatient Services	$15 Copayment **Preauthorization Required**
ABA Treatment for Autism Spectrum Disorder	$15 Copayment **Preauthorization Required**
Assistive Communication Devices for Autism Spectrum Disorder	$15 Copayment **Preauthorization Required**
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	$150 Copayment **Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified facilities.**
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	
• Office Visits	$15 Copayment **Preauthorization Required**

• All Other Outpatient Services • Opioid Treatment Program • All Other Outpatient Services **However, Preauthorization is not required for Participating OASAS-certified Facilities**	$0 Copayment **Preauthorization Required** $15 Copayment **Preauthorization Required**
PRESCRIPTION DRUGS	
Retail Pharmacy	
30-day supply Tier 1 Tier 2 Tier 3 Preauthorization is not required for a covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	 $6 Copayment $15 Copayment $30 Copayment
Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3	 $18 Copayment $45 Copayment $90 Copayment

Mail Order Pharmacy	
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $15 Copayment $37.50 Copayment $75 Copayment
Enteral Formulas Tier 1 Tier 2 Tier 3	 $6 Copayment $15 Copayment $30 Copayment
WELLNESS BENEFITS	
Gym Reimbursement	Up to $200 per six (6)-month period
DENTAL and VISION CARE	
Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (Oral Surgery, Endodontics, Periodontics and Prosthodontics)	 $0 $0 $0

One (1) dental exam and cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals Orthodontics and major dental require Preauthorization	
Vision Care • Exams • Lenses and Frames • Contact Lenses One (1) exam per12-month period, unless otherwise medically necessary One (1) prescribed lenses and frames per Plan Year, unless otherwise medically necessary Contact lenses require Preauthorization	 $0 $0 $0

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Contract, You will be responsible for the full cost of the services.

Eligible American Indians, as determined by the NYSOH, are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

healthfirst
Health Insurance for New Yorkers

Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. Healthfirst does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Healthfirst at **1-866-305-0408**. For TTY services, call 1-888-542-3821.

If you believe that Healthfirst has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Healthfirst by:

- **Mail:** Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- **Phone:** **1-866-305-0408** (for TTY services, call 1-888-542-3821)
- **Fax:** 1-212-801-3250
- **In person:** 100 Church Street, New York, NY 10007
- **Email:** **http://healthfirst.org/members/contact/**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- **Web:** Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- **Phone:** **1-800-368-1019** (TTY 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-305-0408 (TTY: 1-888-542-3821).	Chinese
ملحوظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408 (TTY: 1-888-542-3821).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY: 1-888-542-3821).번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408 (TTY: 1-888-542-3821).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408 (TTY: 1-888-542-3821).	Italian
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408 (TTY: 1-888-542-3821).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY: 1-888-542-3821).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון 1-866-305-0408 (TTY: 1-888-542-3821). רופט אפצאל.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY: 1-888-542-3821).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-305-0408 (TTY: 1-888-542-3821).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-866-305-0408 (TTY: 1-888-542-3821).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408 (TTY: 1-888-542-3821).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408 (TTY: 1-888-542-3821).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-305-0408 (TTY: 1-888-542-3821).	Urdu

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EXHIBIT 6

Excerpts, first page from Essential Plan Member Contracts:

- **2025 EP200-250 Member Contract**
  - **2025 EP1 Member Contract**
  - **2025 EP2 Member Contract**
  - **2026 EP1 Member Contract**
  - **2026 EP2 Member Contract**

healthfirst

This is Your

ESSENTIAL PLAN CONTRACT

Issued by

Healthfirst PHSP, Inc.

This is Your individual Contract for the Essential Plan coverage issued by Healthfirst PHSP, Inc. This Contract, together with the attached Schedule of Benefits, applications and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract.

Renewability. The renewal date for this Contract is twelve months from the effective date of coverage. This Contract will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Contract or by You upon 30 days' prior written notice to Us. If You become pregnant while covered under this Contract, You will have coverage for the duration of the pregnancy, along with one year of postpartum coverage. The 12-month postpartum coverage period will start on the last day of Your pregnancy and end on the last day of the 12th month.

In-Network Benefits. This Contract only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers. Except for care for an Emergency Condition described in the Emergency Services and Urgent Care section of this Contract, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

This Contract is governed by the laws of New York State.



Pat Wang
CEO & President

If You need foreign language assistance to understand this Contract, You may call Us at the number on Your ID card.

healthfirst

This is Your

ESSENTIAL PLAN CONTRACT

Issued by

Healthfirst PHSP, Inc.

This is Your individual Contract for the Essential Plan coverage issued by Healthfirst PHSP, Inc. This Contract, together with the attached Schedule of Benefits, applications and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

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EXHIBIT 7

2023 Qualified Health Plan Model Contract

between Healthfirst and New York State

MISCELLANEOUS/CONSULTANT SERVICES

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

NYS COMPTROLLER'S # C039700

ORIGINATING AGENCY GLBU: DOH01
DEPARTMENT ID: 3450000

CONTRACTOR (Name and Address):

Healthfirst PHSP, Inc.
100 Church Street
New York, NY 10007

TYPE OF PROGRAM(S):

Qualified Health Plans / NY State of Health

CHARITIES REGISTRATION NUMBER:

05-41-57

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

FEDERAL TAX IDENTIFICATION NUMBER:
13-3783732

NYS VENDOR IDENTIFICATION NUMBER:
1000026827

MUNICIPALITY NO. (if applicable)

CONTRACT TERM

FROM: October 1, 2023
TO: December 31, 2028

FUNDING AMOUNT FOR CONTRACT TERM: NOT TO EXCEED $1,317,165,262.00

STATUS:

CONTRACTOR IS ( ) IS NOT (X) A SECTARIAN ENTITY

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

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

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

APPENDICES ATTACHED AND PART OF THIS CONTRACT
Precedence shall be given to these documents in the order listed below.

-X- APPENDIX A Standard Clauses as required by the Attorney General for all State Contracts.
-X- APPENDIX X Contract Amendment Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)
-X- APPENDIX Q Modification of Standard Department of Health Contract Language
-X- NEW YORK STATE DEPARTMENT OF HEALTH CONTRACT
-X- APPENDIX M Participation by Minority and Women-Owned Business Enterprises
-X- APPENDIX C Program Specific Requirements
-X- APPENDIX C-1 Marketplace Facilitated Enroller (FE) Program
-X- APPENDIX D Invitation and Requirements for Insurer Certification and Recertification to Participate in NY State of Health
-X- APPENDIX D-1 Contractor's Proposal to Participate in the NY State of Health, as amended
___ APPENDIX F Technology Terms and Conditions
___ APPENDIX H Federal Health Insurance Portability and Accountability Act ("HIPAA") Business Associate Agreement ("Agreement")
-X- APPENDIX I Trading Partner Agreement

IN WITNESS WHEREOF, the parties hereto have executed this Contract # C039700 on the dates below their signature.

CONTRACTOR

Insert Contractor Name

Healthfirst PHSP, Inc.

By: Kathryn Howell

Kathryn Howell

Printed Name

Title: Chief Legal Officer & General Counsel

Date: 1/10/24

STATE AGENCY

New York State Department of Health

By: Danielle Holahan

Danielle Holahan

Printed Name

Title: Executive Director, NY State of Health

Date: 2/1/24

State Agency Certification:
"In addition to the acceptance of this Contract, I also certify that original copies of this signature page will be attached to all other exact copies of this Contract."

STATE OF NEW YORK)
)SS.:
County of New York)

On the 10th day of January in the year 2024 before me, the undersigned, personally appeared Kathryn Howell personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that they executed the same in their capacity(ies), and that by their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Joshua Harris Pike
Notary Public, State of New York
Registration No. 02PI6379652
Qualified in New York County
My Commission Expires November 18, 2026

1/10/24

(Signature and office of the individual taking acknowledgment)

ATTORNEY GENERAL'S SIGNATURE

Title:

Date:

NYS COMPTROLLER'S SIGNATURE

APPROVED
DEPT. OF AUDIT & CONTROL
Mar 27 2024
James Iwaneczko
FOR THE STATE COMPTROLLER

Title:

Date:

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

PLEASE RETAIN THIS DOCUMENT
FOR FUTURE REFERENCE.

June 2023

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STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law, if this contract exceeds $50,000 (or $75,000 for State University of New York or City University of New York contracts for goods, services, construction and printing, and $150,000 for State University Health Care Facilities) or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $25,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services, either for itself or its customer agencies by the Office of General Services Business Services Center, is required when such contracts exceed $85,000. Comptroller's approval of contracts established as centralized contracts through the Office of General Services is required when such contracts exceed $125,000, and when a purchase order or other procurement transaction issued under such centralized contract exceeds $200,000.

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment, nor subject any individual to harassment, because of age, race, creed, color, national origin, citizenship or immigration status, sexual orientation, gender identity or expression, military status, sex, disability, predisposing genetic characteristics, familial status, marital status, or domestic violence victim status or because the individual has opposed any practices forbidden under the Human Rights Law or has filed a complaint, testified, or assisted in any proceeding under the Human Rights Law. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be a condition precedent to payment by the State of any State approved sums due and owing for work done upon the project.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2 NYCRR § 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, the "Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or (iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, must give the reason or reasons why the payee does not have such number or numbers.

(b) Privacy Notification. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law and 5 NYCRR Part 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and

improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "(a), (b) and (c)" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this clause. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in § 165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby

stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority- and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business and Technology Development
625 Broadway
Albany, New York 12245
Telephone: 518-292-5100

A directory of certified minority- and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
633 Third Avenue 33rd Floor
New York, NY 10017
646-846-7364
email: mwbebusinessdev@esd.ny.gov
https://ny.newnycontracts.com/FrontEnd/searchcertifieddirectory.asp

The Omnibus Procurement Act of 1992 (Chapter 844 of the Laws of 1992, codified in State Finance Law § 139-i and Public Authorities Law § 2879(3)(n)–(p)) requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority- and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively, codified in State Finance Law § 165(6) and Public Authorities Law § 2879(5)) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 2023, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii.

22. COMPLIANCE WITH BREACH NOTIFICATION AND DATA SECURITY LAWS. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law §§ 899-aa and 899-bb and State Technology Law § 208).

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW. If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4)(g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

24. PROCUREMENT LOBBYING. To the extent this agreement is a "procurement contract" as defined by State Finance Law §§ 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law §§ 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.
To the extent this agreement is a contract as defined by Tax Law § 5-a, if the contractor fails to make the certification required by Tax Law § 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law § 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing

written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

26. IRAN DIVESTMENT ACT. By entering into this Agreement, Contractor certifies in accordance with State Finance Law § 165-a that it is not on the "Entities Determined to be Non-Responsive Bidders/Offerers pursuant to the New York State Iran Divestment Act of 2012" ("Prohibited Entities List") posted at: https://ogs.ny.gov/iran-divestment-act-2012

Contractor further certifies that it will not utilize on this Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that should it seek to renew or extend this Contract, it must provide the same certification at the time the Contract is renewed or extended. Contractor also agrees that any proposed Assignee of this Contract will be required to certify that it is not on the Prohibited Entities List before the contract assignment will be approved by the State.

During the term of the Contract, should the state agency receive information that a person (as defined in State Finance Law § 165-a) is in violation of the above-referenced certifications, the state agency will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the state agency shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the Contractor in default.

The state agency reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

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

APPENDIX X
CONTRACT AMENDMENT FORM
ORIGINATING AGENCY: DOH01

Contract Number: C039700 CONTRACTOR:_____

Amendment Number X-_____ BSC Unit ID: 3450000

This is a Contract Amendment between THE STATE OF NEW YORK, acting by and through NYS Department of Health, having its principal office at Corning Tower, Albany, New York, (hereinafter referred to as the DEPARTMENT), and_____(hereinafter referred to as the CONTRACTOR), having its mailing address at_____, for amendment of this Contract.

This amendment makes the following changes to the Contract (check all that apply):

- ☐ Modifies the Contract period at no additional cost
- ☐ Modifies the Contract period at additional cost
- ☐ Modifies the budget or payment terms
- ☐ Modifies the work plan or deliverables
- ☐ Replaces appendix(es)___with the attached appendix(es) ___
- ☐ Adds the attached appendix(es) _____
- ☐ Other: (describe): _____

This amendment *is* ☐ *is not* ☐ a Contract renewal as allowed for in the existing Contract.

All other provisions of said Contract shall remain in full force and effect.

Additionally, CONTRACTOR certifies that it is not included on the prohibited entities list published at https://ogs.ny.gov/iran-divestment-act-2012 as a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York. Under the Act, the Commissioner of the Office of General Services (OGS) has developed a list (prohibited entities list) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). CONTRACTOR (or any assignee) also certifies that it has not used, and agrees that it will not use, on such Contract in any subcontracts that is identified on the prohibited entities list.

Prior to this amendment, the Contract value and period were:

$_____ From___/___/_____to___/___/_____.
(Value before amendment) (Initial Start date) (Amendment end date)

This amendment provides the following modification (complete only items being modified):

$_____ From___/___/_____to___/___/_____.
(Initial Start date) (Amendment end date)

This will result in new Contract terms of:

$_____ From___/___/_____to___/___/_____.
(All years thus far combined) (Initial Start date) (Amendment end date)

Signature Page for:

Contract Number:_____ CONTRACTOR:_____

Amendment Number X-_____ Unit ID: 34500000

IN WITNESS WHEREOF, the parties hereto have executed this Contract Amendment as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE:

By:_____ Date:_____
(signature)

Printed Name:_____

Title:_____

STATE OF NEW YORK)
)SS.:
County of_____)

On the _day of_____in the year_____before me, the undersigned, personally appeared_____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that they executed the same in their capacity(ies), and that by their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

(Signature and office of the individual taking acknowledgement)

STATE AGENCY SIGNATURE

"In addition to the acceptance of this Contract Amendment, I also certify that original copies of this signature page will be attached to all other exact copies of this Contract Amendment."

By:_____ Date:_____
(signature)

Printed Name:_____

Title:_____

ATTORNEY GENERAL'S SIGNATURE

By:_____ Date:_____

STATE COMPTROLLER'S SIGNATURE

By:_____ Date:_____

Appendix Q
MODIFICATION OF STANDARD DEPARTMENT OF HEALTH CONTRACT LANGUAGE

New York State Department of Health Contract, Section I, General Terms and Conditions, paragraph "F" is replaced in its entirety with the following:

F. For the purposes of this Contract, the term "Proposal" includes all Appendix D-1 documents as marked on the Face Page and approved by the DEPARTMENT.

New York State Department of Health Contract, Section I, General Terms and Conditions, paragraph "I" is replaced in its entirety with the following:

I. For the purposes of this Contract, the Appendix D includes the Invitation and Requirements for Insurer Certification and Recertification for Participation as amended, including questions and answer documents (the body of which is attached), and Attachments, which are set forth in their entirety at: https://info.nystateofhealth.ny.gov/invitation

New York State Department of Health Contract, Section II, Payment and Reporting, is amended to add the following provision:

Any funds provided by the DEPARTMENT pursuant to this Contract shall not be used for any partisan political activity, or for activities that may influence legislation or the election or defeat of any candidate for public office.

NEW YORK STATE DEPARTMENT OF HEALTH CONTRACT

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

WITNESSETH:

WHEREAS, the DEPARTMENT has formally requested contractors to submit bid proposals for the project described in Appendix B for which bids were opened on the date noted on the face pages of this AGREEMENT; and

WHEREAS, the STATE has determined that the CONTRACTOR is the successful bidder, and the CONTRACTOR covenants that it is willing and able to undertake the services and provide the necessary materials, labor and equipment in connection therewith; has determined, without a formal bid proposal, that it is in need of the services described in Appendix C; and the CONTRACTOR covenants that it is willing and able to undertake the services and provide thenecessary materials, labor and equipment in connection therewith;

NOW THEREFORE, in consideration of the terms, promises, responsibilities, and covenants set forth below the parties agree as follows:

I. General Terms and Conditions

A. This Contract incorporates the face pages attached and all of the marked appendices identified on the face page.

B. The maximum compensation for the Contract term of this Contract shall not exceed the amount specified on the face page.

C. This Contract may be renewed for an additional period (PERIOD), as specified on the face page.

D. To amend or exercise any renewal option of this Contract, the parties shall prepare new appendices, to the extent that any require modification, and a Contract Amendment Form in the format provided by the DEPARTMENT (Appendix X). Any terms of this Contract not modified shall remain in effect for each PERIOD of the Contract. The Contract Amendment Form is subject to the approval of the Office of the State Comptroller. This Contract may not be amended orally. The CONTRACTOR shall not make any changes in the scope of work at any time without prior authorization in writing from the DEPARTMENT and without prior approval in writing of the amount of compensation for such changes.

E. Appendix A (Standard Clauses as required by the Attorney General for all State Contracts) takes precedence over all other parts of the Contract.

F. For the purposes of this Contract, the term "Proposal" includes all Appendix C documents as marked on the face page.

G. The CONTRACTOR is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the DEPARTMENT nor make any

claims, demand or application to or for any right based upon any different status.

H. The CONTRACTOR agrees, throughout the term of this Contract, to maintain, at CONTRACTOR'S expense, those benefits to which its employees are entitled by law, including health benefits, any necessary insurance for its employees, including professional liability, worker's compensation, disability and unemployment insurance, and to provide the DEPARTMENT with certification of such insurance upon request. The CONTRACTOR remains responsible for all applicable federal, state, and local taxes, and all FICA contributions.

I. For the purposes of this Contract, the Appendix B includes all Request for Proposal (RFP) or Funding Availability Solicitation (FAS) documents including questions and answer documents, amendments and attachments.

J. CONTRACTOR is under an affirmative duty to be informed by personal examination of the specifications and location of the proposed work and by such other means as it may select, of character, quality and extent of work to be performed and the conditions under which the Contract is to be executed.

K. The DEPARTMENT will make no allowance or concession to a CONTRACTOR for any alleged misunderstanding or deception because of quantity, quality, character, location or other conditions.

L. The CONTRACTOR shall have a representative to provide supervision of the work which CONTRACTOR employees are performing to ensure complete and satisfactory performance with the terms of this Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the DEPARTMENT. A confirmation in writing of such orders or directions will be given by the DEPARTMENT when so requested from the CONTRACTOR.

M. If the DEPARTMENT is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, the DEPARTMENT shall have the authority to require the CONTRACTOR to use such additional personnel, to take such steps necessary to perform the services satisfactorily at no additional cost to the DEPARTMENT.

N. The DEPARTMENT shall conduct any inspection at a time during normal business hours where the activities of the work under this Contract are taking place and in a manner so as not to unreasonably disrupt the CONTRACTOR'S business. During its inspection the DEPARTMENT may view and audit any materials related to this Contract.

O. No failure by the DEPARTMENT at any time to give notice of any breach by the other party of, or to require compliance with, any condition or provision of this Contract shall be deemed a waiver of similar or dissimilar provisions or conditions at the same or at any prior or subsequent time.

II. Payment and Reporting

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

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

   Subject: **Unit ID:** 3450475 **Contract Number:** C039700
   (Note: **Do not** send a paper copy in addition to your emailed voucher.)

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

   NYS Department of Health
   Unit ID: 3450475
   Building 5, 5th Floor 1220 Washington Ave
   Albany, NY 12226-1900

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

Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary DEPARTMENT procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at helpdesk@sfs.ny.gov, or by telephone at 1-855-233-8363. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9 must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us./vendors/vendorguide/guide.htm.

Payment terms shall be:

The Contractor will submit monthly invoices, due 30 days after the end of each month, and must be accompanied by a New York State Claim for Payment (form AC3253-S) to ensure payment. The invoice must detail the date of the event, location of the event and break out the services rendered as detailed in Appendix C.

III. Term and Termination

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

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

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

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

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

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

F. Provisions Upon Default

1. In the event that the CONTRACTOR, through any cause, fails to perform any of the terms, covenants or promises of this Contract, the DEPARTMENT thereupon shall have the right to terminate this Contract by giving notice in writing of the fact and date of such termination to the CONTRACTOR.

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

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

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

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

IV. Contract Insurance Requirements

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

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

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

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

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

Name/Title: Sue Mantica / Director
Organization: NYS DOH, Bureau of Contracts
Address: Room 2834, Corning Tower ESP
Address: Albany NY 12237

Unless otherwise agreed, policies shall be written so as to include a provision that the policy will not be canceled, materially changed, or not renewed without at least 30 days prior written notice except for non-payment as required by law to the DEPARTMENT at the address specified above in this paragraph. In addition, if required by the DEPARTMENT, the CONTRACTOR shall deliver to the DEPARTMENT within forty-five (45) days of such request a copy of any or all policies of insurance not previously provided, certified by the insurance carrier as true and complete.

Certificates of Insurance shall:

a. Be in the form approved by the DEPARTMENT.

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

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

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

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

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

Only original documents (Certificates of Insurance, Supplemental Insurance Certificates, and other attachments) will be accepted.
Electronic forms will be accepted as original documents, provided the subject electronic document can be directly traced back to the insurance carrier, agent, or broker via email distribution or similar means.

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

5. Policy Renewal/Expiration. At least two weeks prior to the expiration of any policy required by this Contract, evidence of renewal or replacement policies of insurance with terms no less favorable to the DEPARTMENT than the expiring policies shall be delivered to the DEPARTMENT in the manner required for service of notice in

subsection B.3. Certificates of Insurances/Notices of this Section. If, at any time during the term of this Contract, the coverage provisions and limits of the policies required herein do not meet the provisions and limits set forth in this Contract or proof thereof is not provided to the DEPARTMENT, the CONTRACTOR shall immediately cease work under this Contract. The CONTRACTOR shall not resume work under this Contract until authorized to do so by the DEPARTMENT. Any delay, time lost, or additional cost incurred as a result of the CONTRACTOR not having insurance required by this Contract or not providing proof of same in a form acceptable to the DEPARTMENT shall not give rise to a delay claim or any other claim against the DEPARTMENT. Should the CONTRACTOR fail to provide or maintain any insurance required by this Contract, or proof thereof is not provided to the DEPARTMENT, the DEPARTMENT may withhold further Contract payments, treat such failure as a breach or default of the Contract, and/or, after providing written notice to the CONTRACTOR, require the Surety, if any, to secure appropriate coverage and/or purchase insurance complying with this Contract and charge back such purchase to the CONTRACTOR.

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

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

C. Specific Coverages and Limits

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

1. Workers' Compensation

For work to be performed in New York State, the CONTRACTOR shall provide and maintain coverage during the life of this Contract for the benefit of such employees as are required to be covered by the NYS Workers' Compensation Law. The CONTRACTOR shall provide notice to the DEPARTMENT immediately if CONTRACTOR'S Workers' Compensation coverage has lapsed or terminated during the PERIOD of this Contract.

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

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

a. C-105.2 (September 2007, or most current version) – Certificate of Workers' Compensation Insurance.

b. U-26.3 – Certificate of Workers' Compensation Insurance from the State Insurance Fund.
c. GSI-105/SI-12 – Certificate of Workers' Compensation Self Insurance.
d. CE-200 – Certificate of Attestation of Exemption (If CONTRACTOR meets the requirements)

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

2. Disability Benefits

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

Evidence of Disability Benefits coverage must be provided on one of the following forms specified by the Commissioner of the Workers' Compensation Board:
a. DB-120.1 (May 2006 or most current version) – Certificate of Insurance Coverage under the NYS Disability Benefits Law
b. DB-155 – Certificate of Disability Self Insurance
c. CE-200 – Certificate of Attestation of Exemption

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

3. Commercial General Liability

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

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

Coverage shall include, if applicable, the following:

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

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

The following ISO forms must be endorsed to the policy:

a. CG 00 01 01 96 or an equivalent – Commercial General Liability Coverage Form
b. CG 20 10 11 85 or an equivalent – Additional Insured-Owner, Lessees or CONTRACTORS (Form B)
c. CG 25 03 11 85 or an equivalent – Designated Construction Project(s) general aggregate limit (only required for construction Contracts).

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

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

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

4. Commercial Automobile Liability

Commercial Auto Liability insurance covering liability arising out of the use of any motor vehicle in connection with the work, including owned, leased, hired and non-owned vehicles bearing or, under the circumstances under which they are being used, required by the Motor Vehicle Laws of the State of New York to bear, license plates. Such policy shall have a combined single limit for Bodily Injury and Property Damage of at least one million dollars and shall name the State of New York as additional insured. The limits may be provided through a combination of primary and umbrella/excess liability policies. If this Contract involves the removal of hazardous waste from the project site or otherwise transporting hazardous materials, pollution liability coverage for covered autos shall be provided by form CA 99 48 03 06 or CA 00 12 03 06 and the Motor Carrier Act Endorsement (MCS90) shall be attached.

5. Umbrella and Excess Liability

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

V. Conflicts of Interest

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

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

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

D. The CONTRACTOR shall disclose any existing or contemplated relationship with any other person or entity, including relationships with any member, shareholders of 5% or more, parent, subsidiary, or affiliated entity which would constitute an actual or potential conflict of interest or appearance of impropriety, relating to other clients/customers of the CONTRACTOR or former officers and employees of the DEPARTMENT and its affiliates, in connection with rendering services enumerated in this Contract. If a conflict does or might exist, please describe how you will eliminate or prevent it. Indicate what procedures will be followed to detect, notify the DEPARTMENT of, and resolve any such conflicts. The DEPARTMENT will review the nature of any relationships and reserves the right to terminate this Contract for any reason, or for cause, if, in the judgment of the DEPARTMENT, a real or potential conflict of interest cannot be cured.

E. The CONTRACTOR shall disclose whether it or any of its members, shareholders of 5% or more, parents, affiliates, or subsidiaries have been the subject of any investigation or disciplinary action by the New York State Joint Commission on Public

Ethics, or its predecessors or its predecessor entities (collectively, "Commission"), and if so, shall include a brief description indicating how any matter before the Commission was resolved or whether it remains unresolved. The DEPARTMENT will review the nature of any relationships and reserves the right to terminate this Contract for any reason, or for cause, if, in the judgment of the DEPARTMENT, a real or potential conflict of interest cannot be cured.

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

VI. Public Officers Law

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

VII. Ethics Requirements

The CONTRACTOR and its subcontractors shall not engage any person who is, or has been at any time, in the employ of the DEPARTMENT to perform services in violation of the provisions of the New York Public Officers Law, other laws applicable to the service of DEPARTMENT employees, and the rules, regulations, opinions, guidelines or policies promulgated or issued by the New York State Joint Commission on Public Ethics, or its predecessors (collectively, the "Ethics Requirements"). The CONTRACTOR certifies that all of its employees and those of its subcontractors who are former employees of the DEPARTMENT and who are assigned to perform services under this Contract shall be assigned in accordance with all Ethics Requirements. During the Term, no person who is employed by the CONTRACTOR or its subcontractors and who is disqualified from providing services under this Contract pursuant to any Ethics Requirements may share in any net revenues of the CONTRACTOR or its subcontractors derived from this Contract. The CONTRACTOR shall identify and provide the DEPARTMENT with notice of those employees of the CONTRACTOR and its subcontractors who are former employees of the DEPARTMENT that will be assigned to perform services under this Contract and ensure that such employees comply with all applicable laws and prohibitions. The DEPARTMENT may request that the CONTRACTOR provide whatever information the DEPARTMENT deems appropriate about each such person's engagement, work cooperatively with the DEPARTMENT to solicit advice from the New York State Joint Commission on Public Ethics,

and, if deemed appropriate by the DEPARTMENT, instruct any such person to seek the opinion of the New York State Joint Commission on Public Ethics. The DEPARTMENT shall have the right to withdraw or withhold approval of any subcontractor if utilizing such subcontractor for any work performed hereunder would be in conflict with any of the Ethics Requirements. The DEPARTMENT shall have the right to terminate this Contract at any time if any work performed hereunder is in conflict with any of the Ethics Requirements.

VIII. Subcontracting

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

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

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

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

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

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

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

IX. General Specifications

A. The work shall be commenced and shall be actually undertaken within such time as the DEPARTMENT may direct by notice, whether by mail, e-mail, or other writing, whereupon the undersigned will give continuous attention to the work as directed, to the end and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the DEPARTMENT may prescribe.

B. The CONTRACTOR will be required to complete the entire work or any part thereof as the case may be, to the satisfaction of the DEPARTMENT in strict accordance with the specifications and pursuant to this Contract.

C. CONTRACTOR will possess, and maintain, at no cost to the DEPARTMENT and for the term of the Contract, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this Contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

D. Certification Regarding Debarment and Suspension

Regulations of the Department of Health and Human Services, located at Part 376 of Title 2 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive Departments and agencies shall participate in a government-wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and non-financial assistance and benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the DEPARTMENT (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the DEPARTMENT must require its prospective CONTRACTORS, as prospective lower tier participants, to provide the certification as set forth below:

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

a. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to the other remedies available, the Federal Government, New York State or the DEPARTMENT may pursue available remedies, including suspension and/or debarment.

b. The prospective lower tier participant shall provide immediate written notice to the

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

c. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered Transaction, principal, proposal, and voluntarily excluded, as used in this Section, are defined in 2 CFR Part 180, as supplemented by 2 CFR Part 376.

d. The prospective lower tier participant agrees by signing this Contract or submitting a proposal pursuant to a solicitation issued by the DEPARTMENT that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 2 CFR Part 180, as supplemented by 2 CFR Part 376, or 48 CFR Part 9, Subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the DEPARTMENT.

e. The prospective lower tier participant further agrees by signing this Contract or proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction,' without modification, in all lower tier covered transactions.

f. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 2 CFR Part 180, as supplemented by 2 CFR Part 376, or 48 CFR Part 9, Subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. The DEPARTMENT strongly encourages each participant to check the List of parties Excluded from Federal Procurement and Non-procurement Programs in the System for Award Management.

g. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this Section.

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

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

    i. The prospective lower tier participant certifies, by signing this Contract or submitting a proposal to the Department, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily exclude from participation in this transaction by any federal agency.

ii. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

E. Ownership Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this Contract shall contain the following, or similar acknowledgment: "Funded by the New York State Department of Health." Any such materials must be reviewed and approved by the DEPARTMENT for conformity with the policies and guidelines of the DEPARTMENT prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the CONTRACTOR shall be free to publish in scholarly journals along with a disclaimer that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health. The DEPARTMENT reserves the right to disallow funding for any educational materials not approved through its review process.

2. Any publishable or otherwise reproducible material developed under or in the course of performing this Contract, dealing with any aspect of performance under this Contract, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the DEPARTMENT, and shall not be published or otherwise disseminated by the CONTRACTOR to any other party unless prior written approval is secured from the DEPARTMENT or under circumstances as indicated in paragraph 1 of this subsection. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the DEPARTMENT. The DEPARTMENT shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

3. No report, document or other data produced in whole or in part with the funds provided under this Contract may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report, document or other data developed pursuant to this Contract, without express written permission of the DEPARTMENT.

4. All reports, data sheets, documents, etc. generated under this Contract shall be the sole and exclusive property of the DEPARTMENT. The CONTRACTOR shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the DEPARTMENT or its authorized agents.

5. This is a "Work for Hire" Contract. The DEPARTMENT will be the sole owner of all source code and any software which is developed for use in any application software provided to the DEPARTMENT as a part of this Contract.

F. Confidentiality Clause

The CONTRACTOR, its officers, agents and employees and subcontractors shall treat all information which is obtained by it through its performance under this CONTRACT, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.

G. Date/Time Warranty

1. Definitions: For the purposes of this warranty, the following definitions apply:
"Product" shall include, without limitation: when solicited from a vendor in a state government entity's Contracts, RFPs, IFBs, or mini-bids, any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition, function, calculation, comparing or sequencing. Where services are being furnished, e.g., consulting, systems integration, code or data conversion or data entry, the term "Product" shall include resulting deliverables.

"Third Party Product" shall include product manufactured or developed by a corporate entity independent from the vendor and provided by the vendor on a non-exclusive licensing or other distribution Contract with the third party manufacturer. "Third Party Product" does not include product where vendor is: (a) a corporate subsidiary or affiliate of the third party manufacturer/developer; and/or
(b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

2. Date/Time Warranty Statement
CONTRACTOR warrants that Product(s) furnished pursuant to this Contract shall, when used in accordance with the Product documentation, be able to accurately process date/time data (including, but not limited to, calculating, comparing, and sequencing) transitions, including leap year calculations.

Where a CONTRACTOR proposes or an acquisition requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

Where CONTRACTOR is providing ongoing services, including but not limited to:
(a) consulting, integration, code or data conversion, b) maintenance or support services, c) data entry or processing, or d) contract administration services (e.g., billing, invoicing, claim processing), CONTRACTOR warrants that services shall be provided in an accurate and timely manner without interruption, failure or error due to the inaccuracy of CONTRACTOR'S business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) various date/ time transitions, including leap year calculations. CONTRACTOR shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom, including but not limited to the failure or untimely performance of such services.
This Date/Time Warranty shall survive beyond termination or expiration of this Contract through: (a) ninety (90) days or (b) the CONTRACTOR'S or Product manufacturer or developer's stated date/time warranty term, whichever is longer. Nothing in this warranty statement shall be construed to limit any rights or remedies otherwise available under this Contract for breach of warranty.

H. Lead Guidelines

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

I. On-Going Responsibility

1. General Responsibility Language: The CONTRACTOR shall at all times during this Contract term remain responsible. The CONTRACTOR agrees, if requested by the Commissioner of Health or his or her designee, to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity.

2. Suspension of Work (for Non-Responsibility): The Commissioner of Health or his or her designee, in his or her sole discretion, reserves the right to suspend any or all activities under this Contract, at any time, when he or she discovers information that calls into question the responsibility of the CONTRACTOR. In the event of such suspension, the CONTRACTOR will be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the CONTRACTOR must comply with the terms of the suspension order. Contract activity may resume at such time as the Commissioner of Health or his or her designee issues a written notice authorizing a resumption of performance under this Contract.

3. Termination (for Non-Responsibility): Upon written notice to the CONTRATOR, and a reasonable opportunity to be heard with appropriate DEPARTMENT officials or staff, this Contract may be terminated by Commissioner of Health or his or her designee at the CONTRACTOR'S expense where the CONTRACTOR is determined by the Commissioner of Health or his or her designee to be non-responsible. In such event, the Commissioner of Health or his or her designee may complete the contractual requirements in any manner he or she may deem advisable and pursue available legal or equitable remedies for breach.

J. Indemnification

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

K. Indemnification Relating to the Third-Party Rights

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

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

L. Force Majeure

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

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

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

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

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

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

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

M. Notices

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

a. via certified or registered United States mail, return receipt requested;
b. by facsimile transmission;
c. by personal delivery;
d. by expedited delivery service; or
e. by e-mail

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

Contact at State of New York Department of Health
Name/Title: Margaret Middleton, Direct
Address: ESP, Corning Tower, 23rd Floor, Albany, NY 12237
Email: nyhxpm@health.ny.gov
Phone/Fax: 518-486-9102 / 518-473-1

Contact at Contractor
Name/Title: Shawn Nowicki Director,
Address: 100 Church St. 18th Floor
Email: snowicki@healthfirst.org

Any such notices shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Contract by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this Contract. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

N. Provision Related to Consultant Disclosure Legislation

If this Contract is for the provision of consulting services as defined in Subdivision 17 of Section 8 of the State Finance Law, the CONTRACTOR shall submit a "State Consultant Services Form B, CONTRACTOR'S Annual Employment Report" no later than May 15th following the end of each DEPARTMENT fiscal year included in this Contract term. This report must be submitted to:

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

2. The NYS Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th Floor, Albany NY 12236 ATTN: Consultant Reporting or via fax at (518) 474-8030 or (518) 473-8808; and

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

O. Provisions Related to New York State Information Security Breach and Notification Act

CONTRACTOR shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). CONTRACTOR shall be liable for the costs associated with such breach if caused by CONTRACTOR'S negligent or willful acts or omissions, or the negligent or willful acts or omissions of CONTRACTOR'S agents, officers, employees or subcontractors.

P. Technology Purchases Notification

The following provisions apply if this Request for Proposal (RFP) seeks proposals for "Technology."

1. For the purposes of this policy, "Technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.

2. If this RFP results in procurement of software over $20,000, or of other technology over $50,000, or where the DEPARTMENT determines that the potential exists for coordinating purchases among New York State agencies and/or the purchase may be of interest to one or more other New York State agencies, prior to award selection, this RFP and all responses thereto are subject to review by the New York State Office for Information Technology Services.

3. Accessibility of State Agency Web-based Intranet and Internet Information and Applications. Any web-based intranet and Internet information and applications development, or programming delivered pursuant to the Contract or procurement, will comply with New York State Enterprise IT Policy NYS-P08-005, Accessibility of Web-Based Information and Applications as such policy may be amended, modified

or superseded, which requires that state agency web-based intranet and Internet information and applications are accessible to persons with disabilities. Web content must conform to New York State Enterprise IT Policy NYS-P08-005, as determined by quality assurance testing. Such quality assurance testing will be conducted by the DEPARTMENT and awarded CONTRACTOR and the results of such testing must be satisfactory to the DEPARTMENT before web content will be considered a qualified deliverable under the Contract or procurement.

APPENDIX M

PARTICIPATION BY MINORITY AND WOMEN-OWNED BUSINESS ENTERPRISES

I. General Provisions

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

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

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

II. Contract Goals

A. For purposes of this procurement, the DEPARTMENT hereby establishes an overall goal of 0 % for MWBEs participation, 0 % for Minority-Owned Business Enterprises ("MBE") participation and 0 % for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs).

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

C. Additionally, CONTRACTOR is encouraged to contact the Division of Minority and Women's Business Development ((518) 292-5250; (212) 803-2414; or (716) 846-8200) to discuss additional methods of maximizing participation by MWBEs on the Contract. Where MWBE goals have been established herein, pursuant to 5 NYCRR §142.8, CONTRACTOR must document "good faith efforts" to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of this Contract. In

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

III. Equal Employment Opportunity (EEO)

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

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

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

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

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

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

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

   b. The CONTRACTOR shall state in all solicitations or advertisements for employees that, in the performance of this Contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

   c. The CONTRACTOR shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that

such employment agency, labor union, or representative will not discriminate on the basis of race, creed, color, national origin, sex age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the CONTRACTOR'S obligations herein.

C. Form #4 - Staffing Plan
To ensure compliance with this Section, the CONTRACTOR shall submit a staffing plan to document the composition of the proposed workforce to be utilized in the performance of this Contract by the specified categories listed, including ethnic background, gender, and Federal occupational categories. CONTRACTOR shall complete the Staffing plan form and submit it as part of their bid or proposal or within a reasonable time, but no later than the time of award of this Contract.

D. Workforce Utilization Report

1. The CONTRACTOR shall submit a Workforce Utilization Report and shall require each of its subcontractors to submit a Workforce Utilization Report, in such form as shall be required by the DEPARTMENT on a QUARTERLY basis during the term of the Contract.

2. Separate forms shall be completed by the CONTRACTOR and any subcontractors.

3. Pursuant to Executive Order #162, CONTRACTORS and subcontractors are also required to report the gross wages paid to each of their employees for the work performed by such employees on the contract on a quarterly basis.

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

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

IV. MWBE Utilization Plan

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

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

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

V. Waivers

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

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

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

VI. Quarterly MWBE CONTRACTOR Compliance Report

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

VII. Liquidated Damages - MWBE Participation

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

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

1. All sums identified for payment to MWBEs had the CONTRACTOR achieved the Contractual MWBE goals; and
2. All sums actually paid to MWBEs for work performed or materials supplied under this Contract.

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

APPENDIX C
PROGRAM SPECIFIC REQUIREMENTS

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I. DEFINITIONS

"Actuarial Value (AV)" means 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 Marketplace in 2024 are determined based on the federal Actuarial Value calculator as described in 45 C.F.R. 156.135.

"**Advance Premium Tax Credit (APTC)**" shall mean the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which is provided on an advance basis on behalf of an eligible individual enrolled in a QHP through a Marketplace in accordance with sections 1402 and 1412 of the Affordable Care Act.

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

"Agreement" means this Agreement by and between CONTRACTOR and the New York State Department of Health acting by and on behalf of the State of New York ("STATE") with respect to the purchase and sale of Qualified Health Plans through the Marketplace.

"Annual Open Enrollment Period" means the period each year during which a qualified individual may enroll or change coverage in a QHP through the Marketplace without a Special Enrollment Period.

"**APTC Grace Period**" means, 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.

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

"Certificate of Coverage" means the certificate issued by CONTRACTOR for delivery to enrolled employees, which sets forth in summary form the features of the health care coverage.

"Cost-Sharing Reductions (CSR)" means 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 percentage 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)" means the minimum health benefits specified by the STATE, as set forth in Attachment A of the Invitation.

"Essential Plan" or "EP" means a health benefit plan that has been certified by the STATE as an Essential Plan pursuant to NY Social Services Law section 369-gg(1)(e) or, in the alternative, pursuant to a State Innovation Waiver under section 1332 of the ACA, to be offered through the Marketplace in accordance with applicable law .

"Enrollee" means an individual or employee, or a dependent of an employee, enrolled in a QHP offered through the Marketplace in accordance with applicable law and the terms of the group health plan, if applicable.

"Health Care Services" means 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)" means the Health Information Technology for Economic and Clinical Health Act enacted as part of the American Recovery and Reinvestment Act of 2009, and the regulations issued pursuant thereto or as thereafter amended.

"Health Insurance Portability and Accountability Act of 1996 (HIPAA)" means the Health Insurance Portability and Accountability Act of 1996 and the regulations issued pursuant thereto or as thereafter amended.

"Indian" means a person who is a member of an Indian tribe.

"Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 USCS §§ 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"**Individual Marketplace**" refers to the QHPs and Stand Alone Dental Plans available to Qualified Individuals through the Marketplace.

"**Individual Market**" shall refer to health and stand alone dental products available to individuals both inside and outside of the Marketplace.

"Insurance Affordability Program" or **"IAP"** means a program that is one of the following:

(1) A State Medicaid program under Title XIX of the Social Security Act;

(2) A State children's health insurance program (CHIP) under title XXI of the Social Security Act;

(3) A State basic health program established under section 1331 of the Affordable Care Act.

(4) A program that makes coverage in a qualified health plan through the Marketplace with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals.

(5) A program that makes available coverage in a qualified health plan through the Marketplace with cost-sharing reductions established under section 1402 of the Affordable Care Act.

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

"Invitation" means the Invitation and Requirements for Insurer Certification and Recertification and the attachments thereto, issued by the Marketplace to health and dental plan issuers to participate in the Marketplace, as modified by the Questions and Answers regarding the Invitation posted on the Marketplace website.

"Marketplace" means the NY State of Health, The Official Health Plan Marketplace established within the New York State Department of Health pursuant Executive Order Number 42 on April 12, 2012 and codified in section 268 of the NY Public Health Law.

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

"Medical Record" means a complete record of care rendered by a provider documenting the care rendered to the Enrollee, including inpatient, outpatient, and emergency care, in accordance with all applicable federal, state and local laws, rules and regulations. Such record shall be signed by the medical professional rendering the services.

"Member Handbook" means the publication that may be prepared by the CONTRACTOR, 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.

"Navigator" means an entity that has been authorized by and has an agreement with STATE to provide Navigator program services in accordance with 45 C.F.R. 155.210.

"Non-APTC Grace Period" means, in accordance with NY Insurance Law, a thirty (30) day grace period for payment of premiums for Enrollees not receiving Advance Premium Tax Credits who have paid the first month's premium.

"Non-Participating Provider" means a provider of Health Care Services or Dental Services with which the CONTRACTOR has no Provider Agreement.

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

"Personally Identifiable Information (PII)" means information that can be used to distinguish or trace a person's identity, such as their name, social security number, etc., alone or when combined with other personal or identifying information that is linked or linkable to a particular individual.

"Protected Health Information (PHI)" refers to individually identifiable health information as defined in 45 CFR 164.402.

"Premium" means the dollar amount payable by the Enrollee, Employer, or Employee to the CONTRACTOR to effectuate and maintain coverage. For individuals who are eligible for and elect to receive an Advance Premium Tax Credit, a portion of Enrollee's premium will be payable by the federal government.

"Provider Agreement" means any written contract between the CONTRACTOR and Participating Providers to provide Health Care Services or Dental Services to CONTRACTOR's Enrollees.

"Qualified Employee" means an individual employed by a Qualified Employer who has been offered health insurance coverage by such Qualified Employer in accordance with applicable law and Marketplace policies and procedures.

"Qualified Employer" is an employer that (i) is defined as a "small group" pursuant to the NY State Insurance Law; (ii) elects to offer, at a minimum, all full-time employees coverage in a Qualified Health Plan; and (iii) either: (a) has its principal business address in the Marketplace service area and offers coverage to all its full-time employees; or (b) offers coverage to each eligible employee through the SHOP serving that employee's primary worksite. An employer that meets these criteria and which has at least one employee that is not the owner or the owner's spouse enrolled in coverage shall be authorized to offer Qualified Employees the ability to purchase Qualified Health Plans through the Small Business Marketplace.

"Qualified Health Plan (QHP)" means a health benefit plan that has received the Marketplace's certification pursuant to section 268-d of the NY Public Health law to be offered through the Marketplace, including a Stand-Alone Dental Plan except where otherwise noted.

"Qualified Individual" means an individual that is determined eligible, pursuant to applicable law, to enroll in a QHP through the Marketplace.

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

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

"Small Business Marketplace (SBM or SHOP)" means 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" means an employer that meets the definition of "small group" in the NY Insurance Law.

"Small Group Market" shall refer to health care and stand-alone dental products available to Small Employers both inside and outside of the Marketplace.

"Small Group Market Special Enrollment Period" shall refer to an annual open enrollment period from November 15th through December 15th during which Contractor shall permit a Qualified Employer who cannot meet Contractor's minimum participation requirements to enroll in coverage with a January 1st start date, or to renew coverage that was issued or renewed between November 15th and December 15th.

"Special Enrollment Periods" means, as described in 45 C.F.R. 155.420 and applicable State law, the periods during which a Qualified Individual or Enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Marketplace outside of the Annual Open Enrollment Period; and for SHOP, means, in accordance with 45 C.F.R. 155.726(c) and applicable State law, such periods outside of the Annual Open Enrollment Period during which CONTRACTOR offering QHPs through the SHOP must permit certain Qualified Employees or dependents of Qualified Employees to enroll in or change QHPs.

"Stand-Alone Dental Plan" means a dental services plan that has received the Marketplace's certification to be offered through the Marketplace.

"State" means the State of New York Department of Health.

"Subscriber" means the individual to whom the CONTRACTOR issues a Subscriber Contract.

"Subscriber Contract" means the contract between CONTRACTOR and a Subscriber, approved by the DFS and issued to each Subscriber by the CONTRACTOR at the time of enrollment, which details the provision of health care coverage to the Subscriber or the Subscriber and their dependents under this AGREEMENT.

"Summary of Benefits and Coverage (SBC)" refers to a document provided by CONTRACTOR to Enrollees either directly or through their Employer pursuant to applicable law, describing simple and consistent information about plan benefits and coverage, including cost-sharing. The SBC helps Enrollees to better understand their coverage and compare coverage options.

"System for Electronic Rate and Form Filing (SERFF)" means 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 Marketplace.

B. Independent Contractors

1. The parties acknowledge and agree that in carrying out its responsibilities, the STATE is not acting on behalf of CONTRACTOR. In the performance of this Agreement the STATE and the CONTRACTOR will at all times act as independent contractors and nothing in this Agreement will be deemed to create a relationship of employer or employee or principal or agent between the STATE and CONTRACTOR.

2. Neither CONTRACTOR nor its Participating Providers, authorized subcontractors, agents, officers or employees are agents, officers, employees or representatives of the STATE. Neither the STATE nor its authorized subcontractors, agents, officers, or employees are representatives of the CONTRACTOR.

C. Application of Law

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, NY Insurance Law and NY Public Health Law. The absence of a reference to a 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 in the event that laws and regulations pertaining to QHPs and related issues addressed in this Agreement 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 will support each other in their marketing, enrollment, and Enrollee transition efforts in accordance with applicable law. The Parties will communicate and cooperate with each other on an ongoing basis in accordance with the terms of this Agreement.

E. Participation in Individual Marketplace and/or Small Business Marketplace (or "SHOP")

CONTRACTOR shall offer QHPs in the Individual Marketplace, Small Business Marketplace, 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, 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 DFS and/or STATE.

2. To offer health insurance plan(s) or Stand-Alone Dental Plan(s) through the Individual Marketplace and/or to offer SHOP-certified QHPs in the Small Group Market, CONTRACTOR must assure that such plans are certified as QHP(s) by the STATE.

3. Certification of CONTRACTOR's health insurance plan(s) as QHP(s) by the STATE confirms that the plan(s) comply with the provisions of section 268-d of the NY Public Health Law and the Invitation, including but not limited to:

    i. the Applicant-Specific Requirements, including the provision of Essential Health Benefits;

    ii. the Quality and Enrollee Satisfaction requirements;

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

    iv. the Premium Rate and Policy Form and Filing requirements.

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 provisions of section 268-d of the NY Public Health Law, the Invitation, including but not limited to:

    i. the Applicant-Specific Requirements;

    ii. the Quality and Enrollee Satisfaction requirements;

    iii. the Network Adequacy Requirements; and

    iv. the Premium Rate and Policy Form and Filing requirements.

5. With respect to certification of QHPs in the Small Group Market, STATE shall ensure that each QHP meets the requirements specified in 45 C.F.R. 156.285 of this subchapter.

6. 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 must make available in the Individual Marketplace and/or the Small Business Marketplace, the QHP(s) that have been certified by the Marketplace.

2. In the Individual Marketplace, CONTRACTOR must offer Standard Products as outlined in the Invitation; and may offer certain Non-Standard Products subject to the requirements of the Invitation.

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 must comply with the following documentation submitted by CONTRACTOR and approved by the STATE or DFS, which is incorporated by reference and made a part of this Agreement:

    i. Participation Proposal, attached to this Agreement as an Appendix;

    ii. Network information submitted and approved by the STATE; and

    iii. Quality information submitted and approved by the STATE.

6. CONTRACTOR must submit to the STATE a URL link that provides access to the CONTRACTOR's formulary. The formulary must be an up-to-date list of all covered drugs and must clearly identify that the list is applicable to its QHPs.

7. CONTRACTOR must comply with NY Public Health Law section 4406-c and NY Insurance Law sections 3216(i)(27), 3221(a)(16) and 4303(jj) as applicable, and 45 CFR 156.125, which prohibits discriminatory benefit design. STATE will review CONTRACTOR's formulary to assure compliance with State law.

8. CONTRACTOR must comply with STATE processes, procedures, and requirements established for the certification of QHPs in accordance with applicable law and regulation.

9. CONTRACTOR must have a process in place to comply with the standards related to federal and State risk adjustment programs in accordance with applicable law.

10. 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 to 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 their designee. Decertification must occur in accordance with all applicable laws and regulations governing the removal of a QHP from the Marketplace, including notification to Enrollees.

3. During the Contract Term, other than during recertification, CONTRACTOR must 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, in the case of the Individual Marketplace, suspend enrollment in a QHP in the event that the DFS requires suspension; or, in the case of the Small Business Marketplace, suspend certification and display of a QHP 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 MARKETPLACE AND SHOP

A. Network Adequacy Requirements

For QHPs offered through the Individual Marketplace or SHOP, CONTRACTOR will establish and maintain a network of Participating Providers that satisfies the access standards in 45 C.F.R. 156.230 and 156.235, the Invitation, STATE network adequacy standards, and the requirements of this Agreement, together with instructions and guidance issued by the STATE. The network adequacy requirements and standards for QHPs shall be consistent with the network adequacy requirements and standards that exist outside of the Marketplace pursuant to the NY State Public Health Law and regulation.

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.

2. To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population and to assure that all services will be accessible without unreasonable delay. This includes being geographically accessible (i.e. meeting time / distance standards) and being accessible for people with disabilities.

3. 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.

4. 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 their 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. Will review network adequacy on a county by county basis. For certain network adequacy purposes, the county may be extended by approximately ten (10) miles beyond the county line if CONTRACTOR demonstrates a lack of health care resources or demonstrates that utilization patterns of consumers typically reside outside of the county. In such cases, and in rural areas in particular, CONTRACTOR may contract with providers in adjacent counties to fulfill network adequacy requirements.

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

   c. Will, 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 the 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 its terms; and

   d. Reserves the right to update or modify the process for CONTRACTOR'S submission of its network for review and approval by the STATE, with at least sixty (60) days advance notice to CONTRACTOR.

2. CONTRACTOR:

   a. Will submit its network through the Provider Network Data System ("PNDS") in accordance with the PNDS Instructions provided by STATE, 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. Will update the provider directory on its website and in its PNDS submission(s) no later than fifteen (15) days of the addition or termination of a provider from its network, or a change in a physician's hospital affiliation in accordance with applicable law and this Agreement;

   c. Will ensure that for each provider included in the network that is submitted for review and approval, it has secured a Provider Agreement;

   d. Will 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; and

   e. Will ensure that consumer network protections set forth in applicable law are available to Enrollees, including those related to emergency medical services and surprise bills.

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 applicable law with respect to risk adjustment programs and rating regions, 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 must submit the QHP plan management templates through SERFF or in such other format as directed by the STATE and DFS, which templates must provide prescription drug information, service area and contact information, on or before the date provided by STATE.

2. CONTRACTOR acknowledges that data contained within the QHP plan management templates supply information necessary to populate the Marketplace 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 must adhere to instructions and guidance provided by DFS 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. INDIVIDUAL MARKETPLACE: ELIGIBILITY AND ENROLLMENT

A. Obligations of STATE

1. The STATE shall be responsible for determining eligibility for QHPs, as well as eligibility for IAPs.

2. The STATE shall use a single streamlined application to collect necessary information from applicants and shall determine eligibility for enrollment in a QHP or IAP in accordance with the requirements of applicable law and guidance.

3. The STATE shall permit an applicant for coverage through the Marketplace who is not seeking an eligibility determination for IAPs to request only an eligibility determination for enrollment in a QHP. The STATE shall not permit an applicant seeking an eligibility determination for IAPs to request an eligibility determination for less than all such programs.

4. 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 Annual Open Enrollment Period, the STATE will provide to CONTRACTOR a transaction identification number.

5. 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.

6. The STATE shall reconcile enrollment information with CONTRACTOR and the U.S. Department of Health and Human Services ("HHS") no less than on a monthly basis; and shall send updated eligibility and enrollment information to HHS in a manner and timeframe specified by HHS in accordance with 45 C.F.R. 155.400.

B. Obligations of CONTRACTOR Participating in the Individual Marketplace

1. During the Annual Open Enrollment Periods as well as Special Enrollment Periods throughout the Contract Term, CONTRACTOR shall make available for purchase in the Individual Marketplace the QHPs that have been certified by the Marketplace. Eligible individuals may purchase coverage directly through the Marketplace website, or may use a Navigator, Marketplace Facilitated Enroller, certified application counselor, authorized agent or broker, or to the extent permitted by federal and State law and regulation, other third-party assistors.

2. Enrollment is not effectuated until CONTRACTOR receives initial payment of Premium, if applicable, from the prospective enrollee and sends a confirmation 834 transaction to the STATE (the "Coverage Effective Date"). Unless otherwise required under federal law, CONTRACTOR shall provide a grace period of no less than ten (10) days to Enrollees for their initial premium payment to effectuate coverage. Initial payments received by the 10th of the month in which the initial coverage is in effect will be considered timely. 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.

3. After the Coverage Effective Date, CONTRACTOR shall provide grace periods for each premium payment that is not received by the premium due date, as follows:

   a. For those Enrollees receiving APTC, in accordance with 45 C.F.R. 156.270(d), CONTRACTOR shall adhere to the APTC Grace Period, which is three (3) consecutive months if an Enrollee receiving APTC has previously paid at least one (1) full month's premium during the benefit year. During the APTC Grace Period, CONTRACTOR shall continue to provide coverage for Health Care Services for the first month of the APTC Grace Period and may pend claims for services rendered to Enrollee in the second and third months of the APTC Grace Period. Retroactive termination shall not exceed 61-days.

   b. For those Enrollees not receiving APTC, in accordance with the NY Insurance Law, CONTRACTOR shall adhere to the thirty (30) day Non-APTC Grace Period for those Enrollees not receiving APTC who have paid the first month's premiums. CONTRACTOR shall accept payment for outstanding premiums for thirty (30) days and shall continue to provide coverage for Health Care Services during this Non-APTC Grace Period. If the premium is not paid in full during the Non-APTC Grace Period, CONTRACTOR may terminate coverage retroactively back to the last date premiums were paid.

4. 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.

5. If CONTRACTOR receives an application from a potential enrollee for enrollment in a QHP, the CONTRACTOR must either (i) direct the applicant to the Marketplace for a determination of eligibility and enrollment in a QHP if eligible, or (ii) ensure the applicant received an eligibility determination from the Marketplace through the Marketplace website, whether through coordination with a Navigator, Marketplace Facilitated Enroller, certified application counselor,

or authorized agent or broker or, or by enrolling the individual directly if and when permitted by federal regulation.

6. CONTRACTOR shall not, with respect to its QHP(s), discriminate on the basis of race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

7. CONTRACTOR shall 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, and other such cases agreed to by STATE and CONTRACTOR. In such cases, the Enrollee must pay in full their share of Premiums for all months of coverage received.

8. An individual Enrollee shall be permitted to automatically continue their coverage in a QHP (if available) during the next Annual Open Enrollment Period, unless the Enrollee is terminated for reasons permitted under the Subscriber Contract or has selected another plan.

C. Special Enrollment Periods in Individual Marketplace

1. The STATE shall pursuant to 45 C.F.R. 155.420(d) and applicable State and federal law, allow Qualified Individuals or Enrollees and when specified, their dependent, to enroll in or change from one QHP to another, within sixty (60) days of the following triggering events:

   a. A Qualified Individual or their dependent either (i) involuntarily loses minimum essential coverage; (ii) is enrolled in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement (as defined in Section 9831(d)(2) of the Internal Revenue Code), even if the qualified individual or their dependent has the option to renew such coverage; (iii) loses pregnancy-related coverage as described under applicable law or loses access to health care services through coverage provided to a pregnant woman's unborn child; or (iv) loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year;

   b. A Qualified Individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order, or if covered, domestic partnership; or, the Enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law or if the Enrollee or their dependent dies. In the case of marriage, at least one spouse must have had minimum essential coverage for one or more days during the sixty (60) days preceding the date of the marriage;

   c. A Qualified Individual or their dependent becomes newly eligible for enrollment in a QHP because they newly satisfy the requirements for status as a citizen, national, or as a lawfully present individual, or because they are no longer incarcerated;

d. A Qualified Individual's or their dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the STATE or HHS, its instrumentalities, or a non-Marketplace entity providing enrollment assistance 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;

e. An Enrollee or their dependent 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;

   i. An Enrollee is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR,
   ii. the Enrollee's dependent enrolled in the same QHP is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR; or
   iii. a Qualified Individual or their dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualified coverage in an eligible employer-sponsored plan, or
   iv. a Qualified Individual who was previously ineligible for APTC solely because of a household income below 100 percent of Federal Poverty Level, and who during the same timeframe was ineligible for Medicaid because they were living in a non-Medicaid expansion state, who either experiences a change in income or moves to a different state resulting in the Qualified Individual becoming newly eligible for APTC;
   v. the Qualified Individual, or their dependent (A) Experiences a decrease in household income; (B) is newly determined eligible by the Marketplace for APTC; and (C) Had minimum essential coverage for one or more days during the 60 days preceding the date of the financial change.

f. A Qualified Individual or Enrollee or their dependent gains access to new QHPs as a result of a permanent move and had minimum essential coverage for one or more days during the sixty (60) days preceding the date of the permanent move;

g. A Qualified Individual (i) who gains or maintains status as 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; or (ii) who is or becomes a dependent of an Indian and is enrolled or is enrolling in a QHP through the Marketplace on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian;

h. A Qualified Individual or Enrollee or their dependent demonstrates to the STATE, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the STATE may provide;

i. A Qualified Individual or Enrollee (i) is a victim of domestic abuse or spousal abandonment as defined by 26 C.F.R. 1.36B-2T, as amended, or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or (ii) is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

j. A Qualified Individual or dependent applies for coverage through the Marketplace during the Annual Open Enrollment Period or due to a qualifying event, is assessed by the Marketplace as potentially eligible for Medicaid or Child Health Plus (CHP), and is determined ineligible for Medicaid or CHP either after open enrollment has ended or more than sixty (60) days after the qualifying event;

k. The Qualified Individual or Enrollee, or their dependent, adequately demonstrates to the STATE that a material error related to plan benefits, service area, or premium influenced the Qualified Individual's or Enrollee's decision to purchase a QHP through the Marketplace;

l. The Qualified Individual provides satisfactory documentary evidence to verify their eligibility for an IAP or enrollment in a QHP through the Marketplace following termination of Marketplace enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. 155.315 or is under 100 percent of the Federal Poverty Level and did not enroll in coverage while waiting for HHS to verify their citizenship, status as a national, or lawful presence; or

m. The Qualified Individual, Enrollee, or dependent newly gains access to an individual coverage HRA (as defined in 45 CFR 146.123(b)) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code). The triggering event is the first day on which coverage for the Qualified Individual, Enrollee or dependent under the individual coverage HRA can take effect, for the first day on which coverage under the QSEHRA takes effect.

n. The Qualified Individual or their dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the Qualified Individual's or dependent's COBRA continuation coverage or government subsidies completely cease. The triggering event is the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.

o. Any time after the commencement of pregnancy, as certified by a licensed health care provider, in accordance with the requirements of the NY Insurance Law and NY Public Health Law.

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 CSR 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;

   e. in the case of pregnancy, the first of the month in which the individual received certification of the pregnancy from a licensed health care provider.

3. Use of Special Enrollment Periods

   a. If an Enrollee or their dependents become newly eligible for cost-sharing reductions in accordance with paragraph (d)(6)(i) or (ii) of 42 CFR 155.420 [Enrollee or dependent enrolled in the same QHP determined newly eligible or ineligible for APTC or has a change in eligibility for cost-sharing reductions] and the Enrollee or their dependents are not enrolled in a silver-level QHP, STATE must allow the Enrollee and their dependents to change to a silver-level QHP if they elect to change their QHP enrollment; or
   b. If an Enrollee or their dependents become newly ineligible for cost-sharing reductions in accordance with paragraph (d)(6)(i) or (ii) of 42 CFR 155.420 and the Enrollee or his or her dependents are enrolled in a silver-level QHP, STATE must allow the Enrollee and their dependents to change to a QHP one metal level higher or lower if they elect to change their QHP enrollment; and
   c. If an Enrollee or their dependents become newly ineligible for advance payments of the premium tax credit in accordance with paragraph (d)(6)(i) or (ii) of 42 CFR 155.420, STATE must allow the Enrollee and their dependents to change to a QHP of any metal level, if they elect to change their QHP enrollment.

D. Coverage Effective Date in Individual Marketplace

1. CONTRACTOR must notify a Qualified Individual of their effective date of coverage (the "Coverage Effective Date").

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 their Coverage Effective Date or after their Effective Date of Disenrollment.

E. Enrollment in Individual Marketplace

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 race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

2. CONTRACTOR shall not impose additional or different requirements upon Enrollees than the requirements for individuals who purchased coverage outside of the Marketplace unless required by law.

3. For the Individual Marketplace, CONTRACTOR shall be responsible for collecting premium payments from Enrollees, as well as collecting APTC and CSR from the federal government in accordance with applicable law and guidance. CONTRACTOR shall adhere to the standards set forth by HHS and the process outlined by STATE for the accurate reporting of APTC and CSR.

4. In the Individual Marketplace, 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. CONTRACTOR must accept enrollment information in an electronic format, in a manner consistent with applicable privacy and security provisions of state and federal law and administrative guidance. CONTRACTOR must enter into a Trading Partner Agreement with STATE to address the secure exchange of HIPAA compliant health care transactions.

6. The STATE must transmit enrollment data to CONTRACTOR via HIPAA compliant 834 transactions. CONTRACTOR must be prepared and able to accept daily enrollment information in a HIPAA compliant 834 transaction, and acknowledge receipt of enrollment information by returning HIPAA compliant transactions to STATE, as well as such other HIPAA compliant transactions as may be necessary pursuant to this Agreement. The transfer of enrollment data and other HIPAA compliant transactions shall be conducted pursuant to the Trading Partner Agreement attached as an Appendix to this Agreement and Trading Partner Guides referenced in such Trading Partner Agreement, as amended from time to time.

7. CONTRACTOR shall reconcile enrollment files with the STATE. Error files must be reviewed and errors corrected on a regular basis, but no less often than once per week.

8. In conducting HIPAA transactions, STATE and CONTRACTOR must adhere to the Trading Partner Agreement attached hereto as an Appendix.

VIII. SMALL BUSINESS MARKETPLACE: ELIGIBILITY AND ENROLLMENT

A. General Requirements

1. CONTRACTOR shall adhere to enrollment periods under applicable law, including Special Enrollment Periods pursuant to 45 C.F.R. 155.726(c).

2. CONTRACTOR must permit a Qualified Employer to purchase coverage for its small group at any point during the year. The Qualified Employer's plan year must consist of the 12-month period beginning with the Qualified Employer's Effective Date of Coverage.

B. Eligibility and Enrollment for SHOP Coverage

1. Obligations of STATE

   a. STATE shall determine whether an employer requesting a determination of eligibility to purchase SHOP-certified QHPs is eligible in accordance with the requirements of 45 C.F.R. 155.710. STATE shall have sole authority to determine employer eligibility to purchase SHOP-certified products.

   b. STATE shall provide an employer requesting a determination of eligibility to purchase SHOP-certified QHPs with a written determination confirming or denying its eligibility and including the employer's right to appeal such eligibility determination. The determination will be valid for the tax year in which it is issued.

   c. Employers must submit a new single employer application to the SHOP or withdraw from participating in the SHOP if the employer makes a change that could end its eligibility under 45 C.F.R. 155.710.

   d. The STATE shall hear and decide employer appeals regarding employer eligibility to purchase SHOP-certified QHPs, pursuant to applicable law. The formal written decision of the STATE with respect to employer eligibility will be binding for the applicable period.

2. Obligations of CONTRACTOR

   a. A CONTRACTOR that has elected to participate in the SHOP, and has obtained SHOP certification of QHPs, shall make such QHPs available for purchase by Qualified Employers. Qualified Employers shall be able to purchase coverage for their employees directly from the CONTRACTOR, or may use a SHOP certified agent or broker authorized by the Qualified Employer, a Navigator, a Marketplace Facilitated Enroller or other assistor to the extent permitted by federal or State law or regulation.

b. CONTRACTOR (excepting Contractors who are HMOs) may impose minimum participation requirements on Qualified Employers, provided that such requirements are consistent with the requirements for its off-SHOP small group business and permitted under State law. However, CONTRACTOR must allow groups to enroll during the Small Group Special Enrollment Period without imposing minimum participation requirements. CONTRACTOR may impose minimum participation requirements on renewal outside of the Small Group Special Enrollment Period but only to the extent the same requirements were imposed upon the group's initial application for coverage.

c. CONTRACTOR shall:

   i. offer coverage to and accept every employer deemed a Qualified Employer by the STATE, subject to the exceptions permitted by federal regulation. CONTRACTOR shall comply with federal regulation regarding guaranteed issue.

   ii. accept initial enrollment from a Qualified Employer's new employees, or newly eligible employees as determined 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 applicable law.

   iii. 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 applicable law.

   iv. adjudicate employee eligibility appeals.

   v. collect premium payments from Qualified Employers.

   vi. renew Qualified Employers in the same QHP or QHPs (if available) on the twelve (12) month anniversary date of the Coverage Effective Date in accordance with 42 U.S.C. 18024(b)(4)(D) and applicable law, unless the Qualified Employer is no longer eligible for small group coverage and/or the employer has chosen not to renew or has selected another QHP or QHPs.

d. CONTRACTOR shall not impose additional or different requirements upon Enrollees than the requirements for small employers who purchased coverage outside of the Marketplace unless required by law.

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 thirty (30) days prior to the QHP's anniversary date, unless they are determined eligible 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. In accordance with Part 86 of Title 11 of the New York Code of Rules and Regulations, CONTRACTOR must notify the STATE and DFS in the event it suspects or it appears that a Qualified Employer and/or employees have committed fraud.

C. Coverage Effective Date in SHOP

1. As of the Coverage Effective Date, 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.

2. CONTRACTOR will not be liable for the cost of any services rendered to an Enrollee prior to their Coverage Effective Date.

D. Special Enrollment Periods in SHOP

1. CONTRACTOR must provide Special Enrollment Periods consistent with 45 C.F.R. 155.726(c), during which certain Qualified Employees or dependents of Qualified Employees may enroll in QHPs and Enrollees may change QHPs. A dependent of a Qualified Employee is not eligible for a Special Enrollment Period if the Qualified Employer does not extend an offer of coverage to dependents.
2. CONTRACTOR shall provide a Special Enrollment Periods for a Qualified Employee or a dependent of a Qualified Employee in accordance with applicable law if one of the triggering events occur:

a. A Qualified Individual or their dependent either (i) loses minimum essential coverage, (ii) loses pregnancy-related coverage as described under applicable law or loses access to health care services through coverage provided to a pregnant woman's unborn child; or (iii) loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year;

b. A Qualified Individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption, or placement in foster care, or through a child support order or other court order, or if covered, domestic partnership; or the Enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation, or if the Enrollee or their dependent dies;

c. Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee, or agent of the STATE or HHS, its instrumentalities, or a non-Marketplace entity providing enrollment assistance; 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;

d. An Enrollee or their dependent 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;

e. A Qualified Individual or Enrollee gains access to new QHPs as a result of a permanent move and had minimum essential coverage for one or more days during the sixty (60) days preceding the date of the permanent move;

f. A Qualified Individual (i) who gains or maintains status as 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; or (ii) who is or becomes a dependent of an Indian and is enrolled or is enrolling in a QHP on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian;

g. A Qualified Individual or Enrollee or their dependent demonstrates to the STATE, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the STATE may provide.

h. A Qualified Individual or Enrollee (i) is a victim of domestic abuse or spousal abandonment as defined by 26 C.F.R. 1.36B-2, as amended, or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or (ii) is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

i. A Qualified Individual or dependent applies for coverage through the Marketplace during the Annual Open Enrollment Period or due to a qualifying event, is assessed by the Marketplace as potentially eligible for Medicaid or Child Health Plus (CHP), and is determined ineligible for Medicaid or CHP either after open enrollment has ended or more than 60 days after the qualifying event;

j. The Qualified Individual or Enrollee adequately demonstrates to the Marketplace that a material error related to plan benefits, service area, or premium influenced the Qualified Individual's or Enrollee's decision to purchase a QHP through the Marketplace;

k. A Qualified Employee or dependent of a Qualified Employee loses eligibility for coverage under Medicaid or CHP;

l. A Qualified Employee or dependent of a Qualified Employee becomes eligible for Medicaid or CHP; or

m. Any time after the commencement of pregnancy, as certified by a licensed health care provider, in accordance with the requirements of the NY Insurance Law and NY Public Health Law.

3. In accordance with 45 C.F.R. 155.726(c)(3), a Qualified Employee or dependent of a Qualified Employee who experiences a qualifying event shall have thirty (30) days from the date of the triggering event to select a QHP; excepting the triggering events of (i) loss of eligibility of coverage for Medicaid or CHP; (ii) becoming eligible for coverage for Medicaid or CHP; and (iii)

commencement of a pregnancy as certified by a licensed health care provider, which shall provide sixty (60) days from the date of the triggering event to select a QHP.

4. For a QHP selection received by the CONTRACTOR pursuant to a Special Enrollment Period, provided that the premium has been paid:

   a. in the case of birth, adoption or placement for adoption, the CONTRACTOR shall ensure that the Coverage Effective Date is the date of birth, adoption, or placement for adoption;

   b. in the case of marriage or in the case where a Qualified Individual loses minimum essential coverage, CONTRACTOR must ensure a Coverage Effective Date on the 1st day of the following month.

   c. in the case of pregnancy, the first of the month in which the individual received certification of the pregnancy from a licensed health care provider.

IX. ENROLLEE RIGHTS AND NOTIFICATION

A. Information Requirements

1. CONTRACTOR must provide all Enrollees an information package as required by 45 C.F.R. 156.265(e), including a Subscriber Contract and a Summary of Benefits and Coverage ("SBC").

2. The CONTRACTOR must issue such information to the Enrollee as soon as possible but no later than fourteen (14) days after the Coverage Effective Date. The CONTRACTOR may provide such information to the Enrollee through the Member Handbook / Subscriber Contract in the case of the Individual Marketplace, or Certificate of Coverage in the case of the SHOP.

3. The CONTRACTOR must provide Enrollees with an annual notice that the Subscriber Contract and SBC are available upon request.

4. The CONTRACTOR must make information available to prospective Enrollees and Enrollees (including information regarding internal and external appeals rights) in plain language and in a manner that is accessible and timely to individuals with disabilities, including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. CONTRACTOR must:

   a. Provide written materials in a prose that is understood by an eighth-grade reading level except as otherwise required by STATE and must be printed in at least 10-point type.

   b. Make available written materials and other informational materials in a language other than English whenever at least five percent (5%) of the prospective Enrollees or Enrollees of the CONTRACTOR in any county of the service area speak that particular language and do not speak English as a first language; or, alternatively, provide taglines in common non-English languages indicating the availability of written translation materials in any language the prospective or current Enrollees speak.

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

d. Make available verbal interpretation services in any language to current or potential enrollees who speak a language other than English as a primary language to the extent reasonably practicable. Interpreter services must be offered in person where practical, but otherwise may be offered by telephone.

e. Have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include readers to assist the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies.

f. To the extent that HHS establishes standards on written materials and/or verbal information for the Marketplace that provide greater protections than the standards set forth above, adhere to such standards.

5. CONTRACTOR must inform individuals of the services provided in paragraph "4" above and how to access such services and alternative mechanisms.

B. Provider Directories

1. The CONTRACTOR must maintain, update, and make publicly available, a provider directory for its QHPs including, a listing by specialty of the name, address and telephone number of all Participating Providers, including facilities, in accordance with NY Insurance Law §§ 3217-a(a)(17) as applicable and 4324(a)(17) and NY Public Health Law § 4408(r) (the "Provider Directory"). In the case of physicians, board certification, languages spoken, wheelchair accessibility and any affiliations with participating hospitals shall be listed. The Provider Directory should also identify providers that are considered Primary Care Physicians and providers that are not accepting new patients.

2. CONTRACTOR will post the provider directory on its website and shall update the website within fifteen (15) days of the addition or termination of a provider from the network or a change in a physician's hospital affiliation.

3. CONTRACTOR shall make its provider directory available to the STATE for publication online and to potential enrollees or Enrollees in hard copy upon request.

4. CONTRACTOR must notify Enrollees in writing at least annually that updates to its provider directory are available online, and that updates and/or a copy of the directory may be provided in hardcopy upon request.

C. Treatment Cost Calculator for Services Rendered by a Participating Provider

CONTRACTOR must, in accordance with and to the extent required by federal regulations, have a treatment cost calculator available through an Internet Web site and by toll free telephone number for individuals without access to the Internet. Such treatment cost calculators must be able to demonstrate Enrollee cost sharing under the individual's plan, or coverage with respect to the furnishing of a specific item or service by a Participating Provider in a timely manner upon the request of the individual.

D. 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 must issue an identification card to Enrollees as soon as is possible but no later than seven (7) days following receipt of enrollment transaction from STATE. The identification card shall contain pertinent information required pursuant to applicable law and regulation, including the CONTRACTOR's member services toll-free telephone number, applicable annual deductible, and annual maximum out-of-pocket amount.

2. If unforeseen circumstances prevent the CONTRACTOR from issuing the official identification card to new Enrollees within the above timeframe, the CONTRACTOR must implement an alternative method by which individuals may identify themselves as Enrollees prior to receiving the card or otherwise make the enrollment and cost-sharing information readily available to the Enrollees and Participating Providers. 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

1. The CONTRACTOR must issue to a new Enrollee as soon as possible but no later than fourteen (14) days after the Coverage Effective Date a Subscriber Contract in the case of the Individual Marketplace; a Certificate of Coverage in the case of the SHOP, and, at the option of CONTRACTOR, a Member Handbook.

2. CONTRACTOR must post all approved Subscriber Contracts on their website so that they are available to prospective enrollees prior to the Annual Open Enrollment period.

X. TERMINATION OF COVERAGE

A. Individual Marketplace

1. Obligations of STATE

a. The STATE must permit an Enrollee to terminate their coverage in a QHP, including as a result of the Enrollee obtaining other minimum essential coverage. In such a case the last day of enrollment is:

i. For terminations received between the first and the fifteenth day of the month, the end of that month;

ii. For terminations received between the sixteenth and the end of the month, the end of the next month. For example, a termination received by the Marketplace on April 17, 2024, would provide a termination date of May 31, 2024;

iii. If the Enrollee is newly eligible for Medicaid, CHP, or the Essential Plan, the last day of coverage is the day before the Medicaid, CHP, or Essential Plan coverage begins.

b. In accordance with 45 C.F.R. 155.430(b)(1)(iv), the STATE must permit an Enrollee to retroactively terminate or cancel their enrollment in a QHP in the following circumstances:

i. The Enrollee demonstrates to STATE that they attempted to terminate their enrollment in a QHP and experienced a technical error that did not allow the Enrollee to terminate their enrollment through the Marketplace and requests retroactive termination within sixty (60) days after they discovered the technical error;

ii. The Enrollee demonstrates to STATE that their enrollment in a QHP was unintentional, inadvertent or erroneous and was the result of misconduct or error on the part of an officer, employee or agent of the Marketplace or a non-Marketplace entity providing enrollment assistance. The Enrollee must request cancellation within sixty (60) days of discovering the unintentional, inadvertent, or erroneous enrollment.

iii. The Enrollee demonstrates to the Marketplace that they were enrolled in a QHP without their knowledge or consent by any third-party, including third-parties who have no connection to the Marketplace, and requests cancellation within sixty (60) days of discovering the enrollment.

c. The STATE must initiate termination of an Enrollee's enrollment in a QHP and permit CONTRACTOR to terminate such coverage or enrollment if Enrollee is no longer eligible for coverage in a QHP, in which case the last day of enrollment is the last day of the month following the month in which the notice is sent by the STATE, unless the Enrollee requests an earlier termination date in accordance with applicable regulation;

d. In accordance with 45 C.F.R. 155.430(c), the STATE shall promptly and without undue delay send Enrollee termination information to CONTRACTOR;

e. The STATE shall permit CONTRACTOR to initiate termination of coverage pursuant to a standard policy, in the following circumstances:

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

A) The APTC Grace Period has been exhausted as described in 45 C.F.R. 156.270(d),(g) in which case the last day of coverage is the last day of the first month of the APTC Grace Period;

B) The Non-APTC Grace Period has expired, in which case the last day of coverage is the last paid in full date, in accordance with the requirements of Sections 3216 and 4304 of the NY Insurance Law;

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. 155.1080;

iv. The Enrollee changes from one QHP to another QHP during an Annual Open Enrollment Period or Special Enrollment Period, in which case the last day of coverage in an Enrollee's prior QHP is the day before the effective date of coverage in their new QHP; or

v. The Enrollee was enrolled in a QHP without their knowledge or consent by a third party, including by a third party with no connection with the Marketplace.

vi. 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.

vii. CONTRACTOR may in its own discretion reinstate an Enrollee in the event the Enrollee has failed to pay premium and has exhausted all applicable grace periods.

2. Obligations of CONTRACTOR

a. CONTRACTOR must not terminate coverage because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services.

b. Following the initial payment of premium and Coverage Effective Date, if an Enrollee is delinquent on premium payment, CONTRACTOR must provide the Enrollee with notice of the non-payment of premium within ten (10) business days of the date that the premium payment was due.

c. For the Individual Marketplace, 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 for initial payment of premium required under this Agreement.

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, as set forth in 45 C.F.R. 155.430(c)(3).

e. CONTRACTOR must maintain records of termination of enrollment in a QHP through the Marketplace and retain these records for a period of ten (10) years to facilitate audit functions.

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 Marketplace.

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, subject to the requirements of applicable law.

XI. RECERTIFICATION / TERMINATION OF QHP PLAN AGREEMENT

A. Recertification

1. The STATE shall establish a process for annual recertification of QHPs that includes a review of the general certification criteria outlined at 45 C.F.R. 155.1000(c). Rates and forms must be filed in accordance with DFS processes and timelines. CONTRACTOR may add, remove, or modify QHPs during the recertification process in accordance with STATE and DFS instruction.

2. The STATE must complete the QHP recertification process no later than two (2) weeks prior to the beginning of the Annual Open Enrollment Period of the applicable calendar year.

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

4. 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.

B. Non-renewal

In lieu of annual recertification, CONTRACTOR may opt not to renew participation in the Marketplace. CONTRACTOR shall notify the STATE of its decision not to renew in a manner and timeframe that consistent with applicable 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 Marketplace Customer Service and DFS to facilitate transition.

C. 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 Marketplace 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.

D. Contractor Initiated Termination of Agreement

1. CONTRACTOR must notify STATE of circumstances causing the CONTRACTOR to be unable to perform activities and services required under this AGREEMENT.

2. 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 Marketplace with notice to Enrollees of the conclusion of coverage under this AGREEMENT and the availability of conversion rights pursuant to the Subscriber Contract.

E. State Initiated Termination of Agreement

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

1. the CONTRACTOR substantially fails to meet, perform or observe a material requirement or promise set forth in this Agreement, and/or substantially violates applicable law;

2. there is or has been a breach of the Privacy and Security requirements set forth in this Agreement or the Trading Partner Agreement attached hereto as an Appendix; and/or

3. that CONTRACTOR does not meet financial requirements, except to the extent that a corrective action plan has been approved by DFS.

F. Process for Termination of Coverage

If this Agreement between STATE and CONTRACTOR is terminated for any reason, the CONTRACTOR shall cooperate with STATE to develop a plan which may at the STATE's discretion include a plan to transition Enrollees to another Contractor in the Enrollee's service area. Such plan must include CONTRACTOR notice to Enrollees in accordance with applicable law, follow-up letters to remind Enrollees to enroll with another health plan, and any other requirement under New York State law.

XII. MEMBER SERVICES

A. CONTRACTOR must operate a "Member Services" or "Customer Service" department during regular business hours, which must be accessible to Enrollees via toll free telephone number. Customer service representatives must be available during regular business hours to address complaints and utilization inquiries.

B. CONTRACTOR must maintain a telephone system capable of accepting incoming calls regarding complaints and utilization review outside of regular business hours, providing instructions for leaving a message, and have measures in place to ensure a response to those calls the next business day after the call was received.

i. CONTRACTOR must be prepared to adjust customer service staff to meet expected performance levels on peak Marketplace volume days.

ii. Consumer complaints received through the Marketplace and sent to the CONTRACTOR require a response from CONTRACTOR no later than three (3) business days from the day the Marketplace sends the complaint. If the matter involves an urgent coverage issue, the CONTRACTOR must respond and act upon the complaint within 24 hours of receipt. The timeframes in this subparagraph apply regardless of whether the complaint is generated as a result of technical problems with the CONTRACTOR's system or technical problems with the Marketplace system. In the event that the complaint involves a technical error by the Marketplace or the applicant or Enrollee needs a technical transaction to resolve the complaint, the CONTRACTOR will work cooperatively and diligently with the Marketplace to ensure that coverage is not delayed pending resolution of technical issues.

XIII. 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, certified application counselors, Marketplace Facilitated Enrollers, consumer advocates, small businesses, brokers, and other stakeholders to promote enrollment through the Marketplace.

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 Marketplace.

2. CONTRACTOR may maintain a direct link to the Marketplace website on CONTRACTOR's website. The STATE will provide approved links for this purpose.

3. CONTRACTOR shall cooperate with the STATE to educate its agents and brokers about the QHPs available through the SHOP and the Individual Marketplace; and the process for agent and broker training and certification by the Marketplace to sell such QHPs.

4. CONTRACTOR's marketing of QHPs may, particularly during the Annual Open Enrollment Period, include: (i) advertisements in print, radio, television, outdoor advertising and/or social media, (ii) written and electronic communications sent to CONTRACTOR's Enrollees, 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 NY State of Health name and logo designated by the STATE in referring to the Marketplace in marketing and outreach activities including any printed materials. Such materials must prominently display the Marketplace website and toll-free telephone number. Such materials must be developed in accordance with the Marketplace co-branding guidelines and receive co-branding approval prior to distribution or publication.

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

7. CONTRACTOR shall not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in their QHPs or discriminate on the basis of an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

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 to potential enrollees to enroll in a QHP or renew their coverage (excepting marketing materials of nominal value, such as pens).

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).

XIV. HIPAA COMPLIANCE /PRIVACY AND SECURITY

1. CONTRACTOR acknowledges and agrees that it is a Covered Entity, as defined in 45 C.F.R. 160.103

2. CONTRACTOR acknowledges and agrees that the Marketplace is not a Business Associate of the CONTRACTOR in performing its statutorily required functions pursuant to 45 C.F.R. 155.200.

3. CONTRACTOR must comply with all applicable federal and State laws and regulations to ensure the privacy, security, integrity and availability of PII and PHI received pursuant to this Agreement, including but not limited to the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH").

4. CONTRACTOR must:

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

   b. Maintain information in a timely and accurate manner;

   c. Specify and make available to any Enrollee requesting it (i) the purpose for which information is maintained or used, and (ii) to whom and for what purposes information will be disclosed; and

   d. Except as provided in federal and State law, ensure that each Enrollee may (i) request a copy of their records and information in a designated records set, (ii) receive such records and information in a timely manner, and (iii) request that their records be supplemented or corrected.

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

6. CONTRACTOR shall safeguard PII and PHI with reasonable operational, administrative, technical and physical controls to ensure its confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure. CONTRACTOR shall monitor, periodically assess and update these controls to ensure their continued effectiveness.

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

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

9. CONTRACTOR shall fully and promptly report to the STATE any use or disclosure of Enrollee information, including PII and PHI, 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 (i) unauthorized access, use, disclosure, modification or destruction of

Enrollee information, including PII or PHI, (ii) interference with system operations affecting the exchange of data set forth in this Agreement, and/or (iii) loss of Enrollee information, including PII and PHI, due to the loss or misplacement of hardware, storage devices or paper documents.

XV. REPORTING/DATA COLLECTION

A. General Requirements

1. CONTRACTOR shall establish and maintain the systems and processes to connect to and securely transmit data to, and receive data from the STATE as necessary carry out its responsibilities under this Agreement.

2. 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.

3. 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

1. 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. Each encounter should be recorded in an information system as a unique occurrence between recipient and provider.

2. CONTRACTOR shall submit encounter data on at least a monthly or more frequent basis through the STATE designated vendor in a format and manner to be prescribed by the STATE. STATE shall provide at least ninety (90) days advance notice of its reporting requirements and consult with CONTRACTOR prior to implementation of such reporting requirements.

C. Financial Reporting

1. CONTRACTOR must submit financial reports, 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:

   a. the percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies;

   b. the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type, which includes an independent pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State of New York and that dispenses medication to the general public, that is paid by the CONTRACTOR or the CONTRACTOR's contracted pharmacy benefit manager;

   c. the aggregate amount and type of rebates, discounts or price concessions (excluding bona fide service fees) that the CONTRACTOR or its contracted pharmacy benefit manager negotiates that are attributable to Enrollee utilization under the 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

   d. the aggregate amount of the difference between the amount the CONTRACTOR pays to its contracted pharmacy benefit manager and the amounts that the pharmacy benefit manager pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

E. Transparency Requirements

1. CONTRACTOR must submit in an accurate and timely manner to be determined by HHS, the information set forth below to the STATE, HHS and DFS, and must make such information available to the public in accordance with the requirements of 45 C.F.R. 156.220:

   a. Claims payment policies and practices;
   b. Periodic financial disclosures;
   c. Data on enrollment;
   d. Data on disenrollment;
   e. Data on the number of claims that are denied;

f. Data on rating practices;
g. Information on cost-sharing and payments with respect to any out-of-network coverage; and
h. Information on enrollee rights under Title I of the ACA.

2. CONTRACTOR shall ensure that the above listed information is provided in plain language as defined in 45 C.F.R. 155.20.

3. CONTRACTOR must make available the amount of Enrollee cost-sharing for in-network services under the individual's QHP 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.

XVI. INDIANS AND ALASKA NATIVES

A. CONTRACTOR must comply with all applicable laws, rules and regulations relating to the provision of Health Care Services to any Enrollee who is determined by the STATE to be an eligible Indian or Alaska Native (AI/AN) as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304(d)). Such requirements include the following:

B. CONTRACTOR shall cover Health Care Services if an AI/AN is enrolled in a QHP in the individual market through the Marketplace and is furnished with an item or service directly through an Indian health care provider or through a referral under contract for directly furnishing an item or service to an AI/AN with no cost-sharing in accordance with applicable federal regulations, including 45 C.F.R. 156.430(g), 45 C.F.R. 156.410(a), (b)(2), (b)(3).

C. CONTRACTOR shall not impose any cost-sharing on such individuals whose household income does not exceed three hundred percent (300%) of federal poverty level in accordance with applicable federal regulations, including 45 C.F.R. 155.350(a), 45 C.F.R. 156.410(a), (b)(2).

D. CONTRACTOR shall permit an AI/AN or the dependent of an AI/AN on the same application to change from one QHP to another one time per month as described in 45 C.F.R. 155.420(d)(8).

E. CONTRACTOR shall comply with other applicable laws, rules and regulations relating to the provision of Health Care Services to an AI/AN, including the Indian Health Care Improvement Act Sections 206 (25 U.S.C. 1621e) and 408 (25 U.S.C. 1647a)).

XVII. INDEMNIFICATION

A. Indemnification by Contractor

1. CONTRACTOR must indemnify, defend and hold harmless the STATE, its officers, agents and employees (the STATE Indemnified Parties) from and against any and all claims, actions, losses, costs, liabilities, damages or deficiencies, including interest, penalties and attorney's fees suffered, incurred or sustained by the STATE Indemnified Parties or to which any STATE Indemnified Parties become subject, resulting from, arising out of or relating to:

a. any and all claims and losses accruing or resulting to any and all CONTRACTOR's, materialmen, laborers, and any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Agreement;
b. any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by the CONTRACTOR, its officers, agents, employees, or subcontractors, in connection with the performance of this Agreement;
c. any liability, including costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy by the CONTRACTOR, its officers, agents, employees or subcontractors, arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished under this Agreement, or based on any libelous or otherwise unlawful matter contained in such data.

2. The STATE will provide the CONTRACTOR with prompt written notice of any claim made against the STATE, and the CONTRACTOR, at its sole option, shall defend or settle said claim. The STATE shall cooperate with the CONTRACTOR to the extent necessary for the CONTRACTOR to discharge its obligation under this Section.

3. CONTRACTOR shall have no obligation under this section with respect to any claim or cause of action for damages to persons or property solely caused by the negligence of the STATE, its employees, or agents.

4. The indemnity obligation described in this section shall not limit any other rights or remedies available to the STATE or the CONTRACTOR under this Agreement.

B. Indemnification by the STATE

Subject to the availability of lawful appropriations as required by State Finance Law § 41 and consistent with § 8 of the State Court of Claims Act, the STATE shall hold the CONTRACTOR harmless from and indemnify it for any final judgment of a court of competent jurisdiction to the extent attributable to the negligence of the STATE or its officers or employees when acting within the course and scope of their employment. Provisions concerning the STATE's responsibility for any claims for liability as may arise during the term of this Agreement are set forth in the New York State Court of Claims Act, and any damages arising for such liability shall issue from the New York State Court of Claims Fund or any applicable, annual appropriation of the Legislature of the State of New York.

XVIII. 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.

XIX. OWNERSHIP OF DATA

A. Ownership of Marketplace Data.

As between the STATE and CONTRACTOR, all Marketplace Data, as defined below, shall be and will remain the property of the STATE. For purposes of this section, Marketplace Data means data and information created by the Marketplace and relating to the Marketplace, its employees and agents, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the STATE's approval (in its sole discretion), the Marketplace Data will not be (1) used by CONTRACTOR or its subcontractors other than in connection with carrying out its obligations under this Agreement; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by CONTRACTOR or its subcontractors other than in connection with carrying out its obligations under this Agreement; or (3) commercially exploited by or on behalf of CONTRACTOR or its subcontractors. CONTRACTOR hereby irrevocably assigns, transfers and conveys, and will cause its subcontractors to assign, transfer and convey to the STATE without further consideration all of its and their right, title and interest in and to the Marketplace Data. Upon request by the STATE, CONTRACTOR will execute and deliver, and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve or enable the STATE to enforce its rights with respect to the Marketplace Data. Notwithstanding the foregoing, the CONTRACTOR shall be responsible for compliance with all federal or state requirements regarding the security and privacy of Marketplace Data that is within the CONTRACTOR's custody, including the requirements of HIPAA and the NY State Technology Law.

B. Ownership of CONTRACTOR Data.

As between the STATE and the CONTRACTOR, all CONTRACTOR Data, as defined below, shall be and will remain the property of the CONTRACTOR. For purposes of this section, CONTRACTOR Data means data and information created by the CONTRACTOR and relating to the CONTRACTOR, its directors, officers, employees and agents, Enrollees, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the CONTRACTOR's approval (in its sole discretion), the CONTRACTOR Data will not be (1) used by the STATE or its subcontractors other than in connection with carrying out its obligations under this Agreement and its obligations pursuant to applicable law; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by the STATE or its subcontractors other than in connection with carrying out its obligations under this Agreement and its obligations pursuant to applicable law; or (3) commercially exploited by or on behalf of the STATE or its subcontractors. The STATE hereby irrevocably assigns, transfers and conveys, and will cause its subcontractors to assign, transfer and convey, to the CONTRACTOR without further consideration all of its and their right, title and interest in and to the CONTRACTOR Data, provided however, such assignment shall not be construed to prevent or

delay the STATE from access to and use of the CONTRACTOR Data to fulfill its obligations with respect to QHP Certification and Recertification, Provider Network Review, monitoring of Quality and Enrollee Satisfaction, Reporting / Data Collection and other functions of the Marketplace as set forth in this Agreement and in federal and State law and regulation. Upon request by the CONTRACTOR, the STATE will execute and deliver, and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve or enable the CONTRACTOR to enforce its rights with respect to the CONTRACTOR Data. Notwithstanding the foregoing, the STATE shall be responsible for compliance with all federal and state requirements regarding the security and privacy of CONTRACTOR Data that is within the STATE's custody, including the requirements of HIPAA and NY Technology Law.

XX. 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.

Appendix C-1

Marketplace Facilitated Enrollment (FE) Program

For CONTRACTOR that authorizes employees or representatives to provide application assistance to individuals enrolling in QHPs through NY State of Health, The Official Health Plan Marketplace (Marketplace), who are referred to as Marketplace Facilitated Enrollers

I. Background

1. The ACA establishes a streamlined enrollment system for QHPs and all insurance affordability programs (IAPs). The NY State of Health, The Official Health Plan Marketplace (Marketplace) of the New York State Department of Health ("STATE") has developed an integrated application allowing consumers to enroll in any IAP (Medicaid, Child Health Plus, Advance Premium Tax Credits, Cost-Sharing Reductions, and the Essential Plan (Basic Health Program or 1332 State Innovation Waiver) and QHPs through the Marketplace application. To ensure that consumers have as many opportunities as possible to apply through the Marketplace, STATE is expanding its successful Medicaid and Child Health Plus Health Plan Facilitated Enrollment Program to include QHPs and the Essential Plan.

2. CONTRACTOR's employees and representatives may provide application assistance to individuals applying for coverage through the Marketplace provided that: (i) each individual is trained and authorized as a Marketplace Facilitated Enroller ("Marketplace FE") prior to providing such assistance, and (ii) such authorized Marketplace FEs abide by the requirements outlined below.

II. Obligation of CONTRACTOR

1. CONTRACTOR shall ensure that its employees and representatives complete the Marketplace approved training program regarding QHP options, IAPs, eligibility and benefits rules and regulations governing all IAPs operated in the State, pass an examination to assure successful completion of the training, and are authorized by the Marketplace.

2. CONTRACTOR shall ensure its employees and representatives complete any subsequent training required by the Marketplace, which includes successfully completing annual re-authorization training.

3. CONTRACTOR must establish procedures to ensure that its Marketplace FEs:

    i. Inform applicants of the functions and responsibilities of Marketplace FEs;
    ii. Disclose to potential applicants any relationships the Marketplace FE has with QHPs or IAPs or other potential conflicts of interest;
    iii. Obtain authorization from the applicant prior to obtaining access to an applicant's Personally Identifiable Information (PII) and maintain a record of the authorization in a form and manner determined by the Marketplace; and
    iv. Inform the applicant that he or she may revoke the authorization at any time.

4. CONTRACTOR must establish procedures to ensure that its Marketplace FEs:

    i. Provide information to individual and employee applicants about the full range of QHP options and IAPs for which they are eligible, which includes providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process;
    ii. Assist individual and employee applicants in applying for coverage in a QHP and for IAPs;
    iii. Help facilitate enrollment of eligible individuals in QHPs and IAPs;
    iv. Act in the best interest of the applicant assisted; and
    v. Do not misrepresent the options available to the applicant.

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

6. CONTRACTOR must either directly or through an appropriate referral to an Navigator or non-Navigator assistance personnel or to NY State of Health Customer Service Center, provide or have its staff members and volunteers provide information in a manner that is accessible to individuals with disabilities as defined by the Americans with Disabilities Act, as amended, 42 U.S.C. 12101 et. seq. and section 504 of the Rehabilitation Act, as amended, 29.U.S.C. 794.

7. CONTRACTOR and its Marketplace FEs are prohibited from:

    i. imposing any charge on applicants for application or other assistance related to the Marketplace;
    ii. providing compensation to Marketplace FEs on a per-application, per-individual-assisted, or per-enrollment basis;
    iii. providing gifts, including gift cards or cash, unless they are of nominal value, to any applicant or potential enrollee as an inducement for enrollment. Gifts, gift cards, or cash may exceed nominal value for the purpose of providing reimbursement for legitimate expenses incurred by a consumer in effort to receive NY State of Health application assistance, such as, but not limited to, travel or postage expenses;
    iv. soliciting any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including "cold calling" inquiries or solicitation. "Cold calling" does not include outreach to individuals enrolled in other products or plans offered by CONTRACTOR or to individuals formerly enrolled in products or plans offered by CONTRACTOR; or
    v. initiating any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where CONTRACTOR has a relationship with the consumer and so long as other applicable State and Federal laws are otherwise complied with.

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

9. CONTRACTOR must:

    i. Ensure that only authorized Marketplace FEs submit applications to the Marketplace using their individual identification number. Use of a Marketplace FE identification number by any individual other than the authorized Marketplace FE is strictly prohibited.
    ii. Provide its Marketplace FEs with the equipment necessary to provide in-person application assistance. Except in extraordinary circumstances, applications must be submitted on-line through the Marketplace on-line web portal. Computers must be connected to the internet using one of the following supported browsers: Safari, Google or Mozilla Firefox. All computers used by Marketplace FEs must have supported Operating

Systems and the latest security patches installed. All browsers must be updated to the latest versions that support Transport Layer Security (TLS) security protocol version 1.2.

iii. Generally, Marketplace FEs should not provide assistance by telephone. However, under some circumstances, in accordance with guidelines issued by STATE, Marketplace FEs may provide certain assistance by telephone. This includes but is not limited to collecting follow-up information by telephone if it is more convenient for the applicant.

iv. Identity proof the Marketplace FE using instructions provided by STATE if the Marketplace FE fails the on-line identity proofing process used for the Marketplace.

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

10. CONTRACTOR shall implement plans of correction for Marketplace FEs who are not adequately performing their duties under the Marketplace FE program, and shall rescind authorization to act as a Marketplace FE from all employees and representatives who are not adequately performing their duties in accordance with the requirements set forth in this appendix or who are out of compliance with the requirements of the program.

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

12. CONTRACTOR and its Marketplace FEs must refer to the employees and representatives authorized under this appendix only as Marketplace Facilitated Enrollers or Marketplace FEs.

III. Obligations of STATE

1. Provide or approve a comprehensive training program and any subsequent training updates for Marketplace FEs. Training may be delivered by STATE or its designated contractor in person or through on-line training programs.

2. Provide CONTRACTOR with or approve a training curriculum, including a facilitator guide, for use in training its staff members and volunteers.

3. Provide or approve any forms, applications, brochures or other materials needed to provide application assistance and information about the programs available through the Marketplace.

4. Collect information from CONTRACTOR regarding employees or representatives trained and authorized to provide application assistance so that a unique identifier can be created for each Marketplace FE.

5. Provide CONTRACTOR with or approve a form for Marketplace FEs to disclose conflicts of interest.

6. Provide data and reports to CONTRACTOR for use in monitoring Marketplace FE productivity until such time that the organization can generate this information through the Marketplace.

7. Update the list of trained and authorized Marketplace FEs based on information provided by CONTRACTOR, including terminating Marketplace FE accounts when necessary.

APPENDIX D

nystateofhealth™
The Official Health Plan Marketplace

Invitation and Requirements for Insurer Certification and Recertification for Participation in 2024

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

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2024 Schedule of Key Events

EVENT	DUE DATE	QHP	SADP	EP
Dental Forms and Rate Filings Due to DFS in SERFF	May 2, 2023		X	
Invitation Released	May 5, 2023	X	X	X
Medical Rate Filings Due to DFS in SERFF	May 10, 2023	X		
Letters of Interest Due to NYSoH	May 12, 2023	X	X	X
Written Questions Accepted by NYSoH	May 5 – May 26, 2023	X	X	X
Dental on Exchange Binders Due in SERFF	May 16, 2023		X	
Participation Proposals Due to NYSoH	May 26, 2023	X	X	X
Medical Policy Form Filings Due to DFS in SERFF	May 31, 2023	X		
Medical On Exchange Binders are Due in SERFF	June 9, 2023	X		
Qualified Dental Plan Template Due to NYSoH	June 30, 2023	X	X	
Provider Network Submission Due to NYSoH	July 21, 2023	X	X	X
Essential Plan Templates Due to NYSoH	*July 28, 2023			X
DFS Rate Decision Due Date	*July 31, 2023	X	X	
Essential Plan Subscriber Agreements Due to NYSoH	August 31, 2023			X
Plans Must Complete Approval of Information in Issuer Portal	*September 1, 2023	X	X	X
Certification of Plans by NYSoH	September 15, 2023	X	X	X

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

*Date will be extended due to the 1332 waiver process, if necessary

APPENDIX D



Section I: Introduction and Overview

A. Issuing Office and Purpose

This Invitation is issued by the New York State Department of Health ("DOH") to invite:

i. Insurers offering Qualified Health Plans ("QHPs"), Stand-Alone Dental Plans ("SADPs") and Essential Plans ("EPs"), through NY State of Health, the Official Health Plan Marketplace ("Marketplace"), in 2023, to apply for recertification for 2024; and

ii. Other insurers that are licensed or certified in New York State to apply for certain health insurance plans to be certified as QHPs, SADPs, and EPs to be offered on the Marketplace in calendar year of 2024.

Following the submission and review of the information required by this Invitation, the DOH will review whether Applicants and their proposed products meet all federal minimum participation standards and other requirements necessary for certification as a QHP, SADP or an EP. Applicants and individual plans found by DOH to satisfy all minimum standards and requirements, and in the case of Applicants applying for the first time, Applicants who sign a new Agreement with the DOH, will have products certified as QHPs, SADPs, or EPs available through the Marketplace. This will be the only opportunity for insurers to apply for certification or recertification of products to be offered on the Marketplace in 2024.

The DOH reserves the right to negotiate with Applicants in the best interest of the Marketplace and its consumers, including, but not limited to, ensuring choice for consumers and small businesses, and to provide continuity of coverage for consumers transitioning between Insurance Affordability Programs.

PLEASE NOTE: important changes regarding Essential Plan in Section III of the Invitation.

NOTICE REGARDING ESSENTIAL PLAN CERTIFICATION:

As explained below, DOH has applied for a 1332 State Innovation Waiver, which will change the authority of the Essential Plan program from section 1331 of the Affordable Care Act to section 1332. The program will continue under its current Essential Plan branding even as the legal authority for the program may change. Unless DOH otherwise provides notice, DOH will approve insurers' EP certifications or recertifications under the 1332 State Innovation Waiver program instead of the Basic Health Program. However, if New York's 1332 State Innovation Waiver is not enacted or approved, insurers' Essential Plans will be certified or recertified pursuant to the Basic Health Program.

B. Background

APPENDIX D

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

NY State of Health, the official health plan Marketplace of New York State, authorized by the Federal Patient Protection and Affordable Care Act of 2010 (the "ACA"), was established in April 2012 by Governor Cuomo's Executive Order 42, and codified in the NY Public Health Law in 2019. The NY State of Health Marketplace has successfully increased the affordability and accessibility of health insurance coverage in New York. As of January 31, 2023, more than 6.9 million New Yorkers were enrolled in coverage through the marketplace, an increase of just over 2 million people from 2020, in large part due to the COVID-19 pandemic.

As of January 31, 2023, over 5.2 million New Yorkers were enrolled in Medicaid through NY State of Health and over 1.7 million people enrolled in a non-Medicaid program through the Marketplace. This includes 214,052 people enrolled in a Qualified Health Plan, 377,598 enrolled in CHP, and 1,123,110 enrolled in the Essential Plan.

Consumers can enroll in coverage through NY State of Health online, by telephone, or with the help of an enrollment assistor. Between November 16, 2022, and January 31, 2023, nearly 1.36 million New Yorkers visited the NY State of Health website, Customer Service answered over 596,589 telephone calls, and there were more than 7,200 certified enrollment experts, including navigators, certified application counselors, health plan facilitated enrollers and health insurance brokers who worked with consumers. Enrollment assistors helped about three- quarters (77 percent) of enrollees complete their Marketplace applications in 2023. Through its website, NY State of Health makes available to consumers an easy-to-use plan preview, or anonymous shopping tool, which allows individuals to shop for a health plan and to also receive a personalized premium estimate before starting an application. NY State of Health continues to promote the availability of affordable, comprehensive coverage through a multi-channel and multi-lingual statewide paid advertising campaign.

During the COVID-19 public health emergency, NY State of Health has served as a safety net where individuals who lost jobs and/or income can find and enroll in affordable, comprehensive health coverage. Recognizing the need to ensure that individuals could easily maintain their coverage during the pandemic, NYSOH adopted nearly every option made available by the federal government to eliminate barriers to coverage, including the expedited implementation of the American Rescue Plan Act of 2021 (ARPA) provisions to make commercial, Qualified Health Plan (QHP) coverage more affordable and opening a Special Enrollment Period for the duration of the PHE and "unwind" period. In addition, the passage of the Inflation Reduction Act (IRA) in August 2022 will enable New Yorkers to continue to receive expanded financial assistance for health insurance for an additional three years.

Throughout the PHE, and in alignment with federal Continuous Coverage requirements, NYSOH has been extending coverage without requiring renewal for individuals enrolled in Medicaid, Child Health Plus (CHP), and the Essential Plan (EP) since March 2020. This flexibility will end in Spring 2023, when NYSOH will begin sending renewal notices to enrollees in these programs and

redetermining eligibility. Each month between May 2023 and April 2024, a group of enrollees will receive their renewal notices, depending on their enrollment end date. As the Continuous Coverage Requirement comes to an end, NYSOH is committed to continuing to provide affordable health insurance to all New Yorkers in need.

1332 State Innovation Waiver:

The New York State Fiscal Year 2023 Enacted Budget authorizes the Commissioner of Health to seek a Section 1332 State Innovation Waiver to expand Essential Plan eligibility to additional low- and moderate-income individuals. Through this expansion of Essential Plan coverage, the State seeks to increase access to high quality, affordable health insurance for low- and moderate-income individuals.

The State's draft waiver application is available online here. The final waiver application, reflecting comments received during the public comment period will be submitted in early May. The state hopes to receive timely federal approval permitting implementation in January 2024.

APPENDIX D



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

A. Participation Requirements

1. Licensure and Solvency

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

i. Be licensed as an insurer under Articles 42 or 43 of NY Insurance Law or certified under Article 44 of NY Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or

ii. Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to September 1, 2023, and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by September 1, 2023.

2. Choice of Participation

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

3. Service Area

Applicants must apply to participate in their entire service area, as approved by the Department of Financial Services ("DFS") or the DOH, at the time of application, provided all requirements of this Invitation are met. Applicants may apply to the DOH for an exception to this requirement by submitting a written request to the DOH explaining the facts that justify the exception.

The DOH reserves the right to grant exceptions to this requirement on a case-by-case basis when it determines that granting such exception is necessary, non-discriminatory and in the best interest of the Marketplace and consumers. Pursuant to 45 CFR § 155.1055, Applicants seeking participation must cover geographic areas that are established without regard to racial, ethnic, language, or health status- related factors, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

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

4. Public Health Emergencies and Unwind

In response to a public health emergency, in order to maintain and ensure access to health coverage, the State reserves the right to waive the following provisions, including retroactively:

Eligibility:

- Annual Re-certification: The state shall temporarily waive requirements related to the timely processing of annual recertifications.

Grace Periods:

- The State reserves the right to extend grace periods, as permitted by federal law and/or regulation, for payment of enrollee premium in order to avoid termination or cancellations for non-payment of premium, if applicable, to ensure access to health care services.

5. QHP Applicant Product Offerings

a. Essential Health Benefits

Applicants must agree to provide the Essential Health Benefits ("EHBs") specified by the DOH for calendar year 2024, delineated in Attachment "A." The EHBs must be included in the calculation of the actuarial values of the products.

b. Metal Levels

All products in each metal level must meet the following specified actuarial value ("AV") levels based on the cost-sharing features of the product and determined using the U.S. Department of Health and Human Services ("HHS") AV calculator.

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

Consistent with current federal rules, the following de *minimis* variations from AV are permissible:

Bronze:	4%/+2% if no major service is covered before deductible -2%/+5% if one major service is covered before the deductible or is HSA qualified
Silver:	Individual – 0%/+2% Small Group –2%/+2%
Silver CSRs:	0%/+1%
Gold:	-2/+2%
Platinum:	-2%/+2%

Note that the minimum AV differential between the Silver plan (70%) AV and the Silver CSR (73%) is 2%.

c. Standard Products

QHP applicants must offer one (1) standard product in each metal level and in every county of its Marketplace service area. The standard product offered by QHP Applicants must include the benefits and visit limits as delineated in Attachment "A," and the cost-sharing limitations delineated in Attachment "B," with the exception that the wellness benefit may be substituted for (a) different wellness benefit(s) in accordance with federal and state regulation and guidance, as well as DFS review and approval.

This requirement applies to the individual market; there is no requirement to offer standard products for the small business marketplace. The standard products for 2024 are provided in Attachment "B."

d. Standard Products with Visit(s) Pre-Deductible

The 2024 standard bronze product includes 3 visits to a primary care provider (PCP) or specialist that are not subject to the deductible; copayments are applicable for these visits.

The 2024 standard silver plan, silver 73 and 87 CSR plans include 1 visit to a primary care provider (PCP) or specialist not subject to the deductible; copayments are applicable for these visits.

e. Child-Only Offerings

In accordance with federal regulation, QHP Applicants must agree to offer a child-only product at each metal level described in Section II(A)(4)(b), above, in the individual market. The child-

only product must conform to the benefits and visit limits delineated in Attachment "A" and the same cost sharing limitations delineated in Attachment "B." In other words, it must be the standard product required in Section II (A)(4)(b), above, offered at the child-only rate outlined in Section II(B)(4)(b). Only one child-only product is required per metal level. Please note that a QHP Applicant's participation in the State's Child Health Plus program does not satisfy this requirement.

f. Catastrophic Products

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

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

An Applicant's decision not to offer catastrophic coverage will be for the entire plan year of 2024.

The DOH will inform the QHP Applicant of this option during the certification process and the decision regarding inclusion/exclusion of the catastrophic product will be made by the DOH prior to certification. In the event there is not adequate coverage in a particular county, all QHP Applicants in that county will be obligated to offer the catastrophic product.

g. Out-of-Network Products

An "out-of-network" product is a product that provides coverage for services rendered by health care providers that are not in the health plan issuer's network. QHP Applicants that offer an out-of- network product outside the Marketplace must offer the out-of-network product on the Marketplace, at the silver and platinum levels. This requirement applies to the individual market only.

QHP Applicants that do not offer an out-of-network product outside the Marketplace are strongly encouraged to offer a QHP on the Marketplace with an out-of-network benefit, so consumers have an option to purchase such a product should they chose to do so. An Applicant may use an additional or different license to offer an out-of-network QHP, provided the different or additional license is for an entity within the same family of companies.

h. Non-Standard Products

QHP Applicants may opt to offer up to two (2) "non-standard" products per metal level, as described below, in all or part of its service area, if the partial service area is approved by DOH and DFS in accordance with the requirements listed in Section II(A)(3), those stated below, and any applicable DFS instruction or guidance. This non-standard product limit only applies to the individual market; there will be no limit on the number of products offered by an insurer on the small business marketplace.

Non-standard products must allow consumers to easily identify the differences between non-standard products and standard products, so that consumers can determine which plan provides the highest value at the lowest cost to address their needs. All non-standard products must comply with federal and state laws, regulations and guidance and shall be subject to DFS and Marketplace review and approval. Non-standard silver level products, if offered by the issuers, must have an actuarial value of at least 70%, with a permissible *de minimis* variation of +2% AV.

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

Examples of permissible and non-permissible combinations:

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

QHP Applicants that offered a Bronze QHP that was HSA eligible in 2023, will be permitted to offer the HSA Compliant Bronze set forth in Attachment "B" in 2024, to ensure the HSA can carry over for their respective enrollees.

Child-only products, catastrophic products, out-of-network products, and the HSA Compliant Bronze product set forth in Attachment "B" will not be counted towards the two (2) non-standard product maximum.

i. Prescription Drug Coverage

As required under the federal rules, prescription drug coverage must cover at least the greater of:

(1) One drug in every United States Pharmacopeia ("USP") category and class; or

(2) The same number of prescription drugs in each category and class of the benchmark plan chosen by the state.

All prescription drug information must be submitted to DFS for review. This requirement is not intended to limit the number of drugs that the QHP Applicant may cover in a drug category or class. QHP Applicants are encouraged to develop formularies that exceed the federal requirements when it is determined to be in the best interest of their members.

j. Dental Coverage

Federal law requires coverage for pediatric dental services and permits such services to be covered by health insurers or stand-alone dental carriers. QHP Applicants have the option of embedding pediatric dental coverage within their QHPs, offering QHPs without pediatric dental coverage, or both.

In the event the DOH determines that there is no pediatric stand-alone coverage available in a county, all QHP Applicants in that county will be obligated to offer a QHP with embedded pediatric dental coverage.

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

QHP Applicant's product descriptions must include a plain language description of what services are included within "Basic" and "Major" dental services and must include information about any waiting periods, benefit maximums, any limits on services and benefits that do not count toward the max-of-pocket limit.

To assist the DOH in providing meaningful, detailed benefit and cost sharing dental information to consumers we will be requesting Applicants to complete a Qualified Dental Plan (QDP) Benefit and Cost Sharing Template which will be used to populate the NY State of Health Dental Comparison Tool.

Attachment "S" outlines the QDP instructions and Attachment "T" is the QDP template which

Applicants are required to complete. The data submission due date is outlined in the 2024 Schedule of Key Events.

The Dental Comparison Tool can be found here:
https://info.nystateofhealth.ny.gov/resource/dental-plan-comparison-tool

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

k. QHP and SADP Naming Conventions

To assist consumers in identifying products and differences between products, QHP and SADP Applicants must use the following naming conventions to identify all QHPs and SADPs offered on the Marketplace, in the order as presented below. Insurers will be required to add the network name associated with each product in the naming convention to assist consumers in identifying the specific network associated with the product. Please note that the absence of field name indicates the product DOES NOT include such coverage.

Individual Market

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	This should be the same product name the Applicant uses to market the product.
Metal Tier	Bronze, Silver, Gold, Platinum, Child-Only, Catastrophic	Indicate metal tier using entire the word for metal level.
Standard/ Non-Standard	ST or NS	Indicate standard or non- standard by using "ST" for standard and "NS" for non-standard. ST or NS must immediately follow the Metal Tier.
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Network Name	To be assigned by Applicant	Indicate the network name associated with each Product
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29.

Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, Other Significant Details	List the general categories of benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Specify the type of dental coverage embedded in the QHP. If none, leave blank
Dental Coverage Waiting Period	WP	Include "WP" to indicate any waiting periods for adult dental services.

Examples of permissible QHP Individual Market names are shown below:

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

Small Business Marketplace

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	This should be the same product name the Applicant uses to market the product.
Metal Tier	Bronze, Silver, Gold, Platinum,	Indicate metal tier using the entire word for metal level.
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Network Name	To be assigned by Applicant	Indicate the network name associated with each Product
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29.
Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, Other Significant Details	List the general categories of benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Specify the type of dental coverage embedded in the QHP. If none, leave blank.

Dental Coverage Waiting Period	WP	Include "WP" to indicate any waiting periods for adult dental services.
Domestic Partner	DP	Include only if domestic partners are eligible for coverage.
Family Planning	FP	Include only if the family planning benefit is covered.
Healthy NY	HNY	Include if the product is a Healthy NY product.

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

ABC product, Platinum, ST, INN, 123 Network, Dep25

ABC product, Gold, NS, OON, Adult Dental, XYZ Network, Dep29, DP, FP ABC product, Silver, OON, Main ST Network, Dep25

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

I. Effective Dates

All certified and recertified products offered through the Marketplace will have effective dates of January 1, 2024, in the individual market. Small group coverage runs on a plan year.

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

QHP Applicants, however, will not be able to establish and offer new products at any time during the year. Products to be offered during calendar year 2024 must be established and submitted to DOH and DFS through this Invitation.

6. Stand-Alone Dental Applicant Product Offerings

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

SADP Applicant's product descriptions must include a plain language description of what services are included within "Basic" and "Major" dental services and must include information about any waiting periods, benefit maximums, any limits on services, benefits that do not count toward the max-of-pocket limit and whether a deductible is applicable for adult dental care benefits.

a. Essential Health Benefits

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

b. The Standard Product

The SADP Applicant must offer one standard pediatric stand-alone dental product in every county of its service area. The standard product offered by the SADP Applicant must include the same pediatric benefits as delineated in Attachment "A." The standard product must comply with federal regulation and DFS guidance. This requirement applies to the individual market.

c. Non-Standard Products

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

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

d. Other Applicable Provisions

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

7. Small Business Marketplace

In addition to the above participation requirements, Applicants seeking to participate in the small business marketplace agree to adhere to the following requirements:

a. Definition of a Small Group

Small group is a group that meets the definition of "small group" in the NY Insurance Law and regulations, which is currently defined as a group of one hundred (100) or fewer full time equivalent employees ("FTEs") over the prior calendar year with at least one common law employee enrolled as defined by federal regulation, (see 26 CFR § 31.3121(d)-1(c)). An employee does not include a sole proprietor or the sole proprietor's spouse. The small business marketplace will determine the size of the employer by following the definitions

set forth by the Department of Financial Services, which can be found on their website at: https://www.dfs.ny.gov/consumers/small_businesses/small_group_expansion_faqs

b. Employer Choice

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

c. Product Offerings

Issuers proposing to no longer offer products in 2024 that were certified in 2024 on the small business marketplace, must inform the NY State of Health by the date Medical Policy Forms and Rates are due to DFS as indicated in the 2024 Schedule of Key Events, explaining the reason for the removal.

There will be no designation of "standard" and "non-standard" products in the small business marketplace. That is, Applicants applying for the small business marketplace in 2024 are not required to offer the standard benefits shown in Attachment "B." Applicants must, however, adhere to metal level actuarial value requirements and must agree to offer at least one product at each metal level on the small business marketplace.

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

For Plan Year 2024, Healthy NY issuers will continue to have the option of seeking SHOP-certification. This will allow HNY employers to access the Federal small business health care tax credit, if otherwise eligible.

d. Minimum Participation

While insurers in the small business marketplace and the off-marketplace small group insurance market are discouraged from imposing minimum participation requirements, non-HMO insurers are permitted to impose minimum participation requirements. However, if a small group cannot meet the insurer's minimum participation requirements, an insurer must still permit the group to enroll during an annual small group market open enrollment period that begins November 15 and extends through December 15 of each year.

The annual open enrollment period applies to coverage issued or renewed between November 15 and December 15 and coverage applied for between November 15 and December 15 with an effective date of January 1. Insurers may impose minimum participation

requirements on renewal outside of the open enrollment period but only to the extent the same requirements were imposed upon the group's initial application for coverage.

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

e. Health Savings Accounts and Health Reimbursement Accounts

Health Savings Accounts ("HSAs") and Health Reimbursement Accounts ("HRAs") are financial mechanisms created under law and regulated by the Internal Revenue Service ("IRS") that provide individuals with tax advantages to offset healthcare costs. HSAs are accounts held by a trustee or custodian (i.e., a bank) on behalf of individuals. HRAs are accounts held solely by an employer on behalf of an employee. For more information,
please visit https://www.irs.gov/forms-pubs/about-publication-969.

Applicants will be permitted to offer high deductible health plans that meet the IRS requirements and may arrange for the applicable HSA and HRA, if requested by the consumer and/or employer.

f. Non-Discrimination

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

B. Premium Rates and Policy Form Filings

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

Pursuant to Sections 3201, 3231, 4235, and 4308 of the NY Insurance Law, the New York State Department of Financial Services ("DFS") is authorized and directed to review and approve policy forms and premium rates before such policy forms may be issued or delivered. HHS has determined that New York State has an effective rate review mechanism and, as such, New York State is authorized to conduct rate review pursuant to state standards. Accordingly, pursuant to the requirements of the NY Insurance Law, Applicants must file with DFS proposed policy forms and premium rates for Marketplace products and obtain the Superintendent's approval of such policy forms and premium rates prior to issuing or delivering such contracts and prior to QHP certification or recertification.

2. Policy Form Filings

All policy forms for QHP products and SADPs shall be submitted to DFS by the date shown in the 2024 Schedule of Key Events, for approval through the System for Electronic Rate and Form Filing ("SERFF") in accordance with instructions established by DFS and HHS.

DFS will update a checklist and instructions for policy form filings, which will be available on the DFS website. Applicants should use the checklist and instructions to ensure that all policy form submissions are complete.

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

3. Rate Filings

All premium rate applications for Marketplace products must be received by DFS on or before the due date shown in the 2024 Schedule of Key Events for SADP Applicants and QHP Applicants.

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

DFS will develop a checklist and instructions for premium rate filings, which will be available on the DFS website. Applicants should use the checklist and instructions to ensure that all rate application submissions are complete.

QHP Applicants must use the updated federal AV calculator when determining whether the Marketplace products meet the actuarial values required for the respective products. HHS has updated the AV calculator, so Applicants must rerun their products through the updated AV calculator to ensure that all proposed products meet the required AV levels. To the extent the AV calculator is not built into the rate templates, Applicants must include in the rate application, a printout from the AV calculator for each Marketplace product submitted and a clear benefit description for each product submitted. The federal AV calculator can be found at https://www.cms.gov/cciio/resources/regulations-and-guidance/index#plan- management.

4. Provisions Applicable to QHP Applicants

a. Rating Tiers

Individual and small group products in New York State are community rated in accordance with state law, regulations, and guidance. QHP Applicants cannot consider age, sex, health status, occupation or tobacco use when establishing premium rates.

All products shall be initially priced to reflect five tiers, with the following relativities:

Tier	Relativities
Single person	1.00
Single + spouse	2.00
Single + child(ren)	1.70
Single + spouse + child(ren)	2.85
Child only	0.412

These relativities shall apply to 2024 rates in the individual market and the small business marketplace. The Superintendent of DFS will review and may adjust the relativities for subsequent years.

b. Child-Only Products

QHP Applicants must offer child-only products in conjunction with the standard product designs. Only one child-only product is required per metal level. Separate policy forms must be created and provided to enrollees of child-only products. The Superintendent of DFS will review this requirement and may adjust the factor for subsequent years.

c. Federal Risk Adjustment

QHP Applicant's premium rates should reflect the federalrisk adjustment as directed by DFS.

d. Single Risk Pool Inside and Outside of the Marketplace

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

e. Premium Rate Periods

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

   For example, if the employer's plan year begins April 1, 2023, the rate provided to that employer will be guaranteed for all employees through March 31, 2024, as well as new employees or special enrollments that occur during the plan year, through March 31, 2024.

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

f. Rating Regions

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

5. Role of Brokers and Agents

To maximize access to health insurance coverage for residents of New York State, brokers, and agents (collectively, "Producers") will be permitted to assist both small groups and individuals in purchasing coverage through the Marketplace.

a. Producer Certification

Producers who have successfully completed the training certification program for each applicable market and entered into an agreement with the Marketplace, will be deemed certified to conduct business in the Marketplace. Such agreements will require Producers to

be licensed and in good standing with the DFS.

b. Producer Compliance

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

c. Producer Compensation

All QHP and Essential Plan Applicants' must comply with all applicable provisions of New York State insurance law. In addition, all QHP Applicants' compensation arrangements with Producers must be the same for products sold inside and outside of the Marketplace. For example, compensation for a policy sold on the Marketplace must be the same as the compensation for a policy sold outside of the Marketplace. In addition, if compensation is provided, QHP Applicants must provide the same compensation (I.e., the same (1) flat percentage of premium; (2) flat amount per person; or (3) flat dollar amount per policy) at all metal levels.

Essential Plan compensation arrangements must follow the same requirements as in the individual market. Essential Plan producer compensation schedules will be requested during the Essential Plan rate setting process.

APPENDIX D



Section III: Essential Plans

A. Essential Plan Participation Requirements

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

Additionally, New York is in the process of submitting a draft application to the Centers for Medicare and Medicaid Services ("CMS") and the U.S. Department of Treasury for a 1332 State Innovation Waiver ("1332 Waiver" or "Waiver"), an option provided to states in section 1332 of the ACA. The Waiver application seeks authority to operate the Essential Plan pursuant to section 1332 of the ACA and (proposed) section 369-ii of the NY Social Services Law ("SSL") in lieu of the authority under the Basic Health Program [set forth in section 1331 of the ACA and NY SSL 369-gg.] The transition to 1332 Waiver authority would permit NYSOH to extend eligibility for Essential Plan to individuals with income between 138 and 250 percent of FPL, as outlined below. This transition is intended to be seamless to consumers, as under the 1332 State Innovation waiver the program will continue to be branded as the "Essential Plan". The target implementation date is January 1, 2024, pending federal approval.

If New York's 1332 State Innovation Waiver is not approved in 2023, insurers' Essential Plans will be certified or recertified pursuant to the Basic Health Program.

Essential Plan applicants must demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by September 1, 2023.

1. Choice of Participation

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

2. Service Area

EP Applicants must apply to participate in their entire service area as approved by the Department of Financial Services ("DFS") or the DOH at the time of application, provided all requirements of this Invitation are met. EP Applicants may apply to the DOH for an exception to this requirement by submitting a written request to the DOH explaining the facts that justify the exception. The DOH reserves the right to grant exceptions to this requirement on a case-by-case basis, when it determines that granting such exception is necessary, non-discriminatory and in the best interest of the Marketplace. EP Applicants

seeking participation must cover geographic areas that are established without regard to racial, ethnic, language, or health status-related factors, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

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

DOH reserves the right to negotiate service area with EP Applicants, to ensure choice of EP insurer in each county of the state, consistent with federal requirements.

3. Public Health Emergencies

In response to a public health emergency, to maintain and ensure access to health coverage, the State reserves the right to waive the following provisions, including retroactively:

Eligibility:

- Annual Re-certification: The State shall temporarily waive requirements related to the timely processing of annual recertifications.

4. Benefits, Cost-Sharing and Individual Premium Contributions

a. Standard Essential Plans

EP Applicants must agree to offer five variations of EP products (pursuant to the 1332 Waiver authority) based on enrollee income as a percentage of FPL and other factors as described below (here in after referred to as the "Standard EP").All Standard EPs below are based on the essential health benefits benchmark plan specified by DOH for calendar year 2024, with the following exceptions: pediatric services, will not be included in the benefit, the wellness benefit may be substituted for a different wellness benefit or benefits in accordance with federal and state regulations, guidance and DOH review and approval.

The Standard EPs shall include adult vision and dental benefits as part of the health care services with no premium or cost sharing. EP 1, EP 2, and EP 200-250 will include the Vision and Dental benefit set forth in Attachment K. EP 3 and 4 shall include the adult dental and vision benefits equivalent to those provided under NY Medicaid. All EPs offered shall include only in-network options and at no time shall an EP Applicant impose cost- sharing with respect to preventive health services, or items, as defined in 45 CFR § 147.130.

i. Pending federal approval of the 1332 waiver: For individuals with incomes greater than 200% and less than or equal to 250% of FPL

("Essential Plan 200-250" in Attachment "G"), EP Applicants must provide the Standard EP. Individual enrollees will have a $15 monthly premium for Essential Plan 200-250 coverage. EP Applicants must also offer a version of this product for the American Indian/Alaska Native ("AI/AN") population with no cost-sharing for any services.

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

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

iv. For individuals with incomes greater than 100% and less than or equal to 138% of FPL, who are not eligible for Federal Medicaid due to immigration status ("Essential Plan 3" in Attachment "G"), EP Applicants must provide the Standard EP.

Pursuant to Section 369- gg and 366(1)(g)(ii) of the NY Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 138% of the federal poverty level, and who previously would have qualified for NY Medicaid benefits, EP Applicants must include benefits equivalent to those provided under NY Medicaid, as may be modified from time to time, which include but are not limited to the following additional benefits: non-prescription drugs, orthotic devices, orthopedic footwear, and adult vision and dental services equivalent to the NY Medicaid benefit.

Non- emergency transportation will be covered but administered by DOH. Enrollees will have no monthly premium for Essential Plan 3 coverage.

v. For individuals with incomes at or below 100% of FPL, who are not eligible for Federal Medicaid due to immigration status ("Essential Plan 4", in Attachment "G"), EP Applicants must provide the Standard EP.

Pursuant to Section 369-gg and 366(1)(g)(ii) of the NY Social Services Law, in order to maintain coverage for legally present non- citizens who have an income at or below 100% of the federal poverty level, and who would have previously qualified for NY Medicaid benefits, EP Applicants must include benefits equivalent to those provided under NY Medicaid, as may be modified from time to time, which include but are not limited to the following additional benefits: non- prescription drugs, orthotic devices, orthopedic footwear, and adult vision and dental services equivalent to the NY Medicaid benefit.

Non- emergency transportation will be covered but administered by DOH. Enrollees will have no monthly premium for Essential Plan 4 coverage and will have no cost-sharing on benefits.

b. Standard Essential Plan Plus Adult/Vision/Dental Benefits

Adult vision and dental benefits are included in the health care services in the Standard EP.

c. Additional Features of Essential Plans

EP Applicants must include in the Standard EP, the following features per 42 CFR § 600.410(d):

i. Care coordination and care management for enrollees, with a focus on enrollees with chronic health conditions;

ii. Foster patient involvement in their health care decision-making, including the use of incentives for appropriate health care utilization and patient choice of provider;

iii. Incentives for the use of preventive services.

d. Essential Plan Naming Conventions

To assist consumers in easily identifying the EP Plans, all EP Applicants must use the same names for their products, and the Marketplace will attach the insurer logo and/or company name on its website to identify the insurer. The EPs must be labeled as follows

i. Essential Plan 200 - 250
ii. Essential Plan 1
iii. Essential Plan 2
iv. Essential Plan 3
v. Essential Plan 4

e. Effective Dates

Starting January 1, 2024, individuals who are determined eligible to enroll in the Essential Plan offered through the Marketplace shall have a coverage effective date of the first of the month in which an Essential Plan is selected. Plan selection may occur manually, or via auto-assignment. For example, an individual who selects an Essential Plan on February 20, 2024, will have coverage in the Essential Plan starting February 1, 2024.

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

i. For individuals who have incomes at or below 138% of the FPL, and do not qualify for Federal Medicaid due to immigration status (Essential Plan 3 and 4), and are newly enrolling in coverage, the effective date of Essential Plan coverage will be the first of the month in which they selected an EP plan. For example, an individual who enrolls in an Essential Plan on February 15, 2024, will have coverage starting February 1, 2024.

ii. For individuals who have incomes above 138% of the FPL (Essential Plan 200 – 250, 1, and 2), and are newly enrolling in coverage, the effective date of Essential Plan coverage will be the first of the month in which they selected an EP plan. For example, an individual who enrolls in an Essential Plan on February 15, 2024, will have coverage starting February 1, 2024.

iii. For individuals who have incomes at or below 138% of the FPL (Essential Plan 3 and 4), and do not qualify for Federal Medicaid due to immigration status, and are renewing coverage, the effective date will be the first of the following month.

iv. For individuals who have incomes above 138% of the FPL (Essential Plan 1 and 2), and are renewing coverage, the effective date shall be the first of the following month.

Note that EP enrollees who renew coverage after the fifteenth of the month in their last month of coverage will have no gap in coverage. Coverage will begin the first of the following month and they will be enrolled into their same plan. Consumers who change plans at renewal and renew after the fifteenth of the month will be enrolled into their same plan the first of the following month and then transitioned to their new plan the first of the next month.

For example, an enrollee whose coverage ends December 31, 2023, returns on December 25, 2023, and completes necessary updates and remains eligible for the Essential Plan will be enrolled in their same plan beginning January 1, 2024. If the enrollee is changing plans, coverage in their new plan will begin February 1, 2024.

Additionally, beginning in 2024, EP members who fail to renew before their eligibility end date, but who then complete a late renewal the following month and remain eligible for the same program and health plan, will have their enrollment backdated so there are no gaps in coverage.

For example, a consumer fails to complete their EP renewal and their EP enrollment is terminated 6/30/2024. They then come in on 7/12/2024 and renew and re-enroll with the same EP Issuer; they will be given a 7/1/2024 enrollment start date.

f. Compensation

EP Applicants who contract with the DOH to offer the Essential Plan on the NY State of Health Marketplace will receive from DOH, a monthly capitation payment for each member that has enrolled in its EP. Upon approval of the 1332 waiver for 200% - 250% FPL EP applicants will separately collect the applicable premium made from enrollees. The capitation payments made to the issuer must be used in accordance with federal and state laws and regulations, including New York's approved 1332 Waiver State Innovation Waiver application. EP Applicants will be informed of their monthly capitation payment amount around August 31, 2023.

EP Issuers are subject to the Medical Loss Ratio (MLR) of at least eighty-six percent (86%) and to rebating provisions. (*See* ACA § 1331(b)(3); 45 CFR § 158.210(c), 45 CFR § 158.240(b)).

g. Rating Regions and Risk Adjustment

Capitation payments will be made to EP Applicant on a county basis and in accordance with the nine rating regions set forth in Attachments "H" and "I" to this Invitation. The DOH currently risk adjusts for all rating groups within the Essential Plan rating structure except for the new 200% - 250% FPL EP applicants.

h. Subscriber Agreements and Template Submissions

EP Applicants must use the subscriber agreements that will be provided to them shortly after the release

of this Invitation. Revisions to the model language contained in the subscriber agreements will be limited to the bracketed sections of the subscriber agreements. EP Applicants can include their logos and numerical contract-identifying information on agreements. The subscriber agreements must be submitted to the DOH by the due date shown in the 2024 Schedule of Key Events.

EP Applicants must submit the required EP templates to DOH that provide prescription drug information, links to plan information, service area information, plan rates and contact information. The templates must be submitted to DOH by the due date shown in the 2024 Schedule of Key Events.

i. Non-Discrimination

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

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

A. Administrative Requirements

1. Enrollment and Member Services

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

QHP Applicants and SADP Applicants must adhere to the open enrollment periods and special enrollment periods established under applicable law and guidance. Enrollment is not effectuated until receipt of initial payment of premium from the prospective enrollee. However, once payment is received, the Applicant must adhere to the grace period standards set forth in federal regulation and DFS guidance for those enrollees receiving advance premium tax credit assistance. For enrollees in the individual market that do not receive advance premium tax credit assistance, once the initial premium is paid, the Applicant must provide a thirty (30) day grace period to pay premiums in accordance with DFS guidance.

b. Enrollment Period for the Essential Plan

Enrollment in the Essential Plan will be open all year. Eligibility for the Essential Plan will be recertified every twelve (12) months. If the enrollee is determined to remain eligible for EP, a new 12-month enrollment period will begin.

c. Enrollment/Disenrollment Transactions

Applicants must be able to send and receive HIPAA Compliant 834 and 999 transactions in accordance with the 834 and 999 Companion Guide, developed by the DOH and CMS pursuant to law, regulation, and guidance. In addition, the NYSOH provides these transactions to insurers on a daily basis and Applicants must process these transactions regularly, and more specifically in accordance with the following timeframes:

i. Transaction files, including maintenance and termination transactions, must be picked up daily;

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

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

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

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

d. Member Services General Functions

The Applicant must agree to operate a Member Services Department during regular business hours, which must be accessible to Marketplace enrollees via a toll-free telephone line. Personnel must also be available via a toll-free telephone line (which can be the member services toll-free line or separate toll-free lines), not less than during regular business hours, to address complaints and utilization review inquiries.

In addition, the Applicant must have a telephone system capable of accepting, recording, or providing instruction in response to incoming calls regarding complaints and utilization review during other than normal business hours and measures in place to ensure a response to those calls the next business day after the call was received.

The DOH may require the Applicant to periodically report member services call statistics such as the number of calls received related to the Marketplace, the number of calls answered, and caller wait times.

Applicants must be prepared to adjust member services staff to meet expected performance levels on peak Marketplace volume days.

e. Subscriber Contracts

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

f. Accessibility

Information must be provided to prospective enrollees and enrollees in plain language and in a manner that is accessible and timely to individuals with limited English proficiency ("LEP") and individuals with disabilities, including accessible websites and the provision of auxiliary aids and services at no cost to the individual, in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

The Applicant and its contractors must:

i. Provide written materials in a prose that is understood by an eighth grade reading level and

must be printed in at least ten (10) point font type;

ii. Make available written materials and other informational materials in a language other than English, whenever at least five (5%) of the applicants and/or enrollees of the issuer in any county of the service area speak that particular language and do not speak English as a first language; or, alternatively, in any county of the service area where the applicants and/or enrollees of the issuer speak a common non-English language, the issuer must provide taglines in those languages indicating the availability of written translation of materials in any language the prospective or current enrollees peaks;

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

iv. Make verbal interpretation services available in any language to current or potential enrollees who speak a language other than English as a primary language. Interpreter services must be offered in person, where practical, but otherwise may be offered by telephone;

v. Have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include assistive technologies for the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies; and

vi. To the extent HHS establishes standards on written materials and/or verbal materials for the Marketplace that provides greater protections than the standards set forth above, Applicant shall adhere to such HHS standards.

g. Consumer Complaints

Consumer complaints received through the Marketplace and sent to the Applicant require a response from the Applicant no later than three (3) business days from the day the Marketplace sends the complaint.

If the matter involves an urgent coverage issue, the Applicant must respond and act

upon the complaint within twenty-four (24) hours of issuance by the Marketplace.

These timeframes apply regardless of whether the complaint is generated as a result of technical problems with the Applicant's system or technical problems with the Marketplace system.

In the event the complaint involves a technical error by the Marketplace, or the Applicant needs a technical transaction to resolve the complaint, the Applicant will work cooperatively and diligently with the Marketplace to ensure the consumer's coverage is not delayed in any way as a result of waiting for the technical issues to be resolved.

B. Marketing Standards

1. New York State of Health Marketing and Outreach

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

2. QHP and EP Applicant Responsibilities

Applicants are encouraged to conduct advertising campaigns, including but not limited to television, radio, digital, billboards, subway, and bus posters. The Applicants are encouraged to distribute marketing materials in local community centers, health fairs and other areas where potential enrollees are likely to gather. Distribution of NY State of Health developed public education campaign materials associated with the end of the COVID-19 Public Health Emergency is strongly encouraged.

The Applicant shall use the NY State of Health logo and branding designated by the DOH in referring to Marketplace products in marketing and outreach activities including any printed materials. Such materials must prominently display the Marketplace website and toll-free telephone number. Applicant will cooperate in good faith with DOH's marketing and outreach activities, including the development of advertising materials and descriptive literature for its Marketplace products.

Applicant may not employ marketing practices that will have the effect of discouraging the enrollment of individuals or small businesses with significant health needs in their Marketplace products.

The Applicant shall comply with all provisions of federal and state law regulating advertising

material and marketing practices. The Applicant's advertising materials must accurately reflect general information that would be applicable to a Marketplace enrollee. Materials must not contain false or misleading information. Applicants may not offer incentives to potential enrollees to enroll in a Marketplace product or renew their coverage.

The Applicant may not require participating providers to distribute Applicant-prepared communications to their patients.

Marketing may not take place in patient rooms or treatment areas.

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

C. Network Adequacy

Applicants will establish and maintain a network of participating providers that is consistent with 45 CFR § 156.230 and existing DOH managed care network adequacy standards. Specifically, Applicants must adhere to the following:

1. General Standards

In establishing the network, the Applicant must consider the following: anticipated enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services covered in each product, the number of providers who are not accepting new patients and the geographic location of the providers and enrollees.

To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the enrollee population and to assure that all services will be accessible without undue delay. This includes being geographically accessible (i.e., meeting time/distance standards) and being accessible for people with disabilities.

2. Specific Standards for QHP Applicants and EP Applicants

a. Network Composition

The QHP Applicant's and EP Applicant's network must contain all of the provider types necessary to furnish the Marketplace products, including but not limited to hospitals, physicians (primary care and specialists), mental health and substance use providers, allied health professionals, ancillary providers, durable medical equipment ("DME") providers,

home health providers, and pharmacies. Specifically, the Applicant's network must meet the following minimum standards:

i. Each county network must include at least one (1) hospital; however, for the following counties and boroughs, the network must include at least three (3) hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, Manhattan, and Queens;

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

iii. Provide a choice of three (3) primary care physicians ("PCPs") in each county, but more may be required based on enrollment and geographic accessibility;

iv. Include at least two (2) of each required specialist provider types in each county, but more may be required based on enrollment and geographic accessibility;

v. Meet the following time and distance standards:

Primary Care Providers

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

Dental Providers

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

Other Provider Types

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

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

vii. QHP Applicants and EP Applicants are required to have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in QHP Applicants' and EP Applicants' service area;

viii. The QHP Applicant and EP Applicant must make every good faith effort to include in its network the essential community providers defined under federal regulation, and at a minimum, must include in each county network a federally qualified health center and a tribal operated health clinic, to the extent such providers are available;

ix. January 1, 2023, an update to the public health law will be effective, that requires Medicaid managed care, Qualified Health Plans and Essential Plans to contract with National Cancer Institute (NCI) designated cancer centers, licensed by the department within the health plan's service area that is willing to agree to provide cancer-related inpatient, outpatient, and medical services to the plan's enrollees.

Such contract would be under the prevailing terms and conditions that the plan requires of other similar providers included in the plan's provider network but must include reimbursement of at least the fee for service Medicaid rate and methodology applicable to the center's inpatient and outpatient services. (See, Chapter 57 of the Laws of 2022).

Additional information regarding NCI-Designated Cancer Centers can be found

here: https://www.cancer.gov/research/infrastructure/cancer-centers/find

x. QHP Applicants and EP Applicants are required to include individual providers, outpatient facilities, residential treatment facilities, and inpatient facilities in its behavioral health network. The network must include facilities that provide inpatient, and outpatient mental health and inpatient and outpatient alcohol and substance use services. Facilities providing inpatient alcohol and substance use services must be capable of providing

detoxification and rehabilitation services.

Pursuant to applicable law, QHP Applicants and EP Applicants are required to notify enrollees of significant changes in their networks which will be effective in the 2023 plan year. Applicants are required to submit disruption analysis reports to the NY State of Health, when a network is scheduled to have a hospital disenroll, an IPA or major medical group, or is scheduled to lose or change their pharmacy carrier.

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

b. Specific Standards for Dental Benefits and Stand-Alone Dental Carriers

The Applicant's dental network shall include geographically accessible general dentists sufficient to offer each enrollee a choice of two (2) primary dentists in their service area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 enrollees. Networks must also include at least two (2) orthodontists, one (1) pediatric dentist and at least one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders ("TMD") and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral.

The network must include dentists with expertise serving special needs populations (e.g., HIV+ and developmentally disabled patients).

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

3. Sanctioned Providers Applicable to All Applicants

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

i. Been sanctioned or prohibited from participation in Federal Health Care Programs undereither Section 1128 or Section 1128A of the SSA; or

ii. Had their license suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

4. Method of Review

Network adequacy shall be reviewed by the DOH on a county-by-county basis. For some network adequacy purposes, however, the county may be extended by the DOH in the event the Applicant demonstrates a lack of health care resources or demonstrates that utilization patterns of consumers typically reside outside the county. In such cases, and for rural areas, Applicants may contract with providers in adjacent counties to fulfill the network adequacy requirements, as determined by the DOH.

5. Frequency of Review

The DOH shall review the adequacy of an Applicant's network upon submission of the application, and on a quarterly basis thereafter. Pursuant to NY Insurance Law § 3217-1(a)17, NY Insurance Law §4324(a)(17) and NY Public Health Law § 4408(r), Applicants must update their online directory, as well as their PNDS submission(s) within fifteen (15) days of becoming aware of the addition or termination of a provider from its network, or a change in a physician's hospital affiliation.

6. Submission of the Network

The Applicant shall submit its network through the Provider Network Data System, https://pnds.health.ny.gov , in accordance with instructions issued by the DOH and the Provider Network Submission Instructions set forth in Attachment "P". Submissions must include out-of- state providers within the Applicant's network and must include arrangements with specialty centers and centers of excellence. The DOH reserves the right to ask for further explanations and/or details in the event the system is not able to capture or accurately identify particular service providers.

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

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

D. Enhancements to Network Information.

In addition to the Network Adequacy requirements set forth in Section IV(C), all Applicants shall adhere to the following, unless otherwise specified:

1. Provider Directories

The Applicant shall maintain an up-to-date listing of providers, including facilities and specialty providers, participating in the products offered through the Marketplace (the "Marketplace Provider Directory"). The Marketplace Provider Directory must include names, office addresses, telephone numbers, board certification for physicians, any affiliations with participating hospitals, information on language capabilities and wheelchair accessibility of participating providers. The Marketplace Provider Directory should also identify providers that are considered Primary Care Physicians and identify providers that are not accepting new patients. Consistent with NY Insurance Law § 3217- 1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), such directories shall be updated within fifteen (15) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

The Applicant must make available to DOH, a URL link that provides access to the Applicant's Marketplace Provider Directory. The directory must clearly identify the network of providers participating in the Marketplace QHPs, SADPs or EPs.

If multiple network configurations are offered by the Applicant, the directories must clearly identify the network(s) for the particular Marketplace product(s). For example, if one network is used for an Applicant's standard QHP products, but a different network is used for one particular non-standard QHP product, the provider directory for the standard product and non-standard product must be distinct and identifiable to a consumer. The directories must distinguish individual network(s) offered by the Applicant so a consumer using the directory can clearly and easily access the correct network via the URL link provided to the Marketplace. For tiered networks, the directory must clearly identify the tier in which the provider participates. Applicants should include the word 'NYSOH Marketplace' on their internal provider directory websites to assist consumers with identifying which networks belong to Marketplace products.

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

2. Verification of Networks and Appointment Availability Standards/Monitoring

1 The Applicant shall provide their process to periodically verify the accuracy of its reported Marketplace provider network(s). Such process may include, but not be limited to, direct outreach to providers listed by the Applicant as

participating in Marketplace networks. The Applicant shall provide to the DOH, the method and frequency with which it will carry out such verifications and report to the DOH the results of such verification efforts within a timeframe specified by DOH. The goals of such processes are to validate participation by providers and to make sure providers are aware of their participation in Marketplace networks.

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

3. Addressing Provider Directory Disputes

Applicants must develop and implement protocols to effectively address inquiries and complaints concerning provider directories. Applicants shall provide to the DOH the protocols developed within a timeframe specified by DOH.

4. Treatment Cost Calculators for Participating Providers

The QHP Applicant and EP Applicant must have in place a treatment cost calculator available through an internet website and such other means for individuals without access to the internet. Such treatment cost calculators must be able to demonstrate enrollee cost-sharing using current price data under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual.

E. Consumer Network Protections

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

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

i. QHP Applicants and EP Applicants must hold its members harmless from liability for all out-of-network emergency ("ER") bills. In addition, QHP Applicants and EP Applicants must hold their member harmless

from liability for non- emergency ("non-ER") surprise out-of-network bills: (a) for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center where an in-network provider is unavailable, or a non- participating physician renders services without a member's knowledge, or unforeseen medical circumstances arise (unless a participating physician is available and the member chose to obtain services from a non-participating physician);or (b) whenever a participating physician refers a member to an out-of-network providerwithout the member's written consent.

ii. QHP Applicants and EP Applicants shall allow their members to request a referral to an out-of-network provider or request prior authorization to have a service provided by an out-of-network provider, when there is not an appropriate in-network provider available to the member.

iii. QHP Applicants and EP Applicants must allow members to request:

- A standing referral to a specialist provider when the enrollee's condition requires ongoing care from the specialist provider;
- A referral to a specialist responsible for providing or coordinating the member's care when the member has a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which may require specialized medical care for a prolonged period of time; and
- Direct access to primary care services and preventive obstetric and gynecologic services within the network of providers without having to obtain a referral.

iv. QHP Applicants and EP Applicants will provide its members with all grievance, utilization review and external appeal rights, including the ability to appeal a denial for an out-of- network referral and external appeal rights to denials for an out-of-network referral.

v. QHP Applicants and EP Applicants will provide to its members and to DOH, information on cost-sharing and payments to providers with respect to any out-of-network coverage pursuant to 45 CFR § 156.220(a)(7) and consistent with Part H of Chapter 60 of the Laws of 2014 (the "Out-of-Network Law").

QHP Applicant and EP Applicant may use a treatment cost calculator to provide estimates of out-of- pocket expenses for receiving services at an out-of-network provider, provided such calculators provide the information required by the Out-of-Network Law. Upon request, QHP Applicant and EP Applicant will provide a URL link to its out-of-network treatment cost calculator.

F. Prescription Drug Benefits

1. Formulary Requirements

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

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

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

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

QHP Applicants and EP Applicants must comply with NY Public Health Law § 4406-c, and NY Insurance Law § 3216(i)(27), (28), § 3221(a)(16), § 3221 (l) (18), and § 4303(jj), (kk). Formularies will be reviewed to ensure the intent of the state law is being followed. QHP Applicants and EP Applicants should not place all prescription drugs to treat a specific condition on the highest tier or should provide information to DOH or DFS to demonstrate that they are otherwise in compliance with 45 CFR §156.125 which prohibits discriminatory benefit designs.

2. Pharmacy and Therapeutics Committee

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

3. Pharmacy Rules

Pursuant to 45 C.F.R. § 156.122 (e)(1), QHP Applicants and EP Applicants must allow enrollees to access prescription drug benefits at in-network retail pharmacies, unless: (1) the drug is subject to restricted distribution by the U.S. Food and Drug Administration; or

(2) the drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

4. Prescription Drug Co-payments

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

G. Quality and Enrollee Satisfaction

1. QHP Applicant Requirements

a. Quality Rating System

New York will use U.S. Centers for Medicare and Medicaid Services ("CMS") generated quality ratings in 2024, which is based upon data provided to CMS by health insurers in 2023. Each rated health plan has an "overall" quality rating, ranging from 1 to 5 stars, which accounts for member experience, medical care and health plan administration.

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

b. Quality Improvement Strategy ("QIS") or Quality Strategy("QS")

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

We strongly recommend Applicants post the content of their QIS and QS information on their public website in a form that is appropriate for the public to review.

c. Quality Improvement Strategy ("QIS")

QHP Applicants that offered QHP coverage through the Marketplace in 2021 and 2022, and continues operating in the Marketplace through 2023, and had more than 500 QHP

enrollees in a "product" (defined by CMS for this purpose as insurer model, including HMO, EPO, PPO, POS, etc.) as of July 1, 2022, must submit at least one QIS Implementation Plan form. When a QHP Applicant is continuing a QIS the applicant must submit a QIS Progress Report Form for the 2024 Plan Year.

QHP Applicants that meet the eligibility criteria to submit a QIS are required to use the QIS Implementation Plan form for the 2024 Plan Year if: implementing a QIS for the first time; discontinuing a current QIS and implementing a new QIS; or if implementing an additional QIS. If a QHP Applicant is continuing their current QIS either with or without modification, they do not need to submit a new QIS Implementation Plan Form for the 2024 Plan Year.

The QIS Progress Report Form for the 2024 Plan Year should be submitted for: QHP Applicants who are continuing their current QIS, with or without modifications; and QHP Applicants who are discontinuing their current QIS and implementing a new QIS.

The Modification Summary Supplement for the 2024 Plan Year should be submitted for QHP Applicants to indicate any modifications to an existing QIS Implementation Plan for the upcoming Plan Year (making changes to goals activities, measures, performance targets, and/or the product types). In addition, Applicants are required to use the Quality Improvement Strategy Technical Guidance and User Guide for the 2024 Plan Year resource for completion of the applicable forms.

These resources are available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Quality-Improvement-Strategy/QIS-General. This website contains the 2024 Plan Year QIS forms and instructional documents regarding QIS implementation and reporting.

Applicants that submitted a new QIS Implementation Plan Form in Plan Year 2023 and have not made any changes to the QIS do not need to resubmit the QIS Implementation Plan Form for the 2024 Plan Year. The Applicant would be required to submit a QIS Progress Report Form for the 2024 Plan Year and if applicable a Modification Summary Supplement for the 2024 Plan Year.

Applicants must:

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

ii. Implement a QIS that includes at least one of the following:
   - Activities for improving health outcomes;
   - Activities to prevent hospital readmissions;
   - Activities to improve patient safety and reduce medical errors;

- Activities for wellness and health promotion; and/or

iii. Implement at least one QIS that includes activities to reduce health and health care disparities.

iv. Adhere to guidelines, including the QIS Technical Guidance and QIS User Guide established by Health and Human Services ("HHS"), in consultation with experts in health care quality and interested parties.

v. Report on progress implementing the QIS to the DOH on a periodic basis.

QHP Applicants must submit the required QIS information as part of their participation proposal for the 2024 coverage year by completing the required parts of the 2024 Plan Year applicable forms including: the QIS Implementation Plan Form, the QIS Progress Report Form and the QIS Modification Summary Supplement.

The submitted QIS appropriate forms for the 2024 plan year will be evaluated by the NY State Department of Health (NYS DOH) Office of Quality and Patient Safety, in consultation with the NY State of Health. Based upon the results of the QIS evaluation, an overall outcome of "meets" or "does not meet" will be assigned to the QIS submission. QHP Applicants will be notified in writing regarding any corrective actions required.

a. Quality Strategy ("QS")

QHP Applicants that did not offer QHP coverage through the Marketplace in 2021 and 2022 or did not have more than 500 enrollees enrolled in a product as of July 1, 2022, must develop a Quality Strategy ("QS") that encompasses all the requirements set forth in 1311 (g) of the Affordable Care Act ("ACA"). This strategy must be implemented and updated annually with progress reported to the designated office of the DOH. The quality strategy should describe how the Applicant will address the following:

- The implementation of quality improvement activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication, and care compliance initiatives, including through the use the medical home model, for treatment or services under the plan or coverage;

- The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post discharge reinforcement by an appropriate health care professional;

- The implementation of activities to improve health outcomes, and patient safety, as well as to reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage;

- The implementation of wellness and health promotion activities;

- The implementation of activities to reduce health and health care disparities, including the use of language services, community outreach, social determinants of health, and cultural competency trainings; and including evaluation of such activities.

- A description of any current or proposed innovative programs to expand access to mental health services including, but not limited to, telepsychiatry or consultative services for co- management of common behavioral health conditions in children and adults.

b. Quality Reporting System ("QRS")

QHP Applicants must submit quality data collected as part of the Quality Reporting System ("QRS") and QHP enrollee survey requirements to NYS DOH. QHP Applicants should follow the 2024 Quality Rating System Measure Set Technical Specifications. These quality indicators are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance's ("NCQA") Health Care Effectiveness Date and Information Set ("HEDIS").

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

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

To reduce disparities across patient groups, health plans must first understand where disparities exist, the magnitude of the disparities, and why these disparities are occurring within their member population. As a first step towards stratification of quality data by

patient race, ethnicity, language spoken, and other demographic variables health plans will need to increase reporting of data by race and ethnicity.

The enrollment transactions that NY State of Health provides to health plans include self-reported race and ethnicity information that consumers provide as part of the NY State of Health application. All plans must provide this data as part of the patient record with their QARR submissions.

c. Enrollee Satisfaction Survey

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

2. EP Applicant Requirements

a. Quality Strategy ("QS")

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

b. Quality Reporting

EP Applicants will be required to participate in the NYS DOH Quality Assurance Reporting Requirements ("QARR"). The quality indicators in QARR are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance ("NCQA") and the Health Care Effectiveness Data and Information Set ("HEDIS") with New York State specific measures added to address health issues of importance to the state.

QARR Technical specifications are released annually during the Spring of the measurement year, with reporting of QARR data due on or about the following June 15.

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

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

To reduce disparities across patient groups, health plans must first understand where disparities exist, the magnitude of the disparities, and why these disparities are occurring within their member population. As a first step towards stratification of quality data by patient race, ethnicity, language spoken, and other demographic variables health plans will need to increase reporting of data by race and ethnicity.

The enrollment transactions that NY State of Health provides to health plans include self-reported race and ethnicity information that consumers provide as part of the NY State of Health application. All plans must report this data with their QARR submissions. Essential Plan Applicants should have reached 80% completeness for data on race and ethnicity in the measurement year 2022 submission which will be due to NCQA and the NYS DOH in the Spring of 2023.

c. Screening for Social Determinants of Health

EP Applicants will be required to screen 85% of their members for social determinants of health in their preferred language at enrollment or re-enrollment. The data will be collected via the Social Needs Screening-Electronic HEDIS measure which is required for aggregate and patient level detail reporting in NYS' QARR 2024 specifications.

It is highly encouraged that the EP Applicants use the Center for Medicaid and Medicare (CMS)'s Accountable Health Communities Health Related Social Needs Screening Tool to align with current screening for Health Home members and potential future screening requirements for Medicaid members.

EP Applicants may use health care providers or other tools to help complete screenings but will be responsible for submission as outlined by the HEDIS specifica◆on for the measure. This limits the provision of data to members con◆nuously enrolled as defined by the measure. Screened for social determinants of health is defined as that a screening for food, housing, and transporta◆on was conducted and that a posi◆ve or nega◆ve finding of the screen was captured.

The NY State Department of Health has established an EP Quality Incentive Pool which shall provide incentive payments to health plans that achieve specified levels of performance on quality and consumer satisfaction measures and such other factors, including but not limited to reducing

health care disparities, as determined by the NYS DOH.

d. Satisfaction Survey ("CAHPS")

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

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

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

e. Accreditation

The DOH will not require Applicants to be accredited as a condition of participation in 2024.

H. Reporting

1. General

The Applicant will maintain a health information system that collects, analyzes and reports data. The system must be able to report on utilization, claims payment policies and practices, periodic financial disclosures, enrollment and disenrollment information, the number of claims that are denied, customer service information, rating of provider practices, information on cost-sharing and payments with respect to any out-of-network coverage, prescription drug distribution and cost reporting, quality and customer satisfaction reporting pursuant to the DOH reporting requirements, and any other information requested by the DOH and/or required under applicable federal and state laws or regulations.

2. Timing and Instructions for Reporting

The Applicant must submit required reports to the DOH in a manner consistent with federal requirements under Section 45 CFR Part 156, or as otherwise instructed by the DOH.

3. Encounter Data

Applicants will be required to submit encounter data for all contracted services obtained by each of their members. Encounters are records of each face-to-face interaction a member has with the health care system and includes outpatient visits, inpatients admissions, dental care, emergency room and urgent care visits. Encounters for ordered services, such as pharmacy and labs, shall also be submitted. An encounter is comprised of the procedure(s) or service(s) rendered during the contact and includes information on the site of service and may also include diagnosis information. Each encounter must be recorded in an information system as each unique occurrence between recipient and provider. Encounters must be submitted on at least a monthly or more frequent basis through the DOH designated vendor in a format and manner to be prescribed by the DOH.

4. Financial Reporting

Applicant shall submit financial reports, including certified annual financial statements, and make available documents relevant to its financial condition to the DOH and DFS in a timely manner as required by state and federal laws and regulations. Applicant must also agree to also submit separate premium and expenditure reports, and any additional relevant financial reports and documents related to its financial condition, in a manner and form required by the DOH.

I. Certification, Recertification and Decertification Processes

1. Certification

The Marketplace will grant certification through SERFF and/or email notice. All Applicants that meet the requirements set forth in this Invitation, will have their health plans certified to be offered through the Marketplace.

2. Decertification

A plan issuer certified by the Marketplace may be decertified if it fails to adhere to the certification standards set forth in this application, fails to resolve state agency sanctions, fails to comply with any applicable corrective action plan, or fails to recertify, and for any other reason set forth in the Agreement between DOH and applicable law. Decertification of individual products shall occur in accordance with all applicable laws and regulations governing the removal of a product from the market, including notification to enrollees.

3. Non-Renewal

Plan issuers may opt not to renew participation or products in the Marketplace. The issuer must notify DOH of its decision not to renew, no later than thirty (30) days prior to the start of Open Enrollment. The Issuer shall cooperate with DOH in the development of a plan to facilitate the orderly transition of its members, including, but not limited to, notification to consumers and providing DOH with member specific information to the extent permitted by law. In addition, per Executive Order 167, an issuer that withdraws from the Qualified Health Plan market cannot participate in Medicaid, Child Health Plus or the Essential Plan.[1]

4. Suspension

The DOH may suspend enrollment in a health plan in the event a state agency requires suspension, or in the event the DOH determines it is in the best interest of the public. Notification of such suspension shall occur in accordance with applicable laws and regulations.

J. Federal and State Laws and Regulations

1. Federal Laws, Regulation and Guidance

The Applicant shall always strictly adhere to all applicable federal laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted, including the following:

- The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, as amended. The two laws are collectively referred to as the Affordable Care Act ("ACA");
- American Rescue Plan Act of 2021
- 45 C.F.R. Parts 155 and 156 Marketplace Establishment Standards and Other Related Standards Under the Affordable Care Act, Insurance Standards Under the Affordable Care Act, Including Standards Related to Exchanges;
- Health Information Technology for Economic and Clinical Health Act of 2009;
- Health Insurance Portability and Accountability Act of 1996;
- The Privacy Act of 1974; and
- 42 CFR Part 600 and other related guidance and instruction;

2. State Laws and Regulations

[1] Executive Order No. 167, issued June 9, 2017 [9 NYCRR 8.167], and continued through Executive Order [Hochul] No. 6 [9 NYCRR 9.6].

The Applicant shall always strictly adhere to all applicable state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted. Applicant acknowledges that such laws include, but are not limited to the following:

3. Contracts/Insurance Companies and Non-Profit Medical and Dental Indemnity Corporations

- N.Y. Insurance Law § 3201, 11 N.Y.C.R.R. 52.1, et. seq. (Approval of Policy Forms);
- N.Y. Insurance Law § 3231 (Rating of Individual and Small Group Health Insurance Policies; Approval of Superintendent);
- N.Y. Insurance Law § 4308 (Supervision of Superintendent);
- N.Y. Insurance Law § 4235, 11 N.Y.C.R.R. 52.2 (Group Accident and Health Insurance);
- Executive Order No. 167, issued June 9, 2017 [9 NYCRR 8.167], and continued through Executive Order [Hochul] No. 6 [9 NYCRR 9.6].

4. Access to Care

- N.Y. Public Health Law § 4403(5)(a), 10 N.Y.C.R.R. 98-1.13(b) (Health Maintenance Organizations, Network Adequacy);
- N.Y. Public Health Law § 4403(6)(a), 10 N.Y.C.R.R. 98-1.13(a) (Health Maintenance Organizations, Access to Appropriate Providers);
- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.13(j) (Health Maintenance Organizations, Emergency Health Services);
- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.6, 10 N.Y.C.R.R. 98-1.12 (Health Maintenance Organizations, Quality Management Program);
- N.Y. Insurance Law § 4325 (Prohibitions);
- N.Y. Insurance Law § 3224-a (Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments of Health Care Services);
- The Out-of-Network Law, Chapter 60 of the Laws of2014;
- Health Insurance Coverage for the Treatment of Gender Dysphoria, DFS Insurance Circular - Letter No. 7 (2014) (found here: http://www.dfs.ny.gov/insurance/circltr/2014/cl2014_07.pdf);
- Changes in Utilization Review Standards for Substance Use Disorder Treatment Pursuant to Chapter 41 of the Laws of 2014;
- Updated FAQs Regarding 18 Approved Forms of Contraception Issued by CMS May 11, 2015 (found here: http://www.dol.gov/ebsa/faqs/faq-aca26.html);
- Discrimination Based on Sexual Orientation, Gender Identity and/or Gender Dysphoria, DFS Insurance Circular Letter No. 9 (2018), June 25, 2018

5. Access to Information

- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.16 (Disclosure and Filing);
- N.Y. Public Health Law § 4405-b (Duty to Report);
- N.Y. Public Health Law § 4408 (Disclosure of Information);
- N.Y. Public Health Law § 4909 (Prescription Drug Formulary Changes);
- N.Y. Insurance Law § 4909 (Prescription Drug Formulary Changes);
- N.Y. Public Health Law § 4910 (Right to External Appeal);
- N.Y. Insurance Law § 4323 (Marketing Material); and
- N.Y. Insurance Law §§ 3217-a and 4324 (Disclosure of Information).

6. Medicaid and Child Health Plus Programs

Applicants that also participate in the Medicaid Managed Care Program and the Child Health Plus Program shall adhere to the requirements of the respective programs. Nothing contained herein shall be interpreted to supersede the laws, regulations, guidance or instructions issued under the Medicaid Managed Care Program and Child Health Plus Program.

APPENDIX D



Section V: Application Process

A. Issuing Agency

As stated in Section I (A), this Invitation is issued by the DOH. DOH is responsible for the requirements specified herein and for processing all Applications in partnership with the DFS. This Invitation has been posted on the DOH Marketplace informational website.

DOH shall review Applications in an objective, comprehensive manner designed to benefit both the Marketplace and Applicants. The DOH intends that all Applications will be reviewed uniformly and consistently. For the purpose of its review, the DOH may seek assistance from any person, other than one associated with an Applicant.

B. Letters of Interest

Applicants are requested to submit non-binding Letters of Interest as soon as possible, but no later than the date set forth in the 2024 Schedule of Key Events, via electronic or regular mail at the addresses set forth in paragraph "C" below. Submission of the Letter of Interest does **not** bind a prospective Applicant to submit an application.

If an Applicant would like to receive e-mail notification of updates/modifications to the Invitation, including the issuance of DOH responses to questions raised regarding the Invitation, the Applicant may include such request in their Letter of Interest.

A form Letter of Interest is attached to this Invitation as Attachment "E" for QHP Applicants, EP Applicants, SADP Applicants and Small Business Market (SHOP) Applicants. Please indicate which offerings you are interested in participating in for 2024.

C. Inquiries

All responses and requests for information concerning this Invitation by a prospective Applicant, or an Applicant, or a representative or agent of a prospective Applicant, or Applicant, should be directed to the contact listed below.

In order for DOH to address questions efficiently, prospective Applicants are requested to send their inquiry in writing by email to the address below.

Inquiries of a technical nature may result in either a written response or a referral to the appropriate individual for a verbal response. To the extent possible, written questions concerning a specific requirement of the Invitation should cite the relevant section of the Invitation for which clarification is sought.

Questions of this nature will be responded to by the DOH in writing and such questions and answers will be posted on the NY State of Health website (nystateofhealth.ny.gov),

unless the party submitting a question demonstrates that the question/answer will contain confidential and/or proprietary information.

NAME: Invitation Administrator

EMAIL: nyhxpm@health.ny.gov

ADDRESS:
NY State of Health
NYS Department of Health Corning Tower, Suite
2378 Albany, New York 12237

D. Changes to the Application

The DOH reserves the right to:

- Withdraw the Invitation at any time, at the DOH's sole discretion;
- Disqualify any Applicant whose conduct and/or Application fails to conform to the requirements of this Invitation;
- Seek clarifications and revisions of Applications. The DOH may require clarification from individual Applicants to assure a complete understanding of the Application and/or to assess the Applicant's compliance with the requirements in this Invitation; and
- At any time during the Invitation process, amend the Invitation to correct errors or omissions, and to supply additional information. Prospective Applicants are advised that at any time during the course of this application process, pertinent federal and state laws, regulations, and rules may change, and the protocol for using required systems such as SERFF and the PNDS website may change. In addition, scheduled dates may need to be adjusted. All Prospective Applicants and Applicants will be informed of such changes, and Applicants may be directed to supply additional information in response to such amendments.

E. Submission of the Application

1. Application Contents

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

For QHP Applicants and Stand-Alone Dental Plan Applicants:

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

For EP Applicants:

i. Participation Proposal;
ii. Submission of Subscriber Agreements to DOH for EP Applicants;
iii. Submission of EP Information Templates to DOH;
iv. Submission of Provider Network Information, Verification of Networks and Appointment Availability Standards/Monitoring and
v. Quality Strategy.

Each of the component parts must be received by the due dates set forth in the 2024 Schedule of Key Events, listed in this Invitation. Late submissions may not be accepted.

2. QHP, SADP, and EP Applicant Instructions

a. Participation Proposals

Applicants shall submit one electronic signed copy of the Participation Proposal to the email address noted in Section V (C). Participation Proposals will not be accepted by fax. The Participation Proposal must be signed and executed by an individual with legal authority to bind the Applicant to the authenticity of the information provided.

The Participation Proposal Form to be completed and submitted by Applicants is attached to this Invitation as Attachment "F" (QHP Applicants and SADP Applicants) and Attachment "J1" (EP Applicants). Applicants applying to offer both QHPs and EPs must complete **both** Attachments.

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

As set forth in Section II(B), Marketplace products, rates and policy forms must be submitted to DFS per DFS instruction, which will be available on the DFS website.

c. Submission of Subscriber Agreements and Templates to DOH for EP Applicants

As set forth in Section II (B), EP Applicants will be required to submit EP Subscriber Agreements to DOH. EP Applicants will also be required to submit plan information via DOH required templates. Policy forms and templates must be sent directly to the Applicant's assigned Plan Manager by the due date indicated in the 2024 Schedule of Key Events.

d. Submission of Provider Network Information

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

e. Submission of Quality Improvement Strategy or Quality Strategy

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

f. Vendor Responsibility

On or around the same time that Applicants submit forms and rates, Applicants will be notified of their responsibility to complete the New York State "vendor responsibility" process through the New York State VendRep System. The VendRep system instructions are available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at https://portal.osc.state.ny.us. For questions about the VendRep System contact 866-370-4672 or 518-408-4672 or ITServiceDesk@osc.state.ny.us

g. Submission of HHS Form 690, Assurance of Compliance

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

F. Public Information

Disclosure of information related to this Invitation process and resulting contracts shall be permitted consistent with the laws of the State of New York and specifically the Freedom of Information Law (FOIL) contained in Article 6 of the NY Public Officers Law. Information constituting trade secrets or information that if disclosed would cause substantial injury to the competitive position of the subject enterprise, for purposes of FOIL, shall be clearly marked and identified as such by the Applicant upon submission. Determinations regarding disclosure will be made when a request for such information is received by the DOH Records Access Office.

G. Agreement with DOH

Following completion of the activities outlined in this Invitation and having been determined to have met all the requirements, the DOH will provide Applicants with an Agreement. The Agreement resulting from this Invitation will be effective only upon approval by the New York State Office of the Attorney General (OAG) and the Comptroller of the State of New York (OSC). Applicants must enter into an Agreement with the DOH for their products to be certified and offered through the Marketplace.

APPENDIX D



Section VI: Attachments

APPENDIX D

Attachment Designation	Attachment Name
Attachment "A"	2024 QHP Essential Health Benefits
Attachment "B"	2024 Standard Products Cost-Sharing Chart
Attachment "C"	QHP and SADP Rating Regions by County
Attachment "D"	QHP and SADP Rating Regions Map
Attachment "E"	2024 Letter of Interest
Attachment "F (1)"	2024 QHP and SADP Participation Proposal
Attachment "F (2)"	2024 QHP Products Offered by County and Market
Attachment "F (3)"	2024 SADP Products Offered by County and Market
Attachment "G"	EP Benefits and Cost-Sharing Chart
Attachment "H"	EP Rating Regions
Attachment "I"	EP Rating Regions Map
Attachment "J (1)"	2024 EP Participation Proposal
Attachment "J (2)"	2024 EP Products Offered by County
Attachment "K"	2024 EP Template Instructions
Attachment "L"	2024 EP Admin Template
Attachment "M"	2024 EP Plans Template
Attachment "N"	2024 EP Rates Template
Attachment "O"	2024 EP Service Area Template
Attachment "P"	2024 Provider Network Submission Instructions
Attachment "Q"	2024 URL Template Instructions
Attachment "R"	2024 URL Template
Attachment "S"	2024 QDP Template Instructions
Attachment "T"	2024 QDP Template

APPENDIX D



Section VII: Definitions

For purposes of this Invitation:

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

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

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

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

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

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

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

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

"Marketplace shall mean NY State of Health, The Official Health Plan Marketplace (formerly known as the New York Health Benefit Exchange or Exchange) established within the New York State Department of Health pursuant to Executive Order Number 42 on April 12, 2012 and codified in the NY Public Health Law in 2019.

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

"Participating Provider" shall mean a provider of health care services or dental services that

has a provider agreement with the Applicant.

"Personally Identifiable Information" ("PII") shall mean information that can be used to distinguish or trace a person's identity, such as their name, social security number, etc., alone or when combined with other personal or identifying information that is linked or linkable to a particular individual.

"Protected Health Information" ("PHI") shall refer to individually identifiable health information as defined in 45 CFR 164.402.

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

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

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

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

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

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

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

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

C.F.R. Part 155.

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

"Special Enrollment Periods" shall, as described in 45 C.F.R. § 155.420, and applicable law and guidance, mean the periods during which a qualified individual or enrollee who experiences certain qualifying events as set forth in federal regulation, may enroll in, or change enrollment in, a QHP through the Marketplace outside of the annual open enrollment periods.

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

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nystateofhealth
The Official Health Plan Marketplace

ATTACHMENT F (1)

2024 PARTICIPATION PROPOSAL
QUALIFIED HEALTH PLANS AND STAND-ALONE DENTAL PLANS

All Applicants must submit the following information to the e-mail address set forth in Section V (C) of the Invitation. Answers should be completed within this Participation Proposal Form, unless otherwise directed.

1. Participation.

Indicate below whether Applicant is participating in the Individual Marketplace, Small Business Marketplace or both, and the type of Applicant. If the Applicant is applying as both a Health Insurer Applicant and a Stand-Alone Dental Applicant, submit two separate participation proposals.

PARTICIPANT TYPE		EXCHANGE	
■	Health Insurer Applicant	■	Individual w ped dental
		☐	Individual w/o ped dental
☐	Stand-Alone Dental Applicant	☐	SHOP

2. Organization

a) Identify below the legal entity that will be responsible for offering products in each Exchange and its current license or certification. If Applicant anticipates licensure prior to November 1, 2023, identify what type of licensure is anticipated.

Healthfirst PHSP, Inc., which is licensed as a prepaid health services plan pursuant to Article 44 of the NYS Public Health Law.

b) Identify whether the same legal entity currently contracts with the State Department of Health for the Child Health Plus and/or Medicaid Program, and if so, identify the program(s).

Healthfirst PHSP, Inc. contracts with the State Department of Health for Medicaid and Child Health Plus.

c) Identify any entities that will be involved in the administration of the QHPs and briefly describe the roles of such entities. Include in this section any entity the Applicant is using to satisfy coverage of essential health benefits (e.g., pediatric vision), and for Health Insurer Applicants, any entity used to satisfy the provision of offering out-of-network benefits.

The following vendors will be involved in the administration of the Exchange products:

- **HF Management Services, which provides administrative and management services;**
- **American Specialty Health (ASH), which provides: utilization management, network management and claims payment administration for chiropractic benefits; and manages the fitness incentive program;**
- **University Behavioral Associates, which provides behavioral health utilization management for certain members;**
- **eviCore, which provides utilization management for radiology, radiation therapy, genetic lab, and oncology;**
- **CVS Caremark, which administers pharmacy benefits;**
- **Davis Vision, which provides utilization management for routine vision and medical optometry;**
- **Superior Vision, which provides utilization management for eye surgeries;**
- **DentaQuest, which provides utilization management, network management and claims payment administration for dental services;**
- **Teladoc, which provides telemedicine services for general medicine, behavioral health, and dermatology; and**
- **OrthoNet, which provides utilization management for physical therapy, occupational therapy, and speech therapy, podiatry, vascular and back pain management.**

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3. **Summary of Products Offered**

a) Health Insurer Applicants, indicate the total number of products at each metal level (do not include catastrophic products and child-only products) that you are proposing to offer in the Marketplace:

INDIVIDUAL EXCHANGE		SHOP EXCHANGE	
Metal Tier	**Number**	**Metal Tier**	**Number**
Bronze	2	**Bronze**	
Silver	3	**Silver**	
Gold	3	**Gold**	
Platinum	2	**Platinum**	

b) Identify whether Health Insurer Applicant will be offering an additional Bronze product in 2024 with HSA eligibility that was offered in 2023:

☐ Yes ■ No

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

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

4. **Proposal Attachment Submissions**

a. **Health Insurer Applicants:**

(i) Provide the following information:

Attachment F (2) - For each Standard and Non-Standard Product offered through the Individual Marketplace, provide the Name of the Applicant and place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2024, highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2024 (i.e. a new non-standard product), highlight the column(s) containing the new product(s) in yellow. If you are proposing to leave a county in 2023, highlight the corresponding cells for each product and county in red.

- Provide a list of each standard and non-standard product offered in the Marketplace by using the Product Name (including the naming convention outlined in the Invitation) and the 14-digit HIOS ID. The listing must be provided in excel spreadsheet format and one tab must be used for the Individual Marketplace and a separate tab for the Small Business Marketplace as applicable.

ii) DOH reserves the right to request a copy of all final documents submitted through SERFF and approved by DFS as part of the Rate and Form Filings. Copies may be needed by the DOH for review of consistency with this Application, archival purposes, and to ensure that benefit and rate information is displayed accurately and timely on the Marketplace.

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

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

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

d) **Stand-Alone Dental Applicants**

(i) Provide the following information:

- ***Attachment F (3)*** - Provide the name of Applicant and place an x in each box indicating which product(s) you will offer in each county. If you are proposing to enter a new county in 2024, highlight the cell in yellow indicating the new county. If you are proposing to offer (a) new product(s) for 2024 (i.e. offering EP for the first time, or offering a new non-standard product), highlight the column(s) with the new product(s) in yellow. If you are proposing to leave a county in 2024, highlight the cell in red, indicating a product removal.

- Provide a list of each standard and non-standard product offered in the Marketplace by using the Product Name and the 14-digit HIOS ID. The listing must be provided in excel spreadsheet format and one tab must be used for the Individual Marketplace and a separate tab for the Small Business Marketplace as applicable. Clearly identify the products as Pediatric only or Adult/Family.

5. URL links

Provide URL links for the following areas:

- Plan Brochures/QHP Descriptions (if applicable)

  Product descriptions can be found at: https://healthfirst.org/leaf-plans/#2022.

- Summary(ies) of Benefits

  Summaries of Benefits & Coverage (SBC) can be found at: http://healthfirst.org/healthfirst-summary-of-benefits/.

- Provider Directory

  The provider directory can be accessed at hfdocfinder.org.

- Pharmacy Formulary

  The Pharmacy Formulary can be accessed at www.healthfirst.org/formulary

- Treatment Cost Calculator

  The Treatment Cost Calculator can be accessed at http://hfcostlookup.org/.

6. Plan Contacts

Provide a contact who will be responsible for each of the areas identified below. Include their name, title, telephone number and email address:

- Product/form submissions
  Shawn Nowicki
  Director, Regulatory Affairs
  (212) 801-6210
  snowicki@healthfirst.org

- Network adequacy
  Shpresa Basha
  Manager, Provider Data Reporting
  (212) 401-8457
  sbasha@healthfirst.org

- Provider Directories
  Felechia Pope
  Vice President, Delivery System Operations
  (212) 519-8194
  Fpope@Healthfirst.org

- Quality submissions
  Laisha Washington
  Vice President, Clinical Quality
  (212) 801-6186
  LaWashington@HealthFirst.org

- Customer Service/Call Center Issues
  Kimberly O'Connor
  VP, Call Center Operations & Member Services
  (212) 801-1639
  koconnor@healthfirst.org

- Pharmacy submissions
  Bhavesh Modi
  VP, Pharmacy
  (212) 209-6442
  BModi@Healthfirst.org

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- Enrollment Transactions
  Rachel Sylvester
  VP, Enrollment & Billing
  (212) 453-7772
  RSylvester@Healthfirst.org

- Billing issues/Claims Issues
  Rachel Sylvester
  VP, Enrollment & Billing
  (212) 453-7772
  RSylvester@Healthfirst.org

- Encounter submissions
  Uday Joshi
  VP, Encounters & DA
  (212) 823-2419
  ujoshi@healthfirst.org

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ATTESTATION TO PARTICIPATION PROPOSAL

The following must be signed and executed by an individual with the capacity and legal authority to bind the Applicant to the authenticity of the information provided.

I, Pat Wang,

hereby attest that I have been duly authorized to execute this Participation Proposal on behalf of Applicant, and to the best of my knowledge, the information and data provided by Applicant in response to the Invitation and Requirements for Participation in the NY State of Health, the Official Health Plan Marketplace (the "Invitation") is accurate, true, and complete. I understand that the NY State of Health will rely on my statements above in reviewing the Participation Proposal and the related information and data submitted in response to the Invitation. In completing the certification process set forth in the Invitation, Applicant shall, always, strictly adhere to all applicable federal and state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted.

Pat Wang

Print Name

President & CEO

Print Title

DocuSigned by:
Pat Wang
5846E8BCB2FB4AF...

Signature

May 24, 2023

Date

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Instructions: Place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2024, highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2024 (i.e. a new non-standard product), highlight the column(s) containing the new product(s) in yellow. If you are proposing to leave a county in 2024, highlight the corresponding cells for each product and county in red.

ATTACHMENT F (2)

2024 Qualified Health Plan Product Offerings by County - Individual Market

Applicant Name: HealthFirst PHSP, Inc.

	Bronze Standard	Silver Standard	Gold Standard	Platinum Standard	Catastrophic	Bronze Standard w Child Dental	Silver Standard w Child Dental	Gold Standard w Child Dental	Platinum Standard w Child Dental	Catastrophic w Child Dental	Silver Standard with 3 PCP Visits	Gold Standard with 3 PCP Visits	Bronze Child Only	Silver Child Only	Gold Child Only	Platinum Child Only	Bronze NS1	Silver NS1	Gold NS1	Platinum NS1	Bronze NS1 w Child Dental	Silver NS1 w Child Dental	Gold NS1 w Child Dental	Platinum NS1 w Child Dental	Bronze NS2	Silver NS2	Gold NS2	Platinum NS2	Bronze NS2 w Child Dental	Silver NS2 w Child Dental	Gold NS2 w Child Dental	Platinum NS2 w Child Dental	Bronze NS3	Silver NS3	Gold NS3	Platinum NS3	Bronze NS3 w Child Dental	Silver NS3 w Child Dental	Gold NS3 w Child Dental	Platinum NS3 w Child Dental
Albany																																							
Allegany																																							
Bronx	x	x	x	x	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x		x	x			x	x									
Broome																																								
Cattaraugus																																								
Cayuga																																								
Chautauqua																																								
Chemung																																								
Chenango																																								
Clinton																																								
Columbia																																								
Cortland																																								
Delaware																																								
Dutchess																																								
Erie																																								
Essex																																								
Franklin																																								
Fulton																																								
Genesee																																								
Greene																																								
Hamilton																																								
Herkimer																																								
Jefferson																																								
Kings	x	x	x	x	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x		x	x			x	x									
Lewis																																								
Livingston																																								
Madison																																								
Manhattan	x	x	x	x	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x		x	x			x	x									
Monroe																																								
Montgomery																																								
Nassau	x	x	x	x	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x		x	x			x	x									
Niagara																																								
Oneida																																								
Onondaga																																								
Ontario																																								
Orange																																								
Orleans																																								
Oswego																																								
Otsego																																								
Putnam																																								
Queens	x	x	x	x	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x		x	x			x	x									
Rensselaer																																								
Richmond	x	x	x	x	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x		x	x			x	x									
Rockland																																								
St. Lawrence																																								
Saratoga																																								
Schenectady																																								
Schoharie																																								

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Instructions: Place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2024, highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2024 (i.e. a new non-standard product), highlight the column(s) containing the new product(s) in yellow. If you are proposing to leave a county in 2024, highlight the corresponding cells for each product and county in red.

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ATTACHMENT F (2)
2024 Qualified Health Plan Product Offerings by County - Individual Market

Applicant Name: HealthFirst PHSP, Inc.

	Bronze Standard	Silver Standard	Gold Standard	Platinum Standard	Catastrophic	Bronze Standard w Child Dental	Silver Standard w Child Dental	Gold Standard w Child Dental	Platinum Standard w Child Dental	Catastrophic w Child Dental	Silver Standard with 3 PCP Visits	Gold Standard with 3 PCP Visits	Bronze Child Only	Silver Child Only	Gold Child Only	Platinum Child Only	Bronze NS1	Silver NS1	Gold NS1	Platinum NS1	Bronze NS1 w Child Dental	Silver NS1 w Child Dental	Gold NS1 w Child Dental	Platinum NS1 w Child Dental	Bronze NS2	Silver NS2	Gold NS2	Platinum NS2	Bronze NS2 w Child Dental	Silver NS2 w Child Dental	Gold NS2 w Child Dental	Platinum NS2 w Child Dental	Bronze NS3	Silver NS3	Gold NS3	Platinum NS3	Bronze NS3 w Child Dental	Silver NS3 w Child Dental	Gold NS3 w Child Dental	Platinum NS3 w Child Dental
Schuyler																																								
Seneca																																								
Steuben																																								
Suffolk	x	x	x	x	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x		x	x			x	x									
Sullivan																																								
Tioga																																								
Tompkins																																								
Ulster																																								
Warren																																								
Washington																																								
Wayne																																								
Westchester	x	x	x	x	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x		x	x			x	x									
Wyoming																																								
Yates																																								

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NYSOH INDIVIDUAL QHP PRODUCT LISTINGS - 2024 Healthfirst PHSP, Inc.	
Product Name	**HIOS Plan ID**
Healthfirst Bronze Leaf, Bronze, ST, INN, Dep25, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020003
Healthfirst Bronze Leaf, Bronze, ST, INN, Dep29, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020004
Healthfirst Silver Leaf, Silver, ST, INN, Dep25, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020007
Healthfirst Silver Leaf, Silver, ST, INN, Dep29, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020008
Healthfirst Gold Leaf, Gold, ST, INN, Dep25, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020011
Healthfirst Gold Leaf, Gold, ST, INN, Dep29, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020012
Healthfirst Platinum Leaf, Platinum, ST, INN, Dep25, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020015
Healthfirst Platinum Leaf, Platinum, ST, INN, Dep29, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020016
Healthfirst Green Leaf, Catastrophic, ST, INN, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020018
Healthfirst Bronze Leaf, Bronze, ST, INN, Child-Only, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020020
Healthfirst Silver Leaf, Silver, ST, INN, Child-Only, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020022
Healthfirst Gold Leaf, Gold, ST, INN, Child-Only, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020024
Healthfirst Platinum Leaf, Platinum, ST, INN, Child-Only, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020026
Healthfirst Bronze Leaf Premier, Bronze, NS, INN, Dep25, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020052
Healthfirst Bronze Leaf Premier, Bronze, NS, INN, Dep29, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020053
Healthfirst Silver Leaf Premier, Silver, NS, INN, Dep25, Family Dental, Family Vision, No Deductible PCP Visits, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020054
Healthfirst Silver Leaf Premier, Silver, NS, INN, Dep29, Family Dental, Family Vision, No Deductible PCP Visits, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020055
Healthfirst Gold Leaf Premier, Gold, NS, INN, Dep25, Family Dental, Family Vision, No Deductible PCP Visits, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020056
Healthfirst Gold Leaf Premier, Gold, NS, INN, Dep29, Family Dental, Family Vision, No Deductible PCP Visits, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020057
Healthfirst Platinum Leaf Premier, Platinum, NS, INN, Dep25, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020058
Healthfirst Platinum Leaf Premier, Platinum, NS, INN, Dep29, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020059
Healthfirst Silver Leaf Premier Plus, Silver, NS, INN, Dep25, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020078
Healthfirst Silver Leaf Premier Plus, Silver, NS, INN, Dep29, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020079
Healthfirst Gold Leaf Premier Plus, Gold, NS, INN, Dep25, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020081
Healthfirst Gold Leaf Premier Plus, Gold, NS, INN, Dep29, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020082

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Plan Year	17 Digit HIOS ID	Summary of Benefits and Coverage URL	Formulary URL	Network URL	Plan Brochure URL	Payment URL
2024	91237NY0020003-00	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020003-01	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020003-02	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020003-03	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020004-00	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020004-01	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020004-02	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020004-03	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020007-00	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020007-01	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020007-02	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020007-03	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020007-04	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020007-05	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020007-06	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020008-00	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020008-01	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020008-02	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020008-03	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020008-04	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020008-05	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020008-06	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020011-00	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020011-01	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020011-02	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020011-03	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020012-00	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020012-01	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020012-02	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020012-03	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020015-00	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020015-01	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020015-02	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020015-03	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
2024	91237NY0020016-00	http://healthfirst.org/healthfirst-summary-of-benefits/	https://healthfirst.org/formulary	https://hfdocfinder.org	https://healthfirst.org/leaf-plans	https://www.myhfny.org
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2024 Plan Year
QIS Progress Report Form
OMB 0938-1286
Expiration Date: 02/29/2024

QIS Progress Report Form

Submission date (please indicate the date you are submitting this QIS form via HIOS or SERFF) ☐

Use this form to report on progress made during the previous year of your quality improvement strategy (QIS). Please refer to your baseline QIS Implementation Plan and any subsequent modifications for baseline data.

☑ *Confirm you have reviewed your baseline QIS Implementation Plan (and associated Modification Summary Supplement, if applicable) in preparing this submission.*

For detailed instructions, please refer to the Quality Improvement Strategy: Technical Guidance and User Guide for the current plan year on the Marketplace Quality Initiatives website.

PLEASE NOTE: Only issuers who are CONTINUING a QIS need to submit a Progress Report form. *There are two scenarios for issuers:*

1. ***Progress Report:*** *Issuers who are continuing their current QIS (with or without modifications) should select* ***Progress Report*** *to report on progress made during the previous year of your QIS.*
2. ***Progress Report Closeout Form:*** *Issuers discontinuing their current QIS and implementing a new one should select* ***Progress Report Closeout Form*** *and submit the Progress Report form to close out the discontinued QIS. These issuers should also describe the QIS that will be in place for the 2024 Plan Year by submitting a QIS Implementation Plan for the new QIS.*

For CMS Use Only ☐

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours.
If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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2024 Plan Year
QIS Progress Report Form
OMB 0938-1286
Expiration Date: 02/29/2024

QIS Submission Type

Part A. Progress Report or Closeout QIS Submission

These fields are required, but will not be scored as part of the QIS evaluation.

1. Type of QIS Submission

Select the option that describes the type of QIS submission, and follow the instructions to complete the submission.

Type of QIS	Instructions
◉ **Progress Report**	Issuers must complete one[1] form: 1. Complete the Background Information section (Parts A and B), and the Progress Report Summary section (Part C) of the Progress Report form to report progress on your baseline QIS.
○ **Progress Report Closeout Form**	Issuers must complete 2 forms: 1. Complete the Background Information section (Parts A and B) and the Progress Report Summary section (Part C) of the Progress Report form to close out the discontinued QIS, reporting on progress up until the strategy was discontinued. 2. Complete a new Implementation Plan form. See instructions in the QIS Implementation Plan form: New QIS after Discontinuing a QIS Submitted During a Prior QHP Application Period.

[1] If continuing with modifications, issuers must also complete a Modification Summary Supplement form. See instructions in the QIS Modification Summary Supplement form: Continuing a QIS with Modifications.

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2024 Plan Year
QIS Progress Report Form
OMB 0938-1286
Expiration Date: 02/29/2024

Background Information

Part B. Issuer Information

These fields are required, but will not be scored as part of the QIS evaluation. Issuers may update the information in Part B from year to year, as needed.

2. **Issuer Legal Name**: Healthfirst PHSP, Inc.
3. **Company Legal Name**: Healthfirst PHSP, Inc.
4. **HIOS Issuer ID**: 91237
5. **Issuer State**: New York
6. **QIS Primary Contact's First Name**: Shawn
   QIS Primary Contact's Last Name: Nowicki
7. **QIS Primary Contact's Title**: Director, Regulatory Affairs
8. **QIS Primary Contact's Phone**: (212) 801-6210 **Ext.**:
9. **QIS Primary Contact's Email**: SNowicki@Healthfirst.org
10. **QIS Secondary Contact's First Name**: Laisha
    QIS Secondary Contact's Last Name: Washington
11. **QIS Secondary Contact's Title**: VP, Clinical Quality
12. **QIS Secondary Contact's Phone**: (212) 801-6186 **Ext.**:
13. **QIS Secondary Contact's Email**: LaWashington@Healthfirst.org

14. **Date Issuer Began Offering Coverage Through the Exchange**: 01/01/2014

Note: *For all date fields in this form, use the down arrow key to activate the calendar and then use the mouse or arrow keys to navigate to the correct date.*

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours.
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2024 Plan Year
QIS Progress Report Form
OMB 0938-1286
Expiration Date: 02/29/2024

15. Current Payment Model(s) Description

Select the category(ies) of payment models that are used by the issuer across its Exchange product line. Provide the percentage of payments in each payment model category[2] used by the issuer across its Exchange product line. The total percentage of payments across all four payment model types should equal approximately 100 percent.[3]

Note: *These percentages can be estimates and do not need to be exact figures. Issuers may update this information year to year, as needed.*

Payment Model Type	Payment Model Description	Provide Percentage
☑ **Fee for Service – No Link to Quality and Value**	Payments are based on volume of services and not linked to quality or efficiency.	4 %
☑ **Fee for Service – Linked to Quality and Value**	At least a portion of payments vary based on the quality or efficiency of health care delivery.	15 %
☑ **Alternative Payment Models Built on Fee for Service Architecture**	Some payment is linked to the effective management of a segment of the population or an episode of care. Payments are still triggered by delivery of services, but there are opportunities for shared savings or two-sided risk.	82 %
☐ **Population-based Payment**	Payment is not directly triggered by service delivery, so payment is not linked to volume. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., more than one year).	%
Total	Please confirm the total percentage of payments across all four payment model type categories equals approximately 100%.	100 %

[2] Categories of payment models are defined in the *Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group – Alternative Payment Model (APM) Framework Final White Paper*, available at: https://hcp-lan.org/workproducts/apm-whitepaper.pdf. See the QIS Technical Guidance and User Guide for the current plan year, available on the Marketplace Quality Initiatives website, for examples of payment models within each category.

[3] To calculate the percentage of payments for Fee for Service payments linked to quality or value, and/or Alternative Payment Models tied to quality or value, issuers should use the calculation methodologies defined in the *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs (APM Measurement Effort) Final Paper*, available at: https://hcp-lan.org/groups/apm-fpt/apm-report/. See Table 1 (p. 7-10) for instructions to calculate the percentage of payments for these two payment model categories.

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QIS Progress Report Section

Part C. QIS Progress Report Summary

The Elements in Part C will be scored as part of the QIS evaluation.

Note: *The Goal(s) and Measure(s) identified in this section (Part C: Progress Report Summary) are the Goal(s) and Measure(s) from the Implementation Plan form (and associated Modification Summary Supplement, if applicable) on file against which QIS progress is measured.*

Note: *All references to Implementation Plan form elements and criteria in this form refer to the Implementation Plan form (and associated Modification Summary Supplement, if applicable) on file.*

Note: Please make sure to correctly restate the values and information from the most recent Implementation Plan on file and/or the Modification Summary Supplement on file, when applicable.

16. Analyze Progress Using Baseline Data, as Documented in the Implementation Plan (Must Pass)

Restate Goal 1 identified in Element 20 of the Implementation Plan on file or Criterion 8d of the Modification Summary Supplement on file, if applicable.

QIS Goal 1:

(500 character limit)

Improve the preventive care provided to members.

Measure 1a:

16a. Restate Measure 1a name from Criterion 25a of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable:

Colorectal Cancer Screening

16b. Baseline Assessment: Restate the baseline results from Criterion 25c of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable, by **either**:

- Calculating the rate and providing the associated numerator and denominator: *(**Note:** The numerator and denominator should calculate to the rate provided.)*

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Calculated Rate: 62.09%
Numerator: 249
Denominator: 401

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point:

16c. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline assessment provided in Criterion 25d of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable:

01/2021 – 12/2021

16d. Provide the Progress Report results by either:

- Calculating the rate and providing the associated numerator and denominator: (**Note:** *The numerator and denominator should calculate to the rate provided.)*

  Calculated Rate: 58.64%
  Numerator: 241
  Denominator: 411

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point:

16e. Provide the Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress report assessment:

01/2022 – 12/2022

16f. Restate the numerical value performance target for this measure *(i.e., the target rate or data point the QIS intends to achieve)* from Criterion 25e of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable: (**Note:** *This entry should be a rate (%) or a data point target, NOT a percentage change.)*

70

16g. Was the performance target achieved?

○ Yes ◉ No

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours.
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Measure 1b:

16h. Restate Measure 1b name from Criterion 25f of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable:

16i. Baseline Assessment: Restate the baseline results from Criterion 25h of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable, by **either**:

- Calculating the rate and providing the associated numerator and denominator: (***Note:*** *The numerator and denominator should calculate to the rate provided.*)

  Calculated Rate:
  Numerator:
  Denominator:

- OR -

- Indicating the data point, if the measure is not a rate:

  Data Point:

16j. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline assessment provided in Criterion 25i of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable:

–

16k. Provide the Progress Report results by **either:**

- Calculating the rate and providing the associated numerator and denominator: (***Note:*** *The numerator and denominator should calculate to the rate provided.*)

  Calculated Rate:
  Numerator:
  Denominator:

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point:

16l. Provide the Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress report assessment:

–

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours.
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16m. Restate the numerical value performance target for this measure *(i.e., the target rate or data point the QIS intends to achieve)* from Criterion 25j of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable: (***Note:*** *This entry should be a rate (%) or a data point target, NOT a percentage change.*)

16n. Was the performance target achieved?

◯ Yes ◯ No

QIS Goal 2

Restate Goal 2 identified in Element 20 of the Implementation Plan on file or Criterion 8d of the Modification Summary Supplement on file, if applicable.

QIS Goal 2:

(500 character limit)

Measure 2a:

16o. Restate Measure 2a name from Criterion 25k of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable:

16p. Baseline Assessment: Restate the baseline results from Criterion 25m of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable, by **either**:

- Calculating the rate and providing the associated numerator and denominator (***Note:*** *The numerator and denominator should calculate to the rate provided.*):

  Calculated Rate:
  Numerator:
  Denominator:

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

16q. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline assessment provided in Criterion 25n of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable:

[ ] – [ ]

16r. Provide the Progress Report results by **either:**

- Calculating the rate and providing the associated numerator and denominator: (***Note:*** *The numerator and denominator should calculate to the rate provided.*)

  Calculated Rate: [ ]

  Numerator: [ ]

  Denominator: [ ]

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: [ ]

16s. Provide the Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress report assessment:

[ ] – [ ]

16t. Restate the numerical value performance target for this measure *(i.e., the target rate or data point the QIS intends to achieve)* from Criterion 25o of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable: (**Note:** *This entry should be a rate (%) or a data point target, NOT a percentage change.*)

[ ]

16u. Was the performance target achieved?

○ Yes ○ No

Measure 2b:

16v. Restate Measure 2b name from Criterion 25p of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable:

[ ]

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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16w. Baseline Assessment: Restate the baseline results from Criterion 25r of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable, by **either**:

- Calculating the rate and providing the associated numerator and denominator (***Note:*** *The numerator and denominator should calculate to the rate provided.*):

  Calculated Rate: ☐

  Numerator: ☐

  Denominator: ☐

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: ☐

16x. Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline assessment provided in Criterion 25s of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable:

☐ – ☐

16y. Provide the Progress Report results by **either:**

- Calculating the rate and providing the associated numerator and denominator: (***Note:*** *The numerator and denominator should calculate to the rate provided.)*

  Calculated Rate: ☐

  Numerator: ☐

  Denominator: ☐

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: ☐

16z. Provide the Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress report assessment:

☐ – ☐

16aa. Restate the numerical value performance target for this measure *(i.e., the target rate or data point the QIS intends to achieve)* from Criterion 25t of the Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable: (**Note:** *This entry should be a rate (%) or a data point target, NOT a percentage change.*)

☐

16bb. Was the performance target achieved?

◯ Yes ◯ No

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17. Summary of Progress (Must Pass)

17a. Please provide a summary of progress covering the following details: (**Note:** *Regardless of if you made progress toward the performance target(s), you will be required to describe any barriers encountered in Criterion 18a and any problems meeting timelines in Criterion 18b.*)

- Indicate why progress was or was not made toward the performance target(s) documented in Element 25 of your QIS Implementation Plan on file or Criterion 8f of the Modification Summary Supplement on file, if applicable, and
- Include a description of activities that led to the outcome.

(1,000 character limit)

Healthfirst saw the rate go down this measurement year and progress was not made towards meeting the performance target.

We partnered with our providers through our incentive program in an attempt to meet the stated target. We work closely with providers to stress the importance of colorectal cancer screening and ensuring members have access to their desire mode of screening where available.

This is accomplished by sharing all relevant rate and member care gap information on our Quality App, which is a web-based tool available through the Healthfirst provider portal. The data is refreshed bi-monthly, which was a new feature in past year (previously data was only refreshed monthly).

Healthfirst closely monitors rates on a bi-weekly basis and will be tracking progress on this measure throughout 2023 to ensure we make up the progress we lost and get closer to/meet our performance target for this measurement year.

17b. If the issuer selected **"Progress Report Closeout Form"** in Element 1 of *this* Progress Report form, provide the rationale for discontinuing the QIS.

(1,000 character limit)

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17c. If the issuer received an **"Interim Meets"** determination during the previous QIS Evaluation Period and was instructed to address the deficiencies in its subsequent Plan Year submission, please indicate which elements and/or criteria were updated based on the QIS Evaluation Period Correction Report and describe the changes.

(1,000 character limit)

18. Barriers and Mitigation Activities

18a. Were barriers encountered in implementing the QIS over time? (**Note:** *If your description of activities in Criterion 17a includes barriers to implementing the QIS, you are still required to complete Criterion 18a and elaborate on those barriers and any other barriers in implementing the QIS, if applicable, by providing the below information.*)

◉ Yes ○ No

If "Yes," describe:

- The barriers, and
- The mitigation activities implemented to address **each** barrier.

(1,500 character limit)

Healthfirst did in fact encounter barriers in implementing this QIS. Providers shared hesitancy by members to get a colorectal cancer screening and limited access to appointments for members who agreed to a screening/colonoscopy. The age range was also changed in MY2022 to include 45-49 year olds. This directly impact our rate; that age range will be provided education around the importance of colorectal cancer screening. Healthfirst ensured all providers were offering options to members and let them know the different methodologies that they could use to screen members for colorectal cancer (e.g., colonoscopy, sigmoidoscopy, FoBT, etc.). In addition to the above, Healthfirst was able to begin refreshing the data available to providers on a bi-weekly (as opposed to monthly) schedule to ensure providers have access to most updated data for their respective populations. Healthfirst will be closely monitoring rates on a bi-weekly basis and will be tracking progress on this measure throughout 2023 to ensure we make up the progress we lost and get closer to/meet our performance target for this measurement year.

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18b. Were there problems meeting timelines as indicated in Element 26 of the QIS Implementation Plan on file? (**Note:** *If your description of activities in Criterion 17a includes problems meeting timelines, you are still required to complete Criterion 18b and elaborate on those problems and any other problems in meeting timelines, if applicable, by providing the below information.*)

○ Yes ◉ No

If "Yes," describe:

- The problems in meeting timelines and
- The mitigation activities implemented to address **each** problem in meeting the timeline.

(1,500 character limit)

Optional: *If there is any additional information you would like to provide regarding your QIS Progress Report, please do so in the box below.*

(1,500 character limit)

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healthfirst
Health Insurance for New Yorkers

Verification of Networks and Appointment Availability Standards/Monitoring

Healthfirst (hereinafter, "the Plan") employs an array of different strategies throughout the year to validate the accuracy of provider data and verify provider compliance with access and availability standards. These strategies include audits to verify the accuracy of the Plan's provider directory, provider outreach to verify demographic information, and large-scale reconciliation of provider data for both hospitals and large provider groups.

Provider Directory Audits

Healthfirst conducts quarterly audits on its Provider Directory to proactively identify discrepancies and measure accuracy. The audits comprise the Plan contacting a random sample of provider sites to, request that they validate their participation status and the accuracy of their demographic profile. In addition, both telephonic and fax outreach is conducted throughout the year to verify demographic information. If discrepancies are identified, they are shared with Healthfirst's Delivery System Engagement team to ensure that provider sites are re-educated on the importance of reporting changes to their provider profiles to the Plan in a timely manner. Provider profile corrections are then submitted to Healthfirst's Provider Data Management team, so that the changes could be reflected in Healthfirst's provider directory and PNDS submissions. Hospital systems and large provider groups are engaged in annual roster reconciliations wherein the Plan reviews their full set of provider data for accuracy.

Access and Availability Audits:

Healthfirst uses a secret shopper methodology to conduct provider access and availability audits on a quarterly basis. Sampling for these audits is dependent on the type of provider and number of available providers that met the audit criteria. The audit criteria depend on the provider population being targeted for review.

For example, for an audit of specialty providers in our hospital network the Plan:

- Selects a specialty type and hospital network for review,
- Reviews providers listed in our Directory with a primary specialty tied to the audit scope; (e.g., OB/GYN), and
- Ensures that the providers selected for review are accepting new patients.
- Then, once samples are pulled, the Plan conducts secret shopper calls to request the soonest available appointment based on audit type (e.g., routine visit vs non-urgent sick)
- Providers would then be scored on a pass/fail basis depending on whether the appointment offered meets NYS Timely Appointment Standards.

The same steps would be followed for community providers; however, the samples are typically selected on the basis of county rather than on the basis of facility type.

Appointment availability is assessed for routine visits, non-urgent sick visits, and after-hours access. Results are shared with Healthfirst's Delivery System Engagement team for provider re-education on compliance with appointment availability standards as outlined in the Healthfirst Provider

Manual. Any discrepancies in demographic information identified as part of the audit are reviewed with the Provider and then submitted for correction by Healthfirst's Provider Data Management team.

The Plan's appointment availability standards can be found on its website at www.healthfirst.org.

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QIS Modification Summary Supplement

Submission date (please indicate the date you are submitting this QIS form via HIOS or SERFF) _____

*Use this form to indicate any modifications to an existing quality improvement strategy (QIS) Implementation Plan on file for the upcoming plan year (making changes to topic areas, goals, activities, measures, performance targets, and/or the product types). You must also report progress on your current QIS using the separate **QIS Progress Report form.***

For detailed instructions, please refer to the Quality Improvement Strategy: Technical Guidance and User Guide for the current plan year on the Marketplace Quality Initiatives website.

☑ *Select this box if you are using this QIS Modification Summary Supplement form to add the "Reduce health and health care disparities" topic area to your existing QIS on file, including any other modifications (i.e., goals, activities, measures, performance targets, product types) that result from the "Reduce health and health care disparities" topic area addition.*

QIS Submission Type

Part A. QIS Submission

This field is required, but will not be scored as part of the QIS evaluation.

1. Type of QIS Submission

Select the option that describes the type of QIS submission, and follow the instructions to complete the submission.

Type of QIS	Instructions
○ **Continuing QIS with Modifications**	Issuers must complete 2 forms: 1. Complete the Background Information section (Parts A and B) and the QIS Modification Summary (Part C) of the Modification Summary Supplement to reflect modifications for the upcoming year. 2. Complete the QIS Progress Report form to report on progress achieved on your QIS over the past plan year. See instructions in the QIS Progress Report form: Report on Progress.

For CMS Use Only _____

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Background Information

Part B. Issuer Information

These fields are required, but will not be scored as part of the QIS evaluation. Issuers may update the information in Part B from year to year, as needed.

2. **Issuer Legal Name**
   Healthfirst PHSP, Inc.

3. **HIOS Issuer ID**
   91237

4. **Issuer State**
   New York

5. **QIS Primary Contact's First Name**
   Shawn

QIS Primary Contact's Last Name
Nowicki

6. **QIS Primary Contact's Email**
   SNowicki@Healthfirst.org

7. **QIS Primary Contact's Phone** **Ext.**
   (212) 801-6210

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Part C. QIS Modification Summary

Complete the following section regarding modifications to the QIS for the upcoming plan year.

8. Modifying Product Types, Topic Areas, Goals, Activities, and Measures or Associated Performance Targets (Must Pass)

8a. Which component(s) of your QIS are you modifying for the upcoming plan year? (Check boxes for product types, goals, activities, measures, and performance targets.)

- ☐ Product Types (complete 8b)
- ☑ Topic Areas (complete 8c)
- ☐ Goals (complete 8d)
- ☑ Activities (complete 8e)
- ☐ Measures (complete 8f)
- ☐ Performance Targets (complete 8f)

Note: *ONLY enter information in the fields below for the components you have indicated above.*

8b. Modifying QIS Product Types: For Product Type changes, indicate whether you are adding and/or removing any Product Types to the QIS originally listed in Criterion 2b of your Implementation Plan on file. Select all that apply.

Health Maintenance Organization (HMO)	☐ Add	☐ Remove
Point of Service (POS)	☐ Add	☐ Remove
Preferred Provider Organization (PPO)	☐ Add	☐ Remove
Exclusive Provider Organization (EPO)	☐ Add	☐ Remove

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8c. **Modifying QIS Topic Areas**: For Topic Area changes, indicate whether you are adding and/or removing any Topic Areas to the QIS originally listed in Element 22 of your Implementation Plan on file. Select all that apply.[1,2]

Note that if you are modifying the QIS Topic Areas for your existing QIS, you must also use this form to modify the QIS Goals listed in Element 20 of the Implementation Plan on file by completing Criterion 8d, and the QIS Activities listed in Element 24 of the Implementation Plan on file by completing Criterion 8e. You may also need to update the QIS Measures and Performance Targets listed in Element 25 of the Implementation Plan on file by completing Criterion 8f.

Improve health outcomes	☐ Add	☐ Remove
Prevent hospital readmissions	☐ Add	☐ Remove
Improve patient safety and reduce medical errors	☐ Add	☐ Remove
Implement wellness and health promotion activities	☐ Add	☐ Remove
Reduce health and health care disparities	☑ Add	☐ Remove

If you have added a topic area(s), please describe how that topic area(s) will be addressed within your existing QIS. If you removed a topic area, please describe the rationale or reason for removing.

(*500 character limit)*

Healthfirst will use race and ethnicity data to identify whether disparities exist within its membership and develop tailored interventions around those populations to reduce the disparities within Colorectal Cancer Screening.

[1] Note that QHP issuers are required to select "reduce health and health care disparities" as a topic area within at least one of their quality improvement strategies, as cited in the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 (87 FR 27208).

[2] Issuers with a current QIS on file should review the information they included in criterion 24d of their QIS Implementation Plan. If you've previously indicated that health and health care disparities is NOT one of the topic areas selected in Element 22, but health and health care disparities are addressed elsewhere in the QIS, you must still have a QIS on file that explicitly includes the "reduce health and health care disparities" topic area. You can use this Modification Summary Supplement form to modify your existing QIS to include the "reduce health and health care disparities" topic area, and you may be able to incorporate some of the information that you stated in criterion 24d of your QIS Implementation Plan form into this form.

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8d. **Modifying QIS Goals:** For modified Goal(s), indicate which Goal(s) you are modifying and state the new Goal(s) in the space provided below. Please do not include specific performance targets or goals tied to a specific calendar year or plan year because this Modification Summary Supplement will remain on file, and references to specific years or performance targets will become outdated over time:

☐ Goal 1

☐ Goal 2

Provide a rationale for the modification(s).

(*500 character limit)*

8e. **Modifying QIS Activities:** If you are modifying Activities, describe them here.

(*500 character limit)*

Healthfirst aims to address and reduce health disparities identified in sub-populations within Colorectal Cancer Screening by using a data-driven approach. Data such as race and ethnicity will allow us to identify if disparities exist within our membership and develop tailored interventions around those populations to reduce the disparities. Healthfirst will evaluate the rates within the target populations to determine if health disparities were reduced as a result of the tailored interventions.

Provide a rationale for the modification(s).

(*500 character limit)*

Healthfirst is modifying its existing QIS consistent with the new CMS and NYSOH requirement for plan year 2024 that QHP issuers include at least one QIS aimed at reducing health and health care disparities.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours.
If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

APPENDIX D-1

2024 Plan Year
QIS Modification Summary Supplement
OMB 0938-1286
Expiration Date: 02/29/2024

8f. **Modifying QIS Measures or Associated Performance Targets:** For modified Measures or Associated Performance Targets, indicate which Measure(s) you are modifying and state the **NEW** Measure(s) and Performance Target(s).

Description of modification (e.g., remove measure, change measure or measure specifications, change target, add new measure). ***Note***: *If you are removing a measure, you just need to state which measure you are removing in the space below and you do NOT need to fill out any further information for the measure.*

(500 character limit)

Please select and provide all **NEW** information for each measure which is being changed.

☐ **Measure 1a name:**

Is this a National Quality Forum (NQF)-endorsed measure? ○ Yes ○ No

If yes, provide the 4-digit ID number:

Baseline Assessment: Provide the baseline results by **either**:

- Calculating the rate and providing the associated numerator and denominator: (***Note:*** *The numerator and denominator should calculate to the rate provided.*)

  Calculated Rate:

  Numerator:

  Denominator:

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point:

Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

–

Provide the **NEW** numerical value performance target for this measure (i.e., the target rate or data point the QIS intends to achieve):
(**Note:** This entry should be a rate (%) or a data point target, NOT a percentage change.)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours.
If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Provide a rationale for the modifications.

(500 character limit)

☐ **Measure 1b name:** _____

Is this a National Quality Forum (NQF)-endorsed measure? ○ Yes ○ No

If yes, provide the 4-digit ID number: _____

Baseline Assessment: Provide the baseline results by **either**:

- Calculating the rate and providing the associated numerator and denominator:
  (***Note:*** *The numerator and denominator should calculate to the rate provided.*)

  Calculated Rate: _____

  Numerator: _____

  Denominator: _____

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point: _____

Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

_____ – _____

Provide the **NEW** numerical value performance target for this measure (i.e., the target rate or data point the QIS intends to achieve):
(**Note:** This entry should be a rate (%) or a data point target, NOT a percentage change.)

_____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours.
If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Provide a rationale for the modifications.

(500 character limit)

☐ **Measure 2a name:**

Is this a National Quality Forum (NQF)-endorsed measure? ○ Yes ○ No

If yes, provide the 4-digit ID number:

Baseline Assessment: Provide the baseline results by **either**:

- Calculating the rate and providing the associated numerator and denominator:
  (***Note:*** *The numerator and denominator should calculate to the rate provided.*)

  Calculated Rate:

  Numerator:

  Denominator:

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point:

Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

–

Provide the **NEW** numerical value performance target for this measure:
(**Note:** This entry should be a rate (%) or a data point target, NOT a percentage change.)

Provide a rationale for the modifications.

(500 character limit)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours.
If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

APPENDIX D-1

2024 Plan Year
QIS Modification Summary Supplement
OMB 0938-1286
Expiration Date: 02/29/2024

☐ **Measure 2b name:**

Is this a National Quality Forum (NQF)-endorsed measure? ○ Yes ○ No

If yes, provide the 4-digit ID number:

Baseline Assessment: Provide the baseline results by **either**:

- Calculating the rate and providing the associated numerator and denominator:
  (***Note:*** *The numerator and denominator should calculate to the rate provided.*)

  Calculated Rate:

  Numerator:

  Denominator:

- OR -

- Indicating the data point if the measure is not a rate:

  Data Point:

Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment:

–

Provide the **NEW** numerical value performance target for this measure (i.e., the target rate or data point the QIS intends to achieve):
(**Note:** This entry should be a rate (%) or a data point target, NOT a percentage change.)

Provide a rationale for the modifications.

(500 character limit)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1286. The time required to complete this information collection is estimated to average 48 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

APPENDIX I
TRADING PARTNER AGREEMENT

All trading partners who will be participating in electronic transactions with the NY State of Health, The Official Health Plan Marketplace must first have a fully executed Trading Partner Agreement (TPA) with the NY State of Health. The TPA form is available on the following pages.

Appendix I

TRADING PARTNER AGREEMENT

This Trading Partner Agreement ("***Agreement***") is made and entered into on this 10th day of January, 2024 (the "***Effective Date***"), by and between Healthfirst PHSP, Inc. ("***Trading Partner***"), and the **State of New York Department of Health** (STATE).

WITNESSETH

WHEREAS, the NY State of Health, The Official Health Plan Marketplace ("NYSOH"), as a state-based health benefit exchange, facilitates enrollment in health insurance coverage and the purchase and sale of qualified health plans certified by NYSOH ("QHPs") in the individual market in New York, and enrolls individuals in health coverage for which they are eligible under applicable law; and

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

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

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

together with such other healthcare transactions that may be necessary in accordance with the QHP Contract; and

WHEREAS, STATE and Trading Partner seek to address certain requirements that are applicable to the parties under regulations issued pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (as the same may be amended from time to time, "*HIPAA*") including, without limitation, the Standards for Electronic Transactions, which were issued in their final form on August 17, 2002 (as the same may be amended from time to time, the "*Transaction Regulations*"), and the Security Standards, which were issued in their final form on February 20, 2003 (as the same may be amended from time to time, the *"Security Standards"*); and

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants and agreements herein contained, Trading Partner and STATE agree to the foregoing and as follows:

1. General Obligations.

1.1 Compliance With Transaction Regulations. Each party shall and shall cause its applicable subcontractors and agents to comply with the applicable requirements of the Transaction Regulations and any applicable Implementation Specifications issued therein. STATE shall provide, and shall update from time to time, a HIPAA compliant (i) Trading Partner Information Companion Guide (the "TPI Guide"), (ii) an 834 Companion Guide; (iii) an 820 Companion Guide; (iv) an 837 Post Adjudicated Claims Data Reporting (PACDR) Companion Guide; (v) an Interface Control Document for Group Set Up File, and such other guides that may be necessary to provide specific instructions, where applicable, to assist Trading Partners in appropriately filling out their transactions for STATE (collectively referred to herein as "Trading Partner Guides"). These Trading Partner Guides will be distributed by the NYSOH's Plan Management department.

1.2 No Changes. With respect to each transaction, each party agrees that it will not change any definition, data condition or use of a data element or segment as proscribed in the Transaction Regulations and/or the applicable Implementation Specifications. Further, neither party will take any action to change the meaning or intent of the Implementation Specifications.

1.3 No Additions. With respect to each transaction, each party agrees that it will not add any data elements or segments to the maximum defined data set as proscribed in the Transaction Regulations and/or the applicable Implementation Specifications.

1.4 No Use. With respect to each transaction, each party agrees that it will not use any code or data elements that either are marked "not used" or are not in the Transaction Regulations and/or the applicable Implementation Specifications.

1.5 Testing Requirements. The Trading Partner Guides set forth the testing requirements that Trading Partner and/or its contractors and/or agents must implement and/or complete prior to submitting any live, production transactions to STATE. Trading Partner agrees to satisfy these requirements.

1.6 Communications. The Trading Partner Guides set forth specifications for establishing connectivity with, and transmitting transactions to, STATE. Trading Partner agrees to satisfy these requirements.

1.7 Supplementary Specifications. The Trading Partner Guides set forth the current supplementary specifications ("*Supplementary Specifications*") of STATE with respect to the Transaction Regulations and any applicable Implementation Specifications. STATE shall have the right to amend the Supplementary Specifications and/or to provide additional supplementary specifications to Trading Partner from time to time (all of which shall constitute Supplementary Specifications for purposes of this Agreement). Trading Partner will be expected to implement such amendments and additions within sixty (60) calendar days following STATE publication of same, unless a shorter period is necessary to conform to applicable laws and/or regulations or otherwise required by STATE to ensure effective transactions.

1.8 Security Requirements.
(a) Each party will take reasonable care to ensure that the information submitted in each transaction is timely, complete, accurate and secure, and will take reasonable precautions to prevent unauthorized access to: (i) its own and the other party's transmission and processing systems; (ii) the transmissions themselves; and (iii) the control structure applied to transmissions between them.

(b) Each party is solely responsible for the preservation, privacy and security of data in its possession, including data in transmissions received from the other party and other persons. If either party receives from the other data not intended for it, the receiving party will immediately notify the sender to arrange for its return, re-transmission, or destruction, as the other party directs.

(c) Under the final HIPAA Security Regulations, parties entering into a Business Associate agreement relating to the electronic exchange of data will implement additional requirements as specified in the Security Regulations including, without limitation, requirements relating to encryption, Public Key Infrastructure (PKI) and other similar technologies

(d) Each party and its Business Associates shall be prohibited from: (i) transmitting healthcare transactions covered under this Agreement directly to STATE from outside of the U.S. or its territories, and (ii) from providing IP addresses or other information to STATE that would allow for transmission of healthcare transactions covered under this Agreement directly from STATE to a location outside the U.S. or its territories.

2. Costs and Expenses. Each party shall be responsible for any and all costs and expenses related to such party's compliance with the Transaction Regulations, any applicable Implementation Specifications and the terms of this Agreement. Further, each party shall be responsible for all costs, charges and fees it may incur in connection with transmitting and receiving transactions.

3. Term and Termination.

3.1 Term; Effect of Termination. This Agreement shall remain in effect until one party provides written notice of termination to the other, which termination shall be effective thirty (30) days following the other party's receipt of the notice. Termination or expiration of this Agreement or any other contract between the parties does not relieve either party of its obligations under this Agreement and under federal and State laws and regulations pertaining to the privacy and security of Individually Identifiable Health Information nor its obligations regarding the confidentiality of proprietary information.

4. Miscellaneous.

4.1 Defined Terms. Capitalized terms used in this Agreement but not defined herein shall have the meanings ascribed to them in the Transaction Regulations and/or in HIPAA.

4.2 Interpretation. Any ambiguity in any term or condition of this Agreement shall be resolved in favor of a meaning that permits the parties to comply with HIPAA.

4.3 *Standard Clauses.* Appendix A, Standard Clauses for NYS Contracts, June 2023, is incorporated into this Trading Partner Agreement by reference.

IN WITNESS WHEREOF, STATE and Trading Partner have caused this Agreement to be signed and delivered by their duly authorized representatives as of the date set forth above.

On behalf of STATE and Trading Partner:

STATE OF NEW YORK DEPARTMENT OF HEALTH

By: Danielle Holahan

Print Name: Danielle Holahan

Title: Executive Director, NY State of Health

TRADING PARTNER: Healthfirst PHSP, Inc.

By: Kathryn Howell

Print Name: Kathryn Howell

Title: Chief Legal Officer & General Counsel

EXHIBIT 8

2018 Qualified Health Plan Model Contract

between Healthfirst and New York State

MISCELLANEOUS/CONSULTANT SERVICES

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

NYS COMPTROLLER'S # C033929

ORIGINATING AGENCY GLBU: DOH01
DEPARTMENT ID: 3450000

CONTRACTOR (Name and Address):

Healthfirst PHSP, Inc.
100 Church Street
New York, NY 10007

TYPE OF PROGRAM(S):

Qualified Health Plans / NY State of Health

CHARITIES REGISTRATION NUMBER:

05-41-57

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

FEDERAL TAX IDENTIFICATION NUMBER:
133783732

NYS VENDOR IDENTIFICATION NUMBER:
1000026827

MUNICIPALITY NO. (if applicable)

CONTRACT TERM

FROM: October 1, 2018
TO: December 31, 2023

FUNDING AMOUNT FOR CONTRACT TERM: NOT TO EXCEED $0

STATUS:

CONTRACTOR IS ( ) IS NOT (X) A SECTARIAN ENTITY

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

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

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

APPENDICES ATTACHED AND PART OF THIS CONTRACT
Precedence shall be given to these documents in the order listed below.

-X-	APPENDIX A	Standard Clauses as required by the Attorney General for all State Contracts.
-X-	APPENDIX X	Contract Amendment Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)
-X-	APPENDIX Q	Modification of Standard Department of Health Contract Language
-X-	NEW YORK STATE DEPARTMENT OF HEALTH CONTRACT	
___	APPENDIX M	Participation by Minority and Women-Owned Business Enterprises
-X-	APPENDIX C	Program Specific Requirements
-X-	APPENDIX C-1	Marketplace Facilitated Enroller (FE) Program
-X-	APPENDIX D	Invitation and Requirements for Insurer Certification and Recertification to Participate in NY State of Health, as amended by the Q and A posted on the NY State of Health website
-X-	APPENDIX D-1	Contractor's Proposal to Participate in the NY State of Health, as amended
___	APPENDIX F	Technology Terms and Conditions
___	APPENDIX H	Federal Health Insurance Portability and Accountability Act ("HIPAA") Business Associate Agreement ("Agreement")
-X-	APPENDIX I	Trading Partner Agreement

IN WITNESS THEREOF, the parties hereto have executed or approved this Contract on the dates below their signature.

CONTRACTOR

Healthfirst PHSP, Inc.

By: Linda V Tiano

Linda V. Tiano
Printed Name

Title: Chief Legal Officer & General Counsel

Date: October 16, 2018

STATE AGENCY

New York State Department of Health

By: Donna Frescatore

Donna Frescatore
Printed Name

Title: Executive Director, NY State of Health

Date: 10/24/18

State Agency Certification:
"In addition to the acceptance of this Contract, I also certify that original copies of this signature page will be attached to all other exact copies of this Contract."

STATE OF NEW YORK)
)SS.:
County of New York)

On the 16th day of October in the year 2018 before me, the undersigned, personally appeared Linda V. Tiano, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

PIERRE T. JOSEPH
Notary Public, State of New York
No. 01JO6286786
Qualified in Nassau County
Commission Expires ~~September 9, 2017~~ 1/3/22

(Signature and office of the individual taking acknowledgement)

ATTORNEY GENERAL'S SIGNATURE

APPROVED AS TO FORM
NYS ATTORNEY GENERAL
OCT 29 2018

Title:

Date:

NYS COMPTROLLER'S SIGNATURE

DEPT. OF AUDIT & CONTROL
DEC 06 2018
FOR THE STATE COMPTROLLER

Title:

Date:

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

PLEASE RETAIN THIS DOCUMENT FOR FUTURE REFERENCE.

January 2014

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STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds $50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed $85,000 (State Finance Law Section 163.6-a). However, such pre-approval shall not be required for any contract established as a centralized contract through the Office of General Services or for a purchase order or other transaction issued under such centralized contract.

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex (including gender identity or expression), national origin, sexual orientation, military status, age, disability, predisposing genetic characteristics, marital status or domestic violence victim status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in

hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be a condition precedent to payment by the State of any State approved sums due and owing for work done upon the project.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from

disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or (iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, must give the reason or reasons why the payee does not have such number or numbers.

(b) Privacy Notification. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;
(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
Albany, New York 12245
Telephone: 518-292-5100
Fax: 518-292-5884
email: opa@esd.ny.gov

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
633 Third Avenue
New York, NY 10017
212-803-2414
email: mwbecertification@esd.ny.gov
https://ny.newnycontracts.com/FrontEnd/VendorSearchPublic.asp

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;
(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;
(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and
(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. COMPLIANCE WITH NEW YORK STATE INFORMATION SECURITY BREACH AND NOTIFICATION ACT. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208).

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW. If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

24. PROCUREMENT LOBBYING. To the extent this agreement is a "procurement contract" as defined by State Finance Law Sections 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law Sections 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.
To the extent this agreement is a contract as defined by Tax Law Section 5-a, if the contractor fails to make the certification required by Tax Law Section 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

26. IRAN DIVESTMENT ACT. By entering into this Agreement, Contractor certifies in accordance with State Finance Law §165-a that it is not on the "Entities Determined to be Non-Responsive Bidders/Offerers pursuant to the New York State Iran Divestment Act of 2012" ("Prohibited Entities List") posted at: http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf

Contractor further certifies that it will not utilize on this Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that should it seek to renew or extend this Contract, it must provide the same certification at the time the Contract is renewed or extended. Contractor also agrees that any proposed Assignee of this Contract will be required to certify that it is not on the Prohibited Entities List before the contract assignment will be approved by the State.

During the term of the Contract, should the state agency receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, the state agency will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the state agency limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the Contractor in default.

The state agency reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

APPENDIX X
CONTRACT AMENDMENT FORM
ORIGINATING AGENCY: DOH01

Contract Number:_____ CONTRACTOR:_____

Amendment Number X-_____ BSC Unit ID: 3450000

This is a Contract between THE STATE OF NEW YORK, acting by and through NYS Department of Health, having its principal office at Albany, New York, (hereinafter referred to as the DEPARTMENT), and _____ (hereinafter referred to as the CONTRACTOR), having its mailing address at _____, for amendment of this Contract.

This amendment makes the following changes to the Contract (check all that apply):

_____ Modifies the Contract period at no additional cost

_____ Modifies the Contract period at additional cost

_____ Modifies the budget or payment terms

_____ Modifies the work plan or deliverables

_____ Replaces appendix(es) _____ with the attached appendix(es) _____

_____ Adds the attached appendix(es) _____

_____ Other: (describe) _____

This amendment *is*__ *is not*__ a Contract renewal as allowed for in the existing Contract.

All other provisions of said Contract shall remain in full force and effect.

Additionally, CONTRACTOR certifies that it is not included on the prohibited entities list published at http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf as a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York. Under the Act, the Commissioner of the Office of General Services (OGS) has developed a list (prohibited entities list) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). CONTRACTOR (or any assignee) also certifies that it will not utilize on such Contract in any subcontracts that is identified on the prohibited entities list.

Prior to this amendment, the Contract value and period were:

$_____ (Value before amendment) From__/__/____ to __/__/____. (Initial Start date)

This amendment provides the following modification (complete only items being modified):

$_____ From__/__/____ to __/__/____.

This will result in new Contract terms of:

$_____ (All years thus far combined) From__/__/____ to __/__/____. (Initial Start date) (Amendment end date)

Signature Page for:

Contract Number:_____ CONTRACTOR:_____

Amendment Number X-_____ Unit ID: 34500000

IN WITNESS WHEREOF, the parties hereto have executed this Contract as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE:

By:_____ Date:_____
(signature)

Printed Name:_____

Title:_____

STATE OF NEW YORK)
) SS:
County of_____)

On the ____day of_____in the year_____before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
(Signature and office of the individual taking acknowledgement)

STATE AGENCY SIGNATURE

"In addition to the acceptance of this Contract, I also certify that original copies of this signature page will be attached to all other exact copies of this Contract."

By:_____ Date:_____
(signature)

Printed Name:_____

Title:_____

ATTORNEY GENERAL'S SIGNATURE

By:_____ Date:_____

STATE COMPTROLLER'S SIGNATURE

By:_____ Date:_____

Appendix Q
MODIFICATION OF STANDARD DEPARTMENT OF HEALTH CONTRACT LANGUAGE

New York State Department of Health Contract, Section I, General Terms and Conditions, paragraph "F" is replaced in its entirety with the following:

F. For the purposes of this Contract, the term "Proposal" includes all Appendix D-1 documents as marked on the Face Page and approved by the DEPARTMENT.

New York State Department of Health Contract, Section I, General Terms and Conditions, paragraph "I" is replaced in its entirety with the following:

I. For the purposes of this Contract, the Appendix D includes the Invitation and Requirements for Insurer Certification and Recertification for Participation as amended, including questions and answer documents (the body of which is attached), and Attachments, which are set forth in their entirety at: https://info.nystateofhealth.ny.gov/invitation

New York State Department of Health Contract, Section II, Payment and Reporting, is amended to add the following provision:

Any funds provided by the DEPARTMENT pursuant to this Contract shall not be used for any partisan political activity, or for activities that may influence legislation or the election or defeat of any candidate for public office.

NEW YORK STATE DEPARTMENT OF HEALTH CONTRACT

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

WITNESSETH:

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

☑ **WHEREAS**, the DEPARTMENT has determined, without a formal bid proposal, that it is in need of the services described in Appendix C; and the CONTRACTOR covenants that it is willing and able to undertake the services and provide the necessary materials, labor and equipment in connection therewith;

NOW THEREFORE, in consideration of the terms, promises, responsibilities, and covenants set forth below the parties agree as follows:

I. General Terms and Conditions

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

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

II. Payment and Reporting

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

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

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

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

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

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

Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary DEPARTMENT procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at helpdesk@sfs.ny.gov or by telephone at 1-855-233-8363. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9 must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us./vendors/vendorguide/guide.htm.

Payment terms shall be:

Intentionally left blank. AVY 10/11/18
DB 10/24/18

III. Term and Termination

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

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

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

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

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

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

G. Provisions Upon Default

1. In the event that the CONTRACTOR, through any cause, fails to perform any of the terms, covenants or promises of this Contract, the DEPARTMENT thereupon have the right to terminate this Contract by giving notice in writing of the fact and date of such termination to the CONTRACTOR.

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

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

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

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

IV. Contract Insurance Requirements

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

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

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

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

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

Name/Title: Ilene Matthews, Contract Management Specialist

Organization: NYS Department of Health

Address: Empire State Plaza, Corning Tower Rm 2580

Address: Albany, NY 12237

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

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

Certificates of Insurance shall:

a. Be in the form approved by the DEPARTMENT.

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

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

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

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

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

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

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

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

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

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

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

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

C. Specific Coverages and Limits

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

1. Workers' Compensation

For work to be performed in New York State, the CONTRACTOR shall provide and maintain coverage during the life of this Contract for the benefit of such employees as are required to be covered by the NYS Workers' Compensation Law. The CONTRACTOR shall provide notice to the DEPARTMENT immediately if CONTRACTOR'S Worker's Compensation coverage has lapsed or terminated during the PERIOD of this Contract.

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

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

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

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

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

2. Disability Benefits

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

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

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

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

3. Commercial General Liability

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

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

Coverage shall include, if applicable, the following:

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

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

The following ISO forms must be endorsed to the policy:

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

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

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

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

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

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

4. Commercial Automobile Liability

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

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

5. Umbrella and Excess Liability

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

V. Conflicts of Interest

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

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

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

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

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

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

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

VI. Public Officers Law

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

VII. Ethics Requirements

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

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

VIII. Subcontracting

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

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

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

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

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

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

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

IX. General Specifications

A. The work shall be commenced and shall be actually undertaken within such time as the DEPARTMENT may direct by notice, whether by mail, e-mail, or other writing, whereupon the undersigned will give continuous attention to the work as directed, to the end and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the DEPARTMENT may prescribe.

B. The CONTRACTOR will be required to complete the entire work or any part thereof as the case may be, to the satisfaction of the DEPARTMENT in strict accordance with the specifications and pursuant to this Contract.

C. CONTRACTOR will possess, and maintain, at no cost to the DEPARTMENT and for the term of the Contract, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this Contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

D. Certification Regarding Debarment and Suspension

Regulations of the Department of Health and Human Services, located at Part 376 of Title 2 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive Departments and agencies shall participate in a government-wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and non-financial assistance and benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the DEPARTMENT (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the DEPARTMENT must require its prospective CONTRACTORS, as prospective lower tier participants, to provide the certification as set forth below:

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

a. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to the other remedies available to the Federal Government, New York State or the DEPARTMENT may pursue available remedies, including suspension and/or debarment.

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

c. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered Transaction, principal, proposal, and voluntarily excluded, as used in this Section, are defined in 2 CFR Part 180, as supplemented by 2 CFR Part 376.

d. The prospective lower tier participant agrees by signing this contract or submitting a proposal pursuant to a solicitation issued by the DEPARTMENT that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 2 CFR Part 180, as supplemented by 2 CFR Part 376, or 48 CFR Part 9, Subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the DEPARTMENT.

e. The prospective lower tier participant further agrees by signing this contract or proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction,' without modification, in all lower tier covered transactions.

f. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 2 CFR Part 180, as supplemented by 2 CFR Part 376, or 48 CFR Part 9, Subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of it principals. The DEPARTMENT strongly encourages each participant to check the List of parties Excluded from Federal Procurement and Non-procurement Programs in the System for Award Management.

g. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this Section.

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

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

i. The prospective lower tier participant certifies, by signing this contract or submitting a proposal to the Department, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily exclude from participation in this transaction by any federal agency.

ii. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

E. Ownership Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this Contract shall contain the following, or similar acknowledgment: "Funded by the New York State Department of Health." Any such materials must be reviewed and approved by the DEPARTMENT for conformity with the policies and guidelines of the DEPARTMENT prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the CONTRACTOR shall be free to publish in scholarly journals along with a disclaimer that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health. The DEPARTMENT reserves the right to disallow funding for any educational materials not approved through its review process.

2. Any publishable or otherwise reproducible material developed under or in the course of performing this Contract, dealing with any aspect of performance under this Contract, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the DEPARTMENT, and shall not be published or otherwise disseminated by the CONTRACTOR to any other party unless prior written approval is secured from the DEPARTMENT or under circumstances as indicated in paragraph 1 of this subsection. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the DEPARTMENT. The DEPARTMENT shall have a perpetual royalty-free, non-

exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

3. No report, document or other data produced in whole or in part with the funds provided under this Contract may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report, document or other data developed pursuant to this Contract, without express written permission of the DEPARTMENT.

4. All reports, data sheets, documents, etc. generated under this Contract shall be the sole and exclusive property of the DEPARTMENT. The CONTRACTOR shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the DEPARTMENT or its authorized agents.

5. This is a "Work for Hire" Contract. The DEPARTMENT will be the sole owner of all source code and any software which is developed for use in any application software provided to the DEPARTMENT as a part of this Contract.

F. Confidentiality Clause

The CONTRACTOR, its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this CONTRACT, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.

G. Date/Time Warranty

1. Definitions: For the purposes of this warranty, the following definitions apply:

"Product" shall include, without limitation: when solicited from a vendor in a state government entity's Contracts, RFPs, IFBs, or mini-bids, any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition, function, calculation, comparing or sequencing. Where services are being furnished, e.g., consulting, systems integration, code or data conversion or data entry, the term "Product" shall include resulting deliverables.

"Third Party Product" shall include product manufactured or developed by a corporate entity independent from the vendor and provided by the vendor on a non-exclusive licensing or other distribution Contract with the third party manufacturer. "Third Party Product" does not include product where vendor is: (a) a corporate subsidiary or affiliate of the third party manufacturer/developer; and/or (b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

2. Date/Time Warranty Statement

CONTRACTOR warrants that Product(s) furnished pursuant to this Contract shall, when used in accordance with the Product documentation, be able to accurately process date/time data (including, but not limited to, calculating, comparing, and sequencing) transitions, including leap year calculations.

Where a CONTRACTOR proposes or an acquisition requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

Where CONTRACTOR is providing ongoing services, including but not limited to: (a) consulting, integration, code or data conversion, b) maintenance or support services, c) data entry or processing, or d) contract administration services (e.g., billing, invoicing, claim processing), CONTRACTOR warrants that services shall be provided in an accurate and timely manner without interruption, failure or error due to the inaccuracy of CONTRACTOR'S business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) various date/time transitions, including leap year calculations. CONTRACTOR shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom, including but not limited to the failure or untimely performance of such services.

This Date/Time Warranty shall survive beyond termination or expiration of this Contract through: (a) ninety (90) days or (b) the CONTRACTOR'S or Product manufacturer or developer's stated date/time warranty term, whichever is longer. Nothing in this warranty statement shall be construed to limit any rights or remedies otherwise available under this Contract for breach of warranty.

H. Lead Guidelines

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

I. On-Going Responsibility

1. General Responsibility Language: The CONTRACTOR shall at all times during this Contract term remain responsible. The CONTRACTOR agrees, if requested by the Commissioner of Health or his or her designee, to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity.

2. Suspension of Work (for Non-Responsibility): The Commissioner of Health or his or her designee, in his or her sole discretion, reserves the right to suspend any or all activities under this Contract, at any time, when he or she discovers information that calls into question the responsibility of the CONTRACTOR. In the event of such suspension, the CONTRACTOR will be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the CONTRACTOR must comply with the terms of the suspension order. Contract activity may resume at such time as the Commissioner of Health or his or her designee issues a written notice authorizing a resumption of performance under this Contract.

3. Termination (for Non-Responsibility): Upon written notice to the CONTRATOR, and a reasonable opportunity to be heard with appropriate DEPARTMENT officials or staff, this Contract may be terminated by Commissioner of Health or his or her designee at the CONTRACTOR'S expense where the CONTRACTOR is determined by the Commissioner of Health or his or her designee to be non-responsible. In such event,

the Commissioner of Health or his or her designee may complete the contractual requirements in any manner he or she may deem advisable and pursue available legal or equitable remedies for breach.

J. Indemnification

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

K. Indemnification Relating to the Third Party Rights

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

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

L. Force Majeure

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

prevented. The CONTRACTOR shall provide the DEPARTMENT with written notice of any force majeure occurrence as soon as the delay is known.

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

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

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

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

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

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

M. Notices

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

a. via certified or registered United States mail, return receipt requested;
b. by facsimile transmission;
c. by personal delivery;
d. by expedited delivery service; or
e. by e-mail

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

Contact at State of New York Department of Health

Name/Title	Margaret Middleton, Director of Plan Management
Address	Corning Tower, 23rd Floor, ESP, Albany NY 12237
Email	nyhxpm@health.state.ny.us
Phone/Fax	518-486-9102 / 518-473-1409

Contact at Contractor

Name/Title	Shawn Nowicki, Director of Regulatory Affairs
Address	100 Church Street, New York, NY 10007
Email	snowicki@healthfirst.org
Phone/Fax	212-801-6210

Any such notices shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Contract by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this Contract. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

N. Provision Related to Consultant Disclosure Legislation

If this Contract is for the provision of consulting services as defined in Subdivision 17 of Section 8 of the State Finance Law, the CONTRACTOR shall submit a "State Consultant Services Form B, CONTRACTOR'S Annual Employment Report" no later than May 15th following the end of each DEPARTMENT fiscal year included in this Contract term. This report must be submitted to:

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

2. The NYS Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th Floor, Albany NY 12236 ATTN: Consultant Reporting or via fax at (518) 474-8030 or (518) 473-8808; and

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

O. Provisions Related to New York State Information Security Breach and Notification Act

CONTRACTOR shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). CONTRACTOR shall be liable for the costs associated with such breach if caused by CONTRACTOR'S negligent or willful acts or omissions, or the negligent or willful acts or omissions of CONTRACTOR'S agents, officers, employees or subcontractors.

P. Technology Purchases Notification

The following provisions apply if this Request for Proposal (RFP) seeks proposals for "Technology."

1. For the purposes of this policy, "Technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.

2. If this RFP results in procurement of software over $20,000, or of other technology over $50,000, or where the DEPARTMENT determines that the potential exists for coordinating purchases among New York State agencies and/or the purchase may be of interest to one or more other New York State agencies, prior to award selection, this RFP and all responses thereto are subject to review by the New York State Office for Information Technology Services. Accessibility of State Agency Web-based Intranet and Internet Information and Applications

Any web-based intranet and Internet information and applications development, or programming delivered pursuant to the Contract or procurement, will comply with New York State Enterprise IT Policy NYS-P08-005, Accessibility of Web-Based Information and Applications as such policy may be amended, modified or superseded, which requires that state agency web-based intranet and Internet information and applications are accessible to persons with disabilities. Web content must conform to New York State Enterprise IT Policy NYS-P08-005, as determined by quality assurance testing. Such quality assurance testing will be conducted by the DEPARTMENT and awarded CONTRACTOR and the results of such testing must be satisfactory to the DEPARTMENT before web content will be considered a qualified deliverable under the Contract or procurement.

APPENDIX C
PROGRAM SPECIFIC REQUIREMENTS

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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 Marketplace in 2019 are determined based on the federal Actuarial Value calculator as described in 45 C.F.R. 156.135.

"Advance Premium Tax Credit (APTC)" shall mean the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which is provided on an advance basis on behalf of an eligible individual enrolled in a QHP through a Marketplace in accordance with sections 1402 and 1412 of the Affordable Care Act.

"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) and any amendments thereto or regulations promulgated thereunder.

"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 Marketplace.

"Annual Open Enrollment Period" shall mean the period each year during which a qualified individual may enroll or change coverage in a QHP through the Marketplace without a Special Enrollment Period.

"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.

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

"Certificate of Coverage" shall mean the certificate issued by CONTRACTOR for delivery to enrolled employees, which sets forth in summary form the features of the health care coverage.

"Cost-Sharing Reductions (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, as set forth in Attachment A of the Invitation.

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

"**Enrollee**" shall mean an individual or employee, or a dependent of an employee, enrolled in a QHP offered through the Marketplace in accordance with applicable law and the terms of the group health plan, if applicable.

"**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 Marketplace**" shall refer to the QHPs and Stand Alone Dental Plans available to Qualified Individuals through the Marketplace.

"**Individual Market**" shall refer to health and standalone dental products available to individuals both inside and outside of the Marketplace.

"**Insurance Affordability Program**" or "**IAP**" refers to the Medical Assistance Program ("Medicaid"), Child Health Plus, the Essential Plan, and Advance Premium Tax Credits and Cost-Sharing Reductions for QHPs.

"**Invitation**" shall mean the Invitation for Participation and Requirements for Insurer Certification and Recertification and the attachments thereto, issued by the Marketplace to health and dental plan issuers to participate in the Marketplace, as modified by the Questions and Answers regarding the Invitation posted on the Marketplace website.

"**Marketplace**" shall mean the NY State of Health, The Official Health Plan Marketplace established within the New York State Department of Health pursuant to Executive Order Number 42 on April 12, 2012.

"**Marketplace Facilitated Enroller**" shall mean employees and representative of the CONTRACTOR who have (i) completed Marketplace approved training regarding QHP options, eligibility for

insurance affordability programs and benefit rules and regulations, (ii) passed an examination to assure successful completion of the training; and (iii) received Marketplace authorization to provide application assistance to individuals enrolling in QHPs and IAPs through the Marketplace.

"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 a publication prepared by the CONTRACTOR, 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.

"Navigator" shall mean an entity that has been authorized by and has an agreement with STATE to provide Navigator program services in accordance with 45 C.F.R. 155.210.

"Non-APTC Grace Period" shall mean, in accordance with NY Insurance Law, a thirty (30) day grace period for payment of premiums for Enrollees not receiving Advance Premium Tax Credits who have paid the first month's premium.

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

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

"Personally Identifiable Information (PII)" shall mean elements of information that can be used to distinguish or trace an individual's identity, such as their name, address and social security number, alone or when combined with other elements of personal or identifying information that is linked or linkable to a particular individual.

"Protected Health Information (PHI)" 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 Advance 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 in accordance with applicable law and Marketplace policies and procedures.

"Qualified Employer" is an employer that (i) is defined as a "small group" pursuant to the NY State Insurance Law; (ii) elects to offer, at a minimum, all full-time employees coverage in a Qualified Health Plan; and (iii) either: (a) has its principal business address in the Marketplace service

area and offers coverage to all its full-time employees; or (b) offers coverage to each eligible employee through the SHOP serving that employee's primary worksite. An employer that meets these criteria and which has at least one employee that is not the owner or the owner's spouse enrolled in coverage shall be authorized to offer Qualified Employees the ability to purchase Qualified Health Plans through the Small Business Marketplace.

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

"Qualified Individual" shall mean an individual that is determined eligible, pursuant to applicable law, to enroll in a QHP through the Marketplace.

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

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

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

"Small Employer" shall mean an employer that meets the definition of "small group" in the NY Insurance Law.

"Small Group Market" shall refer to health care and stand-alone dental products available to Small Employers both inside and outside of the Marketplace.

"Small Group Market Special Enrollment Period" shall refer to an annual open enrollment period from November 15th through December 15th during which Contractor shall permit a Qualified Employer who cannot meet Contractor's minimum participation requirements to enroll in coverage with a January 1st start date, or to renew coverage that was issued or renewed during November 15th and December 15th.

"Special Enrollment Periods" shall mean, as described in 45 C.F.R. 155.420 and applicable State law, the periods during which a Qualified Individual or Enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Marketplace outside of the Annual Open Enrollment Period; and for SHOP, shall mean, in accordance with 45 C.F.R. 155.726(c) and applicable State law, such periods outside of the Annual Open Enrollment Period during which CONTRACTOR offering QHPs through the SHOP shall permit certain Qualified Employees or dependents of Qualified Employees to enroll in or change QHPs.

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

"State" shall mean the State of New York Department of Health.

"Subscriber" shall mean the individual to whom the CONTRACTOR issues a Subscriber Contract.

"Subscriber Contract" shall mean the contract between CONTRACTOR and a Subscriber, approved by the DFS and issued to each Subscriber by the CONTRACTOR at the time of enrollment, which details the provision of health care coverage to the Subscriber or the Subscriber and his or her dependents under this AGREEMENT.

"Summary of Benefits and Coverage (SBC)" refers to a document provided by CONTRACTOR to Enrollees either directly or through their Employer pursuant to applicable law, describing plan benefits and coverage, including cost-sharing. 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 Marketplace.

B. Independent Contractors

1. The parties acknowledge and agree that 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, NY Insurance Law and NY Public Health Law. The absence of a reference to a 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 in the event that laws and regulations pertaining to QHPs and related issues addressed in this Agreement 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 Marketplace and/or Small Business Marketplace (or "SHOP")

CONTRACTOR shall offer QHPs in the Individual Marketplace, Small Business Marketplace, 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, 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 DFS and/or STATE.

2. To offer health insurance plan(s) or Stand-Alone Dental Plan(s) through the Individual Marketplace and/or to offer SHOP-certified QHPs in the Small Group Market, CONTRACTOR must assure that such plans are certified as QHP(s) by the STATE.

3. Certification of CONTRACTOR's health insurance plan(s) as QHP(s) by the STATE confirms that the plan(s) comply with the provisions of the Invitation, including but not limited to:

   (i) the Applicant-Specific Requirements, including the provision of Essential Health Benefits;

   (ii) the Quality and Enrollee Satisfaction requirements;

   (iii) the Network Adequacy Requirements, including sufficient geographic distribution of Essential Community Providers; and

   (iv) the Premium Rate and Policy Form and Filing requirements.

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 provisions of the Invitation, including but not limited to:

   (i) the Applicant-Specific Requirements;

   (ii) the Quality and Enrollee Satisfaction requirements;

   (iii) the Network Adequacy Requirements; and

   (iv) the Premium Rate and Policy Form and Filing requirements.

5. With respect to certification of QHPs in the Small Group Market, STATE shall ensure that each QHP meets the requirements specified in 45 C.F.R. 156.285 of this subchapter.

6. 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 Marketplace and/or the Small Business Marketplace, the QHP(s) that have been certified by the Marketplace.

2. In the Individual Marketplace, CONTRACTOR shall offer Standard Products as outlined in the Invitation; and may offer certain Non-Standard Products subject to the requirements of the Invitation.

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 an Appendix;

   (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 for the certification of QHPs in accordance with applicable law and regulation.

7. CONTRACTOR shall have a process in place to comply with the standards related to federal and State risk adjustment programs in accordance with applicable law.

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 to 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 Marketplace, 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, in the case of the Individual Marketplace, suspend enrollment in a QHP in the event that the DFS requires suspension; or, in the case of the Small Business Marketplace, suspend certification and display of a QHP 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 MARKETPLACE AND SHOP

A. Network Adequacy Requirements

For QHPs offered in the Individual Marketplace or SHOP, CONTRACTOR will establish and maintain a network of Participating Providers that complies with 45 C.F.R. 156.230, 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 be consistent with the network adequacy requirements and standards that exist outside of the Marketplace pursuant to the NY 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.

2. 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.

3. 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.

4. 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 as determined by STATE, 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. 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 Marketplace 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 its terms; and

      d. Reserves the right to update or modify the process for CONTRACTOR'S submission of its network for review and approval by the STATE, with at least sixty (60) days advance notice to CONTRACTOR.

   2. CONTRACTOR:

      a. Shall submit its network through the Provider Network Data System ("PNDS") in accordance with the PNDS Instructions provided by STATE, 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. Shall update the provider directory on its website and in its PNDS submission(s) within fifteen (15) days of the addition or termination of a provider from its network, or a change in a physician's hospital affiliation in accordance with applicable law and this Agreement;

c. Shall ensure that for each provider included in the network that is submitted for review and approval, it has secured a Provider Agreement; and

d. Shall 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 applicable law with respect to risk adjustment programs and rating regions, 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 Marketplace 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 DFS 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 report-

ing 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. INDIVIDUAL MARKETPLACE: ELIGIBILITY AND ENROLLMENT

A. Obligations of STATE

1. The STATE shall be responsible for determining eligibility for QHPs, as well as eligibility for IAPs.

2. The STATE shall use a single streamlined application to collect necessary information from applicants and shall determine eligibility for enrollment in a QHP or IAP in accordance with the requirements of applicable law and guidance.

3. The STATE shall permit an applicant for coverage through the Marketplace who is not seeking an eligibility determination for IAPs to request only an eligibility determination for enrollment in a QHP. The STATE shall not permit an applicant seeking an eligibility determination for IAPs to request an eligibility determination for less than all such programs.

4. 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 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.

5. 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.

6. The STATE shall reconcile enrollment information with CONTRACTOR and the U.S. Department of Health and Human Services ("HHS") no less than on a monthly basis; and shall send updated eligibility and enrollment information to HHS in a manner and timeframe specified by HHS in accordance with 45 C.F.R. 155.400.

B. Obligations of CONTRACTOR Participating in the Individual Marketplace

1. During the Annual Open Enrollment Periods as well as Special Enrollment Periods throughout the Contract Term, CONTRACTOR shall make available for purchase in the Individual Marketplace the QHPs that have been certified by the Marketplace. Eligible individuals may purchase coverage directly through the Marketplace website, or may use a Navigator, Marketplace

Facilitated Enroller, certified application counselor, authorized agent or broker, or to the extent permitted by federal and State law and regulation, other third-party assistors.

2. Enrollment is not effectuated until CONTRACTOR receives initial payment of premium, if applicable, from the prospective enrollee and sends a confirmation 834 transaction to the STATE (the "Coverage Effective Date"). Unless required otherwise by federal law, CONTRACTOR shall provide a grace period of no less than ten (10) days 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. 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.

3. After the coverage effective date, CONTRACTOR shall provide grace periods for each premium payment that is not received by the premium due date, as follows:

    a. For those Enrollees receiving APTC, in accordance with 45 C.F.R. 156.270(d), CONTRACTOR shall adhere to the APTC Grace Period, which is three (3) consecutive months if an Enrollee receiving APTC has previously paid at least one (1) full month's premium during the benefit year. During the APTC Grace Period, CONTRACTOR shall continue to provide coverage for Health Care Services for the first month of the APTC Grace Period and may pend claims for services rendered to Enrollee in the second and third months of the APTC Grace Period. Retroactive termination shall not exceed 61-days.

    b. For those Enrollees not receiving APTC, in accordance with the NY Insurance Law, CONTRACTOR shall adhere to the thirty (30) day Non-APTC Grace Period for those Enrollees not receiving APTC who have paid the first month's premiums. CONTRACTOR shall accept payment for outstanding premiums for thirty (30) days, and shall continue to provide coverage for Health Care Services during this Non-APTC Grace Period. If the premium is not paid in full during the Non-APTC Grace Period, CONTRACTOR may terminate coverage retroactively back to the last date premiums were paid.

4. 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.

5. If CONTRACTOR receives an application from a potential enrollee for enrollment in a QHP, the CONTRACTOR must either (i) direct the applicant to the Marketplace for a determination of eligibility and enrollment in a QHP if eligible, or (ii) ensure the applicant received an eligibility determination from the Marketplace through the Marketplace website, whether through coordination with a Navigator, Marketplace Facilitated Enroller, certified application counselor, or authorized agent or broker or, or by enrolling the individual directly if and when permitted by federal regulation.

6. CONTRACTOR shall not, with respect to its QHP(s), discriminate on the basis of race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

7. CONTRACTOR shall 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.

8. An individual Enrollee shall be permitted to automatically continue his or her coverage in a QHP (if available) during the next Annual Open Enrollment Period, unless the Enrollee is terminated for reasons permitted under the Subscriber Contract or has selected another plan.

C. Special Enrollment Periods in Individual Marketplace

1. The STATE shall pursuant to 45 C.F.R. 155.420(d) and applicable State and federal law, allow Qualified Individuals or Enrollees and when specified, his or her dependent, to enroll in or change from one QHP to another, within sixty (60) days of the following triggering events:

   a. A Qualified Individual or his or her dependent either (i) involuntarily loses minimum essential coverage; (ii) is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or his or her dependent has the option to renew such coverage; (iii) loses pregnancy-related coverage as described under applicable law or loses access to health care services through coverage provided to a pregnant woman's unborn child; or (iv) loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year;

   b. A Qualified Individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order, or if covered, domestic partnership; or, the Enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law or if the Enrollee or his or her dependent dies;

   c. A Qualified Individual or his or her dependent becomes newly eligible for enrollment in a QHP because he or she newly satisfies the requirements for status as a citizen, national, or as a lawfully present individual, or because he or she is no longer incarcerated;

   d. A Qualified Individual's or his or her dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the STATE or HHS, its instrumentalities, or a non-Marketplace entity providing enrollment assistance 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;

   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. (i) An Enrollee is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR, (ii) the Enrollee's dependent enrolled in the same QHP is determined newly eligible or ineligible for APTC or has a change in eligibility for CSR; or (iii) a Qualified Individual or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualified coverage in an eligible employer-sponsored plan, or (iv) a Qualified Individual who was previously ineligible for APTC solely because of a household income below 100 percent of Federal Poverty Level, and who during the same timeframe was ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, who either experiences a change in income or moves to a different state resulting in the Qualified Individual becoming newly eligible for APTC;

g. A Qualified Individual or Enrollee or his or her dependent gains access to new QHPs as a result of a permanent move and had minimum essential coverage for one or more days during the sixty (60) days preceding the date of the permanent move;

h. A Qualified Individual (i) who gains or maintains status as 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; or (ii) who is or becomes a dependent of an Indian and is enrolled or is enrolling in a QHP through the Marketplace on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian;

i. A Qualified Individual or Enrollee or his or her dependent demonstrates to the STATE, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the STATE may provide;

j. A Qualified Individual or Enrollee (i) is a victim of domestic abuse or spousal abandonment as defined by 26 C.F.R. 1.36B-2T, as amended, or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or (ii) is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

k. A Qualified Individual or dependent applies for coverage through the Marketplace during the Annual Open Enrollment Period or due to a qualifying event, is assessed by the Marketplace as potentially eligible for Medicaid or Child Health Plus (CHP), and is determined ineligible for Medicaid or CHP either after open enrollment has ended or more than sixty (60) days after the qualifying event;

l. The Qualified Individual or Enrollee, or his or her dependent, adequately demonstrates to the STATE that a material error related to plan benefits, service area, or premium influenced the Qualified Individual's or Enrollee's decision to purchase a QHP through the Marketplace;

m. At the option of the Marketplace, the Qualified Individual provides satisfactory documentary evidence to verify his or her eligibility for an IAP or enrollment in a QHP through the Marketplace following termination of Marketplace enrollment due to a fail-

ure to verify such status within the time period specified in 45 C.F.R. 155.315 or is under 100 percent of the Federal Poverty Level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or

n. Any time after the commencement of pregnancy, as certified by a licensed health care provider, in accordance with the requirements of the NY Insurance Law and NY Public Health Law.

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 CSR 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;

e. in the case of pregnancy, the first of the month in which the individual received certification of the pregnancy from a licensed health care provider.

D. Coverage Effective Date in Individual Marketplace

1. CONTRACTOR must notify a Qualified Individual of his or her effective date of coverage (the "Coverage Effective Date").

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 his or her Coverage Effective Date or after his or her Effective Date of Disenrollment.

E. Enrollment in Individual Marketplace

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 race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

2. CONTRACTOR shall not impose additional or different requirements upon Enrollees than the requirements for individuals who purchased coverage outside of the Marketplace unless required by law.

3. For the Individual Marketplace, CONTRACTOR shall be responsible for collecting premium payments from Enrollees, as well as collecting APTC and CSR from the federal government in accordance with applicable law and guidance. CONTRACTOR shall adhere to the standards set forth by HHS and the process outlined by STATE for the accurate reporting of APTC and CSR.

4. In the Individual Marketplace, 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. CONTRACTOR must accept enrollment information in an electronic format, in a manner consistent with applicable privacy and security provisions of State and federal law.

6. 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 by and between STATE and CONTRACTOR shall be conducted pursuant to the Trading Partner Agreement attached as an Appendix to this Agreement and the 834 Companion Guide referenced in such Agreement, as may be amended from time to time.

7. CONTRACTOR shall reconcile enrollment files with the STATE no less than once per month in accordance with 45 C.F.R. 155.400, and in accordance with procedures established by the STATE and as set forth in the Trading Partner Agreement attached hereto as an Appendix.

VIII. SMALL BUSINESS MARKETPLACE: ELIGIBILITY AND ENROLLMENT

A. General Requirements

1. CONTRACTOR shall adhere to enrollment periods under applicable law, including Special Enrollment Periods pursuant to 45 C.F.R. 155.726(c).

2. CONTRACTOR must permit a Qualified Employer to purchase coverage for its small group at any point during the year. The Qualified Employer's plan year must consist of the 12-month period beginning with the Qualified Employer's Effective Date of Coverage.

B. Eligibility and Enrollment for SHOP Coverage Issued and In Effect Prior to July 1, 2018

1. Obligations of STATE for SHOP Coverage Issued and in Effect Prior to July 1, 2018

a. For QHP coverage that was issued through SHOP and in effect prior to July 1, 2018, the STATE shall:

(i) Collect 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.

(ii) Transmit enrollment data to CONTRACTOR via HIPAA-compliant 834 files pursuant to the Trading Partner Agreement attached as an Appendix to this Agreement and the 834 Companion Guide referenced in such Agreement, as may be amended from time to time.

(iii) Administer renewals for Qualified Employers for coverage issued through SHOP and in effect prior to July 1, 2018, until the end of the individual employer group's plan year. For example, for coverage issued to a Qualified Employer through SHOP and in effect in March,2018, STATE shall issue bills to such Employer through March, 2019 and collect the premium payment.

(iv) Transmit 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.

(v) 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.

b. In conducting HIPAA transactions, STATE and CONTRACTOR shall adhere to the Trading Partner Agreement attached to this Agreement as an Appendix.

2. Obligations of the CONTRACTOR for SHOP Coverage Issued and in Effect Prior to July 1, 2018

a. Prior to July 1, 2018, Qualified Employers were able to purchase coverage for their employees directly through the SHOP Portal on the Marketplace website, or through an authorized agent or broker, Navigator/In Person Assistor or other assistor to the extent permitted by federal or State law or regulation. For coverage issued through SHOP and in effect prior to July 1, 2018, 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.

b. 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.

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.

d. For coverage issued through SHOP and in effect prior to July 1, 2018, CONTRACTOR may not impose minimum participation requirements on Qualified Employers mid-plan year or upon renewal. For coverage issued and in effect prior to July 1, 2018, CONTRACTOR must renew Qualified Employers on the twelve (12) month anniversary date of the Coverage Effective Date in accordance with 42 U.S.C. 18024(b)(4)(D) and applicable law unless the Qualified Employer is no longer eligible for small group coverage and/or the employer has chosen not to renew or has selected another QHP or QHPs.

e. For QHP coverage that was issued through SHOP and in effect prior to July 1, 2018, the CONTRACTOR shall:

   (i) 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 this subsection.

   (ii) 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.

   (iii) Accept enrollments of Qualified Individuals in the order in which the enrollment information is received without regard to the Qualified Individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

f. CONTRACTOR shall not impose additional or different requirements upon Enrollees than the requirements for individuals or small employers who purchased coverage outside of the Marketplace unless required by law.

g. CONTRACTOR must accept enrollment information in an electronic format, in a manner consistent with applicable privacy and security provisions of state and federal law.

h. CONTRACTOR shall reconcile enrollment files with the STATE no less than once per month in accordance with 45 C.F.R. 155.400, and in accordance with procedures established by the STATE and as set forth in the Trading Partner Agreement attached hereto as an Appendix.

C. Eligibility and Enrollment for SHOP Coverage Issued and in Effect After July 1, 2018

1. Obligations of STATE for Coverage Issued and in Effect After July 1, 2018

a. On or after April 1, 2018, the STATE shall determine whether an employer requesting a determination of eligibility to purchase SHOP-certified QHPs is eligible in accordance with the requirements of 45 C.F.R. 155.710. STATE shall have sole authority to determine employer eligibility to purchase SHOP-certified products.

b. On or after April 1, 2018, the STATE shall provide an employer requesting a determination of eligibility to purchase SHOP-certified QHPs with a written determination confirming or denying its eligibility and including the employer's right to appeal such eligibility determination. The determination will be valid for the tax year in which it is issued.

c. Employers must submit a new single employer application to the SHOP or withdraw from participating in the SHOP if the employer makes a change that could end its eligibility under 45 C.F.R. 155.710.

d. The STATE shall hear and decide employer appeals regarding employer eligibility to purchase SHOP-certified QHPs, pursuant to applicable law. The formal written decision of the STATE with respect to employer eligibility will be binding for the applicable period.

2. Obligations of CONTRACTOR for Coverage Issued and in Effect After July 1, 2018

a. A CONTRACTOR that has elected to participate in the SHOP, and has obtained SHOP certification of QHPs, shall make such QHPs available for purchase by Qualified Employers. Qualified Employers shall be able to purchase coverage for their employees directly from the CONTRACTOR, or may use a SHOP certified agent or broker authorized by the Qualified Employer, a Navigator, a Marketplace Facilitated Enroller or other assistor to the extent permitted by federal or State law or regulation.

b. CONTRACTOR (excepting Contractors who are HMOs) may impose minimum participation requirements on Qualified Employers, provided that such requirements are consistent with the requirements for its off-SHOP small group business and permitted under State law. However, CONTRACTOR must allow groups to enroll during the Small Group Special Enrollment Period without imposing minimum participation requirements. CONTRACTOR may impose minimum participation requirements on renewal outside of the Small Group Special Enrollment Period but only to the extent the same requirements were imposed upon the group's initial application for coverage.

c. CONTRACTOR shall:

i. offer coverage to and accept every employer deemed a Qualified Employer by the STATE, subject to the exceptions permitted by federal regulation. CONTRACTOR shall comply with federal regulation regarding guaranteed issue.

ii. accept initial enrollment from a Qualified Employer's new employees, or newly eligible employees as determined 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 applicable law.

iii. 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 applicable law.

iv. adjudicate employee eligibility appeals.

v. collect premium payments from Qualified Employers and 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.

vi. renew Qualified Employers in the same QHP or QHPs (if available) on the twelve (12) month anniversary date of the Coverage Effective Date in accordance with 42 U.S.C. 18024(b)(4)(D) and applicable law, unless the Qualified Employer is no longer eligible for small group coverage and/or the employer has chosen not to renew or has selected another QHP or QHPs.

d. CONTRACTOR shall not impose additional or different requirements upon Enrollees than the requirements for small employers who purchased coverage outside of the Marketplace unless required by law.

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 thirty (30) days prior to the QHP's anniversary date, unless they are determined eligible 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. In accordance with Part 86 of Title 11 of the New York Code of Rules and Regulations, CONTRACTOR must notify the STATE and DFS in the event it suspects or it appears that a Qualified Employer and/or employees have committed fraud.

D. Coverage Effective Date in SHOP

1. As of the Coverage Effective Date, 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.

2. CONTRACTOR shall not be liable for the cost of any services rendered to an Enrollee prior to his or her Coverage Effective Date.

E. Special Enrollment Periods in SHOP

1. CONTRACTOR must provide Special Enrollment Periods consistent with 45 C.F.R. 155.726(c), during which certain Qualified Employees or dependents of Qualified Employees may enroll in QHPs and Enrollees may change QHPs. A dependent of a Qualified Employee is not eligible for a Special Enrollment Period if the Qualified Employer does not extend an offer of coverage to dependents.

2. CONTRACTOR shall provide a Special Enrollment Periods for a Qualified Employee or a dependent of a Qualified Employee in accordance with applicable law if one of the triggering events occur:

   a. A Qualified Individual or his or her dependent either (i) loses minimum essential coverage, (ii) loses pregnancy-related coverage as described under applicable law or loses access to health care services through coverage provided to a pregnant woman's unborn child; or (iii) loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year;

   b. A Qualified Individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption, or placement in foster care, or through a child support order or other court order, or if covered, domestic partnership; or the Enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation, or if the Enrollee or his or her dependent dies;

   c. A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee, or agent of the STATE or HHS, its instrumentalities, or a non-Marketplace entity providing enrollment assistance; 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;

   d. An Enrollee or his or her dependent 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;

   e. A Qualified Individual or Enrollee gains access to new QHPs as a result of a permanent move and had minimum essential coverage for one or more days during the sixty (60) days preceding the date of the permanent move;

   f. A Qualified Individual (i) who gains or maintains status as 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; or (ii) who is or becomes a dependent of an Indian and is enrolled or is enrolling in a QHP on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian;

   g. A Qualified Individual or Enrollee or his or her dependent demonstrates to the STATE, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the STATE may provide.

h. A Qualified Individual or Enrollee (i) is a victim of domestic abuse or spousal abandonment as defined by 26 C.F.R. 1.36B-2T, as amended, or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or (ii) is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

i. A Qualified Individual or dependent applies for coverage through the Marketplace during the Annual Open Enrollment Period or due to a qualifying event, is assessed by the Marketplace as potentially eligible for Medicaid or Child Health Plus (CHP), and is determined ineligible for Medicaid or CHP either after open enrollment has ended or more than 60 days after the qualifying event;

j. The Qualified Individual or Enrollee adequately demonstrates to the Marketplace that a material error related to plan benefits, service area, or premium influenced the Qualified Individual's or Enrollee's decision to purchase a QHP through the Marketplace;

k. A Qualified Employee or dependent of a Qualified Employee loses eligibility for coverage under Medicaid or CHP;

l. A Qualified Employee or dependent of a Qualified Employee becomes eligible for Medicaid or CHP; or

m. Any time after the commencement of pregnancy, as certified by a licensed health care provider, in accordance with the requirements of the NY Insurance Law and NY Public Health Law.

3. In accordance with 45 C.F.R. 155.726(c), a Qualified Employee or dependent of a Qualified Employee who experiences a qualifying event shall have thirty (30) days from the date of the triggering event to select a QHP; excepting the triggering events of (i) loss of eligibility of coverage for Medicaid or CHP; (ii) becoming eligible for coverage for Medicaid or CHP; and (iii) commencement of a pregnancy as certified by a licensed health care provider, which shall provide sixty (60) days from the date of the triggering event to select a QHP.

4. For a QHP selection received by the CONTRACTOR pursuant to a Special Enrollment Period, provided that the premium has been paid:

a. in the case of birth, adoption or placement for adoption, the CONTRACTOR shall ensure that the Coverage Effective Date is the date of birth, adoption, or placement for adoption;

b. in the case of marriage or in the case where a Qualified Individual loses minimum essential coverage, CONTRACTOR must ensure a Coverage Effective Date on the 1st day of the following month.

c. in the case of pregnancy, the first of the month in which the individual received certification of the pregnancy from a licensed health care provider.

IX. 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 a 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 Marketplace, or Certificate of Coverage in the case of the SHOP.

3. The CONTRACTOR must provide Enrollees with an annual notice that the SBC is available upon request.

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. 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 Marketplace 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.

B. Provider Directories

1. The CONTRACTOR shall maintain a provider directory for its QHPs including a listing by specialty of the name, address and telephone number of all participating providers, including facilities, in accordance with NY Insurance Law §§ 3217-a(a)(17) and 4324(a)(17) and NY Public Health Law § 4408(r). In the case of physicians, board certification, languages spoken, wheelchair accessibility and any affiliations with participating hospitals shall be listed. The provider directory should also identify providers that are considered primary care physicians and providers that are not accepting new patients.

2. CONTRACTOR shall post the provider directory on its website and shall update the website within fifteen (15) days of the addition or termination of a provider from the network or a change in a physician's hospital affiliation, in accordance with applicable law.

3. CONTRACTOR shall make its provider directory available to the STATE for publication online and to potential enrollees or Enrollees in hard copy upon request.

4. CONTRACTOR shall notify Enrollees in writing at least annually that updates to its provider directory are available online, and that updates and/or a copy of the directory may be provided in hardcopy upon request.

C. Treatment Cost Calculator for 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 the information required pursuant to applicable law and regulation.

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

1. 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 in the case of the Individual Marketplace; a Certificate of Coverage in the case of the SHOP, and, at the option of CONTRACTOR, a Member Handbook.

2. CONTRACTOR must post all approved Subscriber Contracts on their website so that they are available to prospective enrollees prior to the Annual Open Enrollment period.

X. TERMINATION OF COVERAGE

A. Individual Marketplace

1. Obligations of the STATE

a. The STATE shall permit an Enrollee to terminate his or her coverage in a QHP, including as a result of the Enrollee obtaining other minimum essential coverage. In such case the last day of enrollment is:

i. For terminations received between the first and the fifteenth day of the month, the end of that month;

ii. For terminations received between the sixteenth and the end of the month, the end of the next month. For example, a termination received by the Marketplace on April 17, 2019 would provide a termination date of May 31, 2019;

iii. If the Enrollee is newly eligible for Medicaid, CHP, or the Essential Plan, the last day of coverage is the day before the Medicaid, CHP or Essential Plan coverage begins.

b. In accordance with 45 C.F.R. 155.430(b)(1)(iv), the STATE shall permit an Enrollee to retroactively terminate or cancel his or her enrollment in a QHP in the following circumstances:

i. The Enrollee demonstrates to STATE that he or she attempted to terminate his or her enrollment in a QHP and experienced a technical error that did not allow the Enrollee to terminate his or her enrollment through the Marketplace and requests retroactive termination within sixty (60) days after he or she discovered the technical error;

ii. The Enrollee demonstrates to STATE that his or her enrollment in a QHP was unintentional, inadvertent or erroneous and was the result of misconduct or error

on the part of an officer, employee or agent of the Marketplace or a non-Marketplace entity providing enrollment assistance. The Enrollee must request cancellation within sixty (60) days of discovering the unintentional, inadvertent, or erroneous enrollment.

iii. The Enrollee demonstrates to the Marketplace that he or she was enrolled in a QHP without his or her knowledge or consent by any third-party, including third-parties who have no connection to the Marketplace, and requests cancellation within sixty (60) days of discovering the enrollment.

c. The STATE shall initiate termination of an Enrollee's enrollment in a QHP if Enrollee is no longer eligible for coverage in a QHP, in which case the last day of enrollment is the last day of the month following the month in which the notice is sent by the STATE, unless the Enrollee requests an earlier termination date in accordance with applicable regulation.

d. In accordance with 45 C.F.R. 155.430(c)(2), the STATE shall promptly and without undue delay send Enrollee termination information to CONTRACTOR.

e. The STATE shall permit CONTRACTOR to initiate termination of coverage in the following circumstances:

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

A) The APTC Grace Period has been exhausted as described in 45 C.F.R. 156.270(d),(g) in which case the last day of coverage is the last day of the first month of the APTC Grace Period;

B) The Non-APTC Grace Period has expired, in which case the last day of coverage is the last paid in full date, in accordance with the requirements of Sections 3216 and 4304 of the NY Insurance Law;

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. 155.1080;

iv. The Enrollee changes from one QHP to another QHP during an Annual Open Enrollment Period or Special Enrollment Period, 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; or

v. The Enrollee was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Marketplace.

vi. 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.

vii. CONTRACTOR may in its own discretion reinstate an Enrollee in the event the Enrollee has failed to pay premium and has exhausted all applicable grace periods.

2. Obligations of CONTRACTOR Participating in the Individual Marketplace

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 Marketplace, 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 for initial payment of premium required under this Agreement.

c. 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, as set forth in 45 C.F.R. 155.430(c)(3).

d. CONTRACTOR must maintain records of termination of enrollment in a QHP through the Marketplace and retain these records for a period of ten (10) years to facilitate audit functions.

e. 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 Marketplace.

f. 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.

g. CONTRACTOR is not responsible for providing benefits after the effective date of disenrollment, subject to the requirements of applicable law.

B. Small Business Marketplace

1. Obligations of STATE for Coverage Issued and In Effect Prior to July 1, 2018

As set forth in Section VII of this Agreement [Small Business Marketplace: Eligibility and Enrollment], for coverage issued and in effect prior to July 1, 2018, in addition to determining the eligibility of employers to participate in SHOP, the SHOP processed employee enrollment information and payment remittance. As a result, for QHP coverage that was issued through SHOP and in effect prior to July 1, 2018:

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 Marketplace 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 Marketplace 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 a 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 Marketplace. 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.

c. The STATE may process the termination of a Qualified Employer, in the following circumstances:

i. Qualified Employer elects to discontinue 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 Marketplace has received premium payments;

ii. In accordance with the NY 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 elects to discontinue coverage through the SHOP, the STATE shall ensure that:

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 Marketplace.

iv. In the event the STATE determines a Qualified Employer has committed fraud.

2. Obligations of CONTRACTOR Participating in SHOP for Coverage Issued and in Effect Prior to July 1, 2018

a. CONTRACTOR may only terminate a Qualified Employer and employee as permitted by STATE.

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.

c. If an employee changes from one QHP to another during a 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.

d. If a Qualified Employer decides to discontinue coverage, 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.

XI. RECERTIFICATION / TERMINATION OF QHP AGREEMENT

A. Recertification

1. The STATE shall establish a process for annual recertification of QHPs that includes a review of the general certification criteria outlined at 45 C.F.R. 155.1000(c). Rates and forms must be filed in accordance with DFS processes and timelines. CONTRACTOR may add, remove or modify QHPs during the recertification process in accordance with STATE and DFS instruction.

2. The STATE must complete the QHP recertification process no later than two (2) weeks prior to the beginning of the Annual Open Enrollment Period of the applicable calendar year.

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

4. 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.

B. Non-renewal

In lieu of annual recertification, CONTRACTOR may opt not to renew participation in the Marketplace. CONTRACTOR shall notify the STATE of its decision not to renew in a manner and

timeframe that consistent with applicable 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 Marketplace Customer Service and DFS to facilitate transition.

C. 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 Marketplace 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.

D. Contractor Initiated Termination of Agreement

CONTRACTOR shall notify the Marketplace 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 Marketplace with notice to Enrollees of the conclusion of coverage under this AGREEMENT and the availability of conversion rights pursuant to the Subscriber Contract.

E. State Initiated Termination of Agreement

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

1. the CONTRACTOR substantially fails to meet, perform or observe a material requirement or promise set forth in this Agreement, and/or substantially violates applicable law;

2. there is or has been a breach of the Privacy and Security requirements set forth in this Agreement or the Trading Partner Agreement attached hereto as an Appendix; and/or

3. that CONTRACTOR does not meet financial requirements, except to the extent that a corrective action plan has been approved by DFS.

F. Process for Termination of Coverage

If this Agreement between STATE and CONTRACTOR is terminated for any reason, the CONTRACTOR shall cooperate with STATE to develop a plan which may at the STATE's discretion

include a plan to transition Enrollees to another Contractor in the Enrollee's service area. Such plan must include CONTRACTOR notice to Enrollees in accordance with applicable law, follow-up letters to remind Enrollees to enroll with another health plan, and any other requirement under New York State law.

XII. MEMBER SERVICES

A. CONTRACTOR shall operate a "Member Services" or "Customer Service" department during regular business hours, which must be accessible to Enrollees via toll free telephone number. Customer service representatives must be available during regular business hours to address complaints and utilization.

B. 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

XIII. 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, certified application counselors, Marketplace Facilitated Enrollers, consumer advocates, small businesses, brokers, and other stakeholders to promote enrollment through the Marketplace.

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 Marketplace.

2. CONTRACTOR may maintain a direct link to the Marketplace website on CONTRACTOR's website. The STATE will provide approved links for this purpose.

3. CONTRACTOR shall cooperate with the STATE to educate its agents and brokers about the QHPs available through the SHOP and the Individual Marketplace; and the process for agent and broker training and certification by the Marketplace to sell such QHPs.

4. CONTRACTOR's marketing of QHPs may, particularly during the Annual Open Enrollment Period, include: (i) advertisements in print, radio, television, outdoor advertising and/or social media, (ii) written and electronic communications sent to CONTRACTOR's Enrollees, 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 NY State of Health name and logo designated by the STATE in referring to the Marketplace in marketing and outreach activities including any printed materials.

Such materials must prominently display the Marketplace website and toll-free telephone number. Such materials must be developed in accordance with the Marketplace co-branding guidelines and receive co-branding approval prior to distribution or publication.

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

7. CONTRACTOR shall not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in their QHPs or discriminate on the basis of an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

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 to potential enrollees to enroll in a QHP or renew their coverage (excepting marketing materials of nominal value, such as pens).

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).

XIV. PRIVACY AND SECURITY

1. CONTRACTOR acknowledges and agrees that it is a Covered Entity, as defined in 45 C.F.R. 160.103.

2. CONTRACTOR acknowledges and agrees that the Marketplace is not a Business Associate of the CONTRACTOR in performing its statutorily required functions pursuant to 45 C.F.R. 155.200.

3. CONTRACTOR shall comply with all applicable federal and State laws and regulations to ensure the privacy, security, integrity and availability of PII and PHI received pursuant to this Agreement, including but not limited to the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH").

4. CONTRACTOR shall:

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

b. Maintain information in a timely and accurate manner;

c. Specify and make available to any Enrollee requesting it (i) the purpose for which information is maintained or used, and (ii) to whom and for what purposes information will be disclosed; and

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

5. CONTRACTOR's privacy and security standards shall be consistent with the principles outlined in 45 C.F.R. 155.260(a)(3), specifically: (i) Individual access; (ii) Correction; (iii) Openness and transparency; (iv) Individual choice; (v) Collection, use and disclosure limitations; (vi) Data quality and integrity; (vii) Safeguards; and (viii) Accountability.

6. CONTRACTOR shall safeguard PII and PHI with reasonable operational, administrative, technical and physical controls to ensure its confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure. CONTRACTOR shall monitor, periodically assess and update these controls to ensure their continued effectiveness.

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

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

9. CONTRACTOR shall fully and promptly report to the STATE any use or disclosure of Enrollee information, including PII and PHI, 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 (i) unauthorized access, use, disclosure, modification or destruction of Enrollee information, including PII or PHI, (ii) interference with system operations affecting the exchange of data set forth in this Agreement, and/or (iii) loss of Enrollee information, including PII and PHI, due to the loss or misplacement of hardware, storage devices or paper documents.

XV. REPORTING/DATA COLLECTION

A. General Requirements

1. CONTRACTOR shall establish and maintain the systems and processes to connect to and securely transmit data to, and receive data from the STATE as necessary carry out its responsibilities under this Agreement.

2. 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.

3. 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

1. 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. Each encounter should be recorded in an information system as a unique occurrence between recipient and provider.

2. CONTRACTOR shall submit encounter data 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 shall 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:

(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.

3. CONTRACTOR must make available the amount of Enrollee cost-sharing for in-network services under the individual's QHP 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.

XVI. 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 Alaska Native (AI/AN) 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 if an AI/AN is enrolled in a QHP in the individual market through the Marketplace and is furnished with an item or service directly through an Indian health care provider or through a referral under contract for directly furnishing an item or service to an AI/AN with no cost-sharing in accordance with applicable federal regulations, including 45 C.F.R. 156.430(g), 45 C.F.R. 156.410(a), (b)(2), (b)(3).

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. 156.410(a), (b)(2).

C. CONTRACTOR shall permit an AI/AN or the dependent of an AI/AN on the same application to change from one QHP to another one time per month as described in 45 C.F.R. 155.420(d)(8).

D. CONTRACTOR shall comply with other applicable laws, rules and regulations relating to the provision of Health Care Services to an AI/AN, including the Indian Health Care Improvement Act Sections 206 (25 U.S.C. 1621e) and 408 (25 U.S.C. 1647a)).

XVII. 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.

XVIII. 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.

XIX. OWNERSHIP OF DATA

A. Ownership of Marketplace Data. As between the STATE and CONTRACTOR, all Marketplace Data, as defined below, shall be and will remain the property of the STATE. For purposes of this section, Marketplace Data means data and information created by the Marketplace and relating to the Marketplace, its employees and agents, technology, operations, facilities, consumer markets, products, capacities, systems, procedures, security practices, research, development, business affairs, ideas, concepts, innovations, inventions, designs, business methodologies, improvements, trade secrets, copyrightable subject matter and other proprietary information. Without the STATE's approval (in its sole discretion), the Marketplace Data will not be (1) used by CONTRACTOR or its subcontractors other than in connection with carrying out its obligations under this Agreement; (2) disclosed, sold, assigned, leased or otherwise provided to third parties by CONTRACTOR or its subcontractors other than in connection with carrying out its obligations under this Agreement; or (3) commercially exploited by or on behalf of CONTRACTOR or its subcontractors. CONTRACTOR hereby irrevocably assigns, transfers and conveys, and will cause its subcontractors to assign, transfer and convey to the STATE without further consideration all of its and their right, title and interest in and to the Marketplace Data. Upon request by the STATE, CONTRACTOR will execute and deliver, and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve, or enable the STATE to enforce its rights with respect to the Marketplace Data. Notwithstanding the foregoing, the CONTRACTOR shall be responsible for compliance with all federal or state requirements regarding the security and privacy of Marketplace Data that is within the CONTRACTOR's custody, including the requirements of HIPAA and the NY 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 Marketplace as set forth in this Agreement and in federal and State law and regulation. Upon request by the CONTRACTOR, the STATE will execute and deliver, and will cause its subcontractors and agents to execute and deliver, any documents that may be necessary or desirable under any law to preserve, or enable the CONTRACTOR to enforce its rights with respect to the CONTRACTOR Data. Notwithstanding the foregoing, the STATE shall be responsible for compliance with all federal and state requirements regarding the security and privacy of CONTRACTOR Data that is within the STATE's custody, including the requirements of HIPAA and NY Technology Law.

XX. 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.

Appendix C-1

Marketplace Facilitated Enrollment (FE) Program

For CONTRACTOR that authorizes employees or representatives to provide application assistance to individuals enrolling in QHPs through NY State of Health, The Official Health Plan Marketplace (Marketplace), who are referred to as Marketplace Facilitated Enrollers

I. Background

1. The ACA establishes a streamlined enrollment system for QHPs and all insurance affordability programs (IAPs). The NY State of Health, The Official Health Plan Marketplace (Marketplace) of the New York State Department of Health ("STATE") has developed an integrated application allowing consumers to enroll in any IAP (Medicaid, Child Health Plus, Advance Premium Tax Credits, Cost-Sharing Reductions, and the Essential Plan (Basic Health Program) and QHPs through the Marketplace application. To ensure that consumers have as many opportunities as possible to apply through the Marketplace, STATE is expanding its successful Medicaid and Child Health Plus Health Plan Facilitated Enrollment Program to include QHPs and the Essential Plan.

2. CONTRACTOR's employees and representatives may provide application assistance to individuals applying for coverage through the Marketplace provided that: (i) each individual is trained and authorized as a Marketplace Facilitated Enroller ("Marketplace FE") prior to providing such assistance, and (ii) such authorized Marketplace FEs abide by the requirements outlined below.

II. Obligation of CONTRACTOR

1. CONTRACTOR shall ensure that its employees and representatives complete the Marketplace approved training program regarding QHP options, IAPs, eligibility and benefits rules and regulations governing all IAPs operated in the State, pass an examination to assure successful completion of the training, and are authorized by the Marketplace.

2. CONTRACTOR shall ensure its employees and representatives complete any subsequent training required by the Marketplace, which includes successfully completing annual re-authorization training.

3. CONTRACTOR must establish procedures to ensure that its Marketplace FEs:

    i. Inform applicants of the functions and responsibilities of Marketplace FEs;
    ii. Disclose to potential applicants any relationships the Marketplace FE has with QHPs or IAPs or other potential conflicts of interest;
    iii. Obtain authorization from the applicant prior to obtaining access to an applicant's Personally Identifiable Information (PII) and maintain a record of the authorization in a form and manner determined by the Marketplace; and
    iv. Inform the applicant that he or she may revoke the authorization at any time.

4. CONTRACTOR must establish procedures to ensure that its Marketplace FEs:

    i. Provide information to individual and employee applicants about the full range of QHP options and IAPs for which they are eligible, which includes providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process;
    ii. Assist individual and employee applicants in applying for coverage in a QHP and for IAPs;
    iii. Help facilitate enrollment of eligible individuals in QHPs and IAPs;
    iv. Act in the best interest of the applicant assisted; and
    v. Do not misrepresent the options available to the applicant.

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

6. CONTRACTOR must either directly or through an appropriate referral to an Navigator or non-Navigator assistance personnel or to NY State of Health Customer Service Center, provide or have its staff members and volunteers provide information in a manner that is accessible to individuals with disabilities as defined by the Americans with Disabilities Act, as amended, 42 U.S.C. 12101 et. seq. and section 504 of the Rehabilitation Act, as amended, 29.U.S.C. 794.

7. CONTRACTOR and its Marketplace FEs are prohibited from:

    i. imposing any charge on applicants for application or other assistance related to the Marketplace;
    ii. providing compensation to Marketplace FEs on a per-application, per-individual-assisted, or per-enrollment basis;
    iii. providing gifts, including gift cards or cash, unless they are of nominal value, to any applicant or potential enrollee as an inducement for enrollment. Gifts, gift cards, or cash may exceed nominal value for the purpose of providing reimbursement for legitimate expenses incurred by a consumer in effort to receive NY State of Health application assistance, such as, but not limited to, travel or postage expenses;
    iv. soliciting any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including "cold calling" inquiries or solicitation. "Cold calling" does not include outreach to individuals enrolled in other products or plans offered by CONTRACTOR or to individuals formerly enrolled in products or plans offered by CONTRACTOR; or
    v. initiating any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where CONTRACTOR has a relationship with the consumer and so long as other applicable State and Federal laws are otherwise complied with.

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

9. CONTRACTOR must:

    i. Ensure that only authorized Marketplace FEs submit applications to the Marketplace using their individual identification number. Use of a Marketplace FE identification number by any individual other than the authorized Marketplace FE is strictly prohibited.
    ii. Provide its Marketplace FEs with the equipment necessary to provide in-person application assistance. Except in extraordinary circumstances, applications must be submitted on-line through the Marketplace on-line web portal. Computers must be connected to the internet using one of the following browsers: Internet Explorer Versions 7, 8 or 9, Safari Versions 5 or 6, Google Chrome Versions 18 or 19 or Mozilla Firefox

Versions 12 or 13. All computers used by Marketplace FEs must have supported Operating Systems and the latest security patches installed.

iii. Generally, Marketplace FEs should not provide assistance by telephone. However, under some circumstances, in accordance with guidelines issued by STATE, Marketplace FEs may provide certain assistance by telephone. This includes but is not limited to collecting follow-up information by telephone if it is more convenient for the applicant.

iv. Identity proof the Marketplace FE using instructions provided by STATE if the Marketplace FE fails the on-line identity proofing process used for the Marketplace.

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

10. CONTRACTOR shall implement plans of correction for Marketplace FEs who are not adequately performing their duties under the Marketplace FE program, and shall rescind authorization to act as a Marketplace FE from all employees and representatives who are not adequately performing their duties in accordance with the requirements set forth in this appendix or who are out of compliance with the requirements of the program.

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

12. CONTRACTOR and its Marketplace FEs must refer to the employees and representatives authorized under this appendix only as Marketplace Facilitated Enrollers or Marketplace FEs.

III. Obligations of STATE

1. Provide or approve a comprehensive training program and any subsequent training updates for Marketplace FEs. Training may be delivered by STATE or its designated contractor in person or through on-line training programs.

2. Provide CONTRACTOR with or approve a training curriculum, including a facilitator guide, for use in training its staff members and volunteers.

3. Provide or approve any forms, applications, brochures or other materials needed to provide application assistance and information about the programs available through the Marketplace.

4. Collect information from CONTRACTOR regarding employees or representatives trained and authorized to provide application assistance so that a unique identifier can be created for each Marketplace FE.

5. Provide CONTRACTOR with or approve a form for Marketplace FEs to disclose conflicts of interest.

6. Provide data and reports to CONTRACTOR for use in monitoring Marketplace FE productivity until such time that the organization can generate this information through the Marketplace.

7. Update the list of trained and authorized Marketplace FEs based on information provided by CONTRACTOR, including terminating Marketplace FE accounts when necessary.

APPENDIX D

QUESTIONS AND ANSWERS ON THE 2019 INVITATION

May 30, 2018

May 30, 2018
Quality Requirements

Update: *On May 22, 2018 the posting of the Technical Guidance and User Guide for the 2019 Plan Year and 2019 Quality Improvement Strategy Implementation Plan and Progress Report was updated on the CMS website.*

With the receipt of the above information NYSoH is granting Applicants an extension until June 19th for submission of these documents.

May 25,2018
Quality Requirements - SHOP

Question: Please advise if the interpretation below is correct:

In reviewing the quality requirements for NY SHOP plans, since we would not have any NY SHOP membership until 1/1/2019, we are interpreting the requirements below, as follows - the HEDIS and enrollee survey requirements (QRS) as well as the QIS requirements would not be applicable until the 2020 NYSoH QHP application for the NY SHOP.

It appears we would only be required potentially to submit a Quality Strategy (QS) for the NY SHOP with the 2019 application. Can you please confirm we would not have any quality submission requirements for the 2019 application submission for the NY SHOP?

Answer: We agree that your interpretation is correct, for 2019 you would only need to submit a Quality Strategy.

May 14, 2018

Quality Requirements

Update: ***On the posting of the Technical Guidance and User Guide for the 2019 Plan Year and 2019 Quality Improvement Strategy Implementation Plan and Progress Report.***

We have received additional information from CMS, they understand the time sensitivity of this issue, and are working to publish the QIS guidance. They did indicate there are no substantive changes to the

APPENDIX D

Plan 2019 QIS Guidance or Form.

To expedite issuers' preparation of submissions, CMS recommends using the 2018 Plan Year QIS Implementation Plan and Progress Report form (QIS form).

With the receipt of the above information NYSoH is granting Applicants an extension until June 8th for submission of these documents. We are advising Applicants to use the 2018 Plan Year QIS Implementation Plan and Progress Report Form and the QIS Technical Guidance and User Guide for the 2018 Plan Year for their 2019 submission.

May 9, 2018

Quality Requirements

We are aware the posting of the Technical Guidance and User Guide for the 2019 Plan Year and 2019 Quality Improvement Strategy Implementation Plan and Progress Report have yet to be posted.

We would like to give all Applicants an automatic extension for submission of these documents. We will be requiring the submission of the 2019 QIS Implementation Plan and Progress Report form to be due **4 weeks** from the date of the posting of the CMS resources on their website.

All other plan participation proposal information will still be due on May 25, 2018.

Dental Coverage

Question: Does the plain language description apply to Stand-Alone Dental products as well?

The change for Dental Coverage: includes both QHP & SADP applicants' product descriptions to include a plain language description of what services are included within "Basic" and "Major" dental services.

Answer: This language was added on Page 20 of the invitation under SADP.

APPENDIX D

nystateofhealth™
The Official Health Plan Marketplace

Invitation and Requirements for Insurer Certification and Recertification for Participation in 2019

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

Revised May 22, 2018

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2019 Schedule of Key Events

EVENT	DUE DATE	QHP	SADP	EP
Invitation Released	April 24, 2018	x	x	x
Letters of Interest Due to NYSoH	May 1, 2018	x	x	x
Written Questions Accepted by NYSoH	April 24 – May 24, 2018	x	x	x
Stand-Alone Dental Policy Forms and Rates Due to DFS	May 14, 2018		x	
Medical Policy Forms and Rates Due to DFS	May 14, 2018	x		
Stand-Alone Dental Binders are Due in SERFF	May 21, 2018		x	
Participation Proposals Due to NYSoH	May 25, 2018	x	x	x
Medical Binders are Due in SERFF	June 1, 2018	x		
Provider Network Submission Due to NYSoH	July 23, 2018	x	x	x
DFS Rate Decision Due Date	August 2, 2018	x	x	
Essential Plan Templates Due to NYSoH	August 17.2018			x
Essential Plan Subscriber Agreements Due to NYSoH	August 28, 2018			x
Plans Must Complete Approval of Information in Issuer Portal	September 7, 2018	x	x	x
Certification of Plans by NYSoH	September 28, 2018	x	x	x

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

APPENDIX D



Section I: Introduction and Overview

APPENDIX D

A. Issuing Office and Purpose

This Invitation is issued by the New York State Department of Health ("DOH") to invite:

(i) Insurers offering Qualified Health Plans ("QHPs"), Stand-Alone Dental Plans ("SADPs") and Essential Plans ("EPs"), through NY State of Health, the Official Health Plan Marketplace ("Marketplace"), in 2018, to apply for recertification for 2019; and

(ii) Other insurers that are licensed or certified in New York State to apply for certain health insurance plans to be certified as QHPs, SADPs, and EPs to be offered on the Marketplace in calendar year of 2019.

Following the submission and review of the information required by this Invitation, the DOH will review whether Applicants and their proposed products meet all federal minimum participation standards and other requirements necessary for certification as a QHP, SADP or an EP. Applicants and individual plans found by DOH to satisfy all minimum standards and requirements, and in the case of Applicants applying for the first time, Applicants who sign a new Agreement with the DOH, will have products certified as QHPs, SADPs, or EPs available through the Marketplace. This will be the only opportunity for insurers to apply for certification or recertification of products to be offered on the Marketplace in 2019.

The DOH reserves the right to negotiate with Applicants in the best interest of the Marketplace and its consumers, including, but not limited to, ensuring choice for consumers and small businesses, and to provide continuity of coverage for consumers transitioning between Insurance Affordability Programs.

B. Background

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

NY State of Health, the state's Official Health Plan Marketplace, authorized by the Federal Patient Protection and Affordable Care Act of 2010, was established in April 2012 by Governor Cuomo's Executive Order 42. The NY State of Health Marketplace has successfully increased the affordability and accessibility of health insurance coverage in New York. By January 31, 2018, more than 4.3 million New Yorkers were enrolled in coverage, an increase of 700,000 people from 2017. This increase in coverage has resulted in a historic decline in New York State's uninsured rates, dropping from 10 percent in 2013, to 4.7 percent in 2017.

As of January 31, 2018, 2.9 million New Yorkers were enrolled in Medicaid through NY State of Health and more than 1.3 million people enrolled in a non-Medicaid program through the

Marketplace. This includes 253,102 people enrolled in a Qualified Health Plan; 24,000 of whom enrolled during the six-week extension period between December 15, 2017 and January 31, 2018. In addition, 738,851 individuals were enrolled in the Essential Plan. New York launched the Essential Plan under the Affordable Care Act's Basic Health Program option in January 2016 making comprehensive coverage even more affordable for lower-income New Yorkers. The 2018 Open Enrollment Period finished with nearly 1 million people enrolled in a Qualified Health Plan or the Essential Plan, an increase of 84,000 since the end of open enrollment in 2017.

Applicants can enroll in coverage through NY State of Health online, by telephone, or with the help of an in-person assistor. During the 2018 Open Enrollment Period, more than 2 million New Yorkers visited the NY State of Health website, Customer Service answered more than 1.8 million telephone calls, in 102 different languages, and there were more than 8,158 certified enrollment experts, including navigators, certified application counselors, health plan facilitated enrollers and health insurance brokers who worked with consumers. Through its website, NY State of Health makes available to consumers, an easy to use plan preview, or anonymous shopping tool, which allows individuals to shop for a health plan and to also receive a personalized premium estimate before starting an application.

In 2018, NY State of Health increased efforts to reach non-English speaking residents across the state. The Marketplace continued its comprehensive statewide advertising campaign in English, Spanish, and Mandarin, advertising on tv, radio, digital platforms, and print, including an expanded number of ethnic community publications. Additionally, to reach a diverse range of eligible New Yorkers, the Marketplace arranged more than 470 community outreach and education events, including many focused in non-English speaking communities.

APPENDIX D

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The Official Health Plan Marketplace

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

APPENDIX D

A. Participation Requirements

1. Licensure and Solvency

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

- Be licensed as an insurer under Articles 42 or 43 of New York State Insurance Law or certified under Article 44 of New York State Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or

- Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to November 1, 2018 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 1, 2018.

2. Choice of Participation

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

3. Service Area

Applicants must apply to participate in their entire service area, as approved by the Department of Financial Services ("DFS") or the DOH, at the time of application, provided all requirements of this Invitation are met. Applicants may apply to the DOH for an exception to this requirement by submitting a written request to the DOH explaining the facts that justify the exception.

The DOH reserves the right to grant exceptions to this requirement on a case-by-case basis when it determines that granting such exception is necessary, non-discriminatory and in the best interest of the Marketplace and consumers. Pursuant to 45 CFR § 155.1055, Applicants seeking participation must cover geographic areas that are established without regard to racial, ethnic, language, or health status-related factors, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

4. QHP Applicant Product Offerings

a. Essential Health Benefits

Applicants must agree to provide the Essential Health Benefits ("EHBs") specified by the DOH for calendar year 2019, delineated in Attachment "A." The EHBs must be included in the calculation of the actuarial values of the products.

b. Metal Levels

All products in each metal level must meet the following specified actuarial value ("AV") levels based on the cost-sharing features of the product and determined using the U.S. Department of Health and Human Services ("HHS") AV calculator.

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

Consistent with current federal rules, reflected in 2018 final federal regulation, a *de minimus* variation of -4/+2% AV is permissible, except with respect to the Silver Level CSR (cost-share reduction) variations, which only permits a variation of +/- 1% AV. For purposes of this invitation, standard silver, and non-standard silver level products if offered by the issuer, must have an actuarial value of at least 70%, with a permissible *de minimus* variation of +2% AV. This limit on silver level product variation applies to the Individual Market only, and does not apply to the small business marketplace (SHOP).

c. Standard Products

QHP applicants must offer one (1) standard product in each metal level and in every county of its Marketplace service area. The standard product offered by QHP Applicants must include the benefits and visit limits as delineated in Attachment "A," and the cost-sharing limitations delineated in Attachment "B," with the exception that the wellness benefit may be substituted for (a) different wellness benefit(s) in accordance with federal and state regulation and guidance, as well as DFS review and approval. This requirement applies to the individual market; there is no requirement to offer standard products for the small business marketplace. The standard products for 2019 are provided in Attachment "B."

d. Standard Products With 3 PCP Visits

To align the goals of encouraging appropriate use and access to primary care, QHP Applicants may also offer a standard product with 3 visits to a primary care provider that are not subject to the deductible. Copayments will apply.

For this purpose, primary care visits are defined as visits to a provider whose primary specialty is in family medicine, internal medicine, pediatric medicine, obstetrics/gynecology, outpatient mental health or outpatient substance use.

This additional product will not count towards the number of non-standard products offered by the

QHP Applicant in the individual marketplace. If the QHP Applicant opts to offer this product, it must:

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

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

e. Child-Only Offerings

In accordance with federal regulation, QHP Applicants must agree to offer a child-only product at each metal level described in Section II(A)(4)(b), above, in the individual market. The child-only product must conform to the benefits and visit limits delineated in Attachment "A" and the same cost sharing limitations delineated in Attachment "B." In other words, it must be the standard product required in Section II (A)(4)(b), above, offered at the child-only rate outlined in Section II(B)(4)(b). Only one child-only product is required per metal level. Please note that QHP Applicant's participation in the State's Child Health Plus program does not satisfy this requirement.

f. Catastrophic Products

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

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

An Applicant's decision not to offer catastrophic coverage will be for the entire plan year of 2019.

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

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

g. Out-of-Network Products

An "out-of-network" product, is a product that provides coverage for services rendered by health care providers, that are not in the health insurer's network. QHP Applicants that offer an out-of-network product outside the Marketplace must offer the out-of-network product on the Marketplace, at the

silver and platinum levels. This requirement applies to the individual market only.

QHP Applicants that do not offer an out-of-network product outside the Marketplace are strongly encouraged to offer a QHP on the Marketplace with an out-of-network benefit, so consumers have an option to purchase such a product should they chose to do so. An Applicant may use an additional or different license to offer an out-of-network QHP, provided the different or additional license is for an entity within the same family of companies.

h. Non-Standard Products

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

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

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

Examples of permissible and non-permissible combinations:

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

QHP Applicants that offered a Bronze QHP that was HSA eligible in 2018, will be permitted to offer the HSA Compliant Bronze set forth in Attachment "B" in 2019, to ensure the HSA can carry over for their respective enrollees.

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

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

i. Prescription Drug Coverage

As required under the federal rules, prescription drug coverage must cover at least the greater of:

(i) One drug in every United States Pharmacopeia ("USP") category and class; or

(ii) The same number of prescription drugs in each category and class of the benchmark plan chosen by the state.

All prescription drug information must be submitted to DFS for review. This requirement is not intended to limit the number of drugs that the QHP Applicant may cover in a drug category or class. QHP Applicants are encouraged to develop formularies that exceed the federal requirements when it is determined to be in the best interest of their members.

j. Dental Coverage

Federal law requires coverage for pediatric dental services and permits such services to be covered by health insurers or stand-alone dental carriers. QHP Applicants have the option of embedding pediatric dental coverage within their QHPs, offering QHPs without pediatric dental coverage, or both.

In the event the DOH determines that there is no pediatric stand-alone coverage available in a particular county, all QHP Applicants in that county will be obligated to offer a QHP with embedded pediatric dental coverage.

QHP Applicant's product descriptions must include a plain language description of what services are included within "Basic" and "Major" dental services.

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

APPENDIX D

k. QHP and SADP Naming Conventions

To assist consumers in identifying products and differences between products, QHP and SADP Applicants must use the following naming conventions to identify all QHPs and SADPs offered on the Marketplace, in the order as presented below. Please note that the absence of field name indicates the product DOES NOT include such coverage.

Individual Market

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	This should be the same product name the Applicant uses to market the product.
Metal Tier	Bronze, Silver, Gold, Platinum, Child-Only, Catastrophic	Indicate metal tier using entire the word for metal level.
Standard/ Non-Standard	ST, ST3PCP or NS	Indicate standard, standard with 3 PCP visits or non-standard by using "ST" for standard, ST3PCP for the standard with 3 PCP visits, and "NS" for non-standard.
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Indicate the type of dental coverage embedded in the QHP.
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29.
Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, Other Significant Details	List the general categories of benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank.

Examples of permissible QHP Individual Market names are shown below:

ABC Product, Platinum, ST, INN, Dep25
ABC Product, Gold, ST, INN, Dep29
ABC Product, Silver, NS, OON, Family Dental, Dep29, Family Vision

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Small Business Marketplace

Field Name	Values	Instructions
Product Name	To be assigned by Applicant	This should be the same product name the Applicant uses to market the product.
Metal Tier	Bronze, Silver, Gold, Platinum,	Indicate metal tier using the entire word for metal level.
Network Coverage	INN or OON	Indicate network type using "INN" for in-network and "OON" for out-of-network coverage.
Dental Coverage	Pediatric Dental, Adult/Family Dental	Indicate the type of dental coverage embedded in the QHP.
Dependent Age Coverage	Dep25, Dep29	Indicate the age for dependent coverage by using "Dep25" for dependent coverage through age 25 and "Dep29" for dependent coverage through age 29.
Non-Standard Details	Adult Vision, Family Dental, Family Vision, Wellness, Other Significant Details	List the general categories of benefits and services, in alphabetical order separated by commas, that are not part of the essential health benefits. If none, leave blank.
Domestic Partner	DP	Include only if domestic partners are eligible for coverage.
Family Planning	FP	Include only if the family planning benefit is covered.

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

ABC product, Platinum, ST, INN, Dep25
ABC product, Platinum, ST, INN, Dep29, FP
ABC product, Gold, NS, OON, Adult Dental, Dep29, DP, FP
ABC product, Silver, ST3PCP, ONN, Dep25

I. Effective Dates

All initial and recertified products offered through the Marketplace, will have effective dates of January 1, 2019, in the individual market and the small business marketplace.

Qualified employers will be able to purchase coverage through a small business marketplace-certified insurer at any point during the year.

QHP Applicants, however, will not be able to establish and offer new products at any time during the year. Products to be offered during calendar year 2019, must be established and submitted to DOH and DFS through this Invitation.

APPENDIX D

5. Stand-Alone Dental Applicant Product Offerings

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

SADP Applicant's product descriptions must include a plain language description of what services are included within "Basic" and "Major" dental services.

a. Essential Health Benefits

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

b. The Standard Product

The SADP Applicant must offer one standard pediatric stand-alone dental product in every county of its service area. The standard product offered by the SADP Applicant must include the same pediatric benefits as delineated in Attachment "A." The standard product must comply with federal regulation and DFS guidance. This requirement applies to the individual market.

c. Non-Standard Products

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

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

d. Other Applicable Provisions

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

e.

6. Small Business Marketplace

APPENDIX D

In addition to the above participation requirements, Applicants seeking to participate in the small business marketplace agree to adhere to the following requirements:

a. Definition of a Small Group

Small group is a group that meets the definition of "small group" in the NY Insurance Law, which is currently defined as a group of one hundred (100) or fewer full time equivalent employees ("FTEs") over the prior calendar year with at least one common law employee enrolled as defined by federal regulation, (see 26 CFR § 31.3121(d)-1(c)). An employee does not include a sole proprietor or the sole proprietor's spouse. The small business marketplace will determine the size of the employer by following the definitions set forth by the Department of Financial Services, which can be found on their website at: http://www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm

b. Employer Choice

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

c. Product Offerings

Issuers proposing to no longer offer products in 2019 that were certified in 2018 on the small business marketplace, must inform the NY State of Health by the date Medical Policy Forms and Rates are due to DFS as indicated in the 2019 Schedule of Key Events, explaining the reason for the removal.

There will be no designation of "standard" and "non-standard" products in the small business marketplace. That is, Applicants applying for the small business marketplace in 2019 are not required to offer the standard benefits shown in Attachment "B." Applicants must, however, adhere to metal level actuarial value requirements and must agree to offer at least one product at each metal level on the small business marketplace.

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

d. Minimum Participation and Employer Contribution Standards

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

Insurers may impose minimum participation requirements on renewal outside of the open enrollment period but only to the extent the same requirements were imposed upon the group's initial application for coverage.

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

e. Health Savings Accounts and Health Reimbursement Accounts

Health Savings Accounts ("HSAs") and Health Reimbursement Accounts ("HRAs") are financial mechanisms created under law and regulated by the Internal Revenue Service ("IRS") that provide individuals with tax advantages to offset healthcare costs. HSAs are accounts held by a trustee or custodian (i.e., a bank) on behalf of individuals. HRAs are accounts held solely by an employer on behalf of an employee. For more information, please visit https://www.irs.gov/uac/About-Publication-969

Applicants will be permitted to offer high deductible health plans that meet the IRS requirements and may arrange for the applicable HSA and HRA, if requested by the consumer and/or employer.

f. Payment and Grace Period

Applicants must adhere to the methodology and processes developed by the Marketplace for payment and remittance of premium. Applicants must provide employers purchasing health care coverage through the Small business marketplace with a thirty (30) day payment grace period.

g. Non-Discrimination

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

B. Premium Rates and Policy Form Filings

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

Pursuant to Sections 3201, 3231, 4235, and 4308 of the NY Insurance Law, the New York State Department of Financial Services ("DFS") is authorized and directed to review and approve policy forms and premium rates before such policy forms may be issued or delivered. HHS has determined that New York State has an effective rate review mechanism and, as such, New York State is authorized to conduct rate review pursuant to state standards. Accordingly, pursuant to the requirements of the NY Insurance Law, Applicants must file with DFS proposed policy forms and

premium rates for Marketplace products and obtain the Superintendent's approval of such policy forms and premium rates prior to issuing or delivering such contracts and prior to QHP certification or recertification.

2. Policy Form Filings

All policy forms for QHP products and SADPs shall be submitted to DFS by the date shown in the 2019 Schedule of Key Events, for approval through the System for Electronic Rate and Form Filing ("SERFF") in accordance with instructions established by DFS and HHS.

DFS will update a checklist and instructions for policy form filings, which will be available on the DFS website. Applicants should use the checklist and instructions to ensure that all policy form submissions are complete.

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

3. Rate Filings

All premium rate applications for Marketplace products must be received by DFS on or before the due date shown in the 2019 Schedule of Key Events for SADP Applicants and QHP Applicants.

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

DFS will develop a checklist and instructions for premium rate filings, which will be available on the DFS website. Applicants should use the checklist and instructions to ensure that all rate application submissions are complete.

QHP Applicants must use the updated federal AV calculator when determining whether the Marketplace products meet the actuarial values required for the respective products. HHS has updated the AV calculator, so Applicants must rerun their products through the updated AV calculator to ensure that all proposed products meet the required AV levels. To the extent the AV calculator is not built into the rate templates, Applicants must include in the rate application, a printout from the AV calculator for each Marketplace product submitted and a clear benefit description for each product submitted. The federal AV calculator can be found at http://www.cciio.cms.gov/resources/regulations/index.html#hie.

4. Provisions Applicable to QHP Applicants

a. Rating Tiers

Individual and small group products in New York State are community rated in accordance with state

law, regulations and guidance. QHP Applicants cannot consider age, sex, health status, occupation or tobacco use when establishing premium rates.

All products shall be initially priced to reflect four tiers, with the following relativities:

Tier	Relativities
Single person	1.00
Singe + spouse	2.00
Single + child(ren)	1.70
Single + spouse + child(ren)	2.85

These relativities shall apply to 2019 rates in the individual market and the small business marketplace. The Superintendent of DFS will review and may adjust the relativities for subsequent years.

b. Child-Only Products

In addition to the tiers specified above, QHP Applicants must offer child-only products in conjunction with the standard product designs. Only one child-only product is required per metal level. Separate policy forms must be created and provided to enrollees of child-only products. The child-only rate must be set at 41.2% of the corresponding single rate product. The Superintendent of DFS will review this requirement and may adjust the factor for subsequent years.

c. Risk Adjustment and Reinsurance

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

d. Single Risk Pool Inside and Outside of the Marketplace

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

e. Premium Rate Periods

(i.) Small Group Products: Applicants may use quarterly rolling rates for Marketplace products

offered through the small business marketplace, with a 12-month guarantee for the employer.
For example, if the employer's plan year begins April 1, 2019, the rate provided to that employer will be guaranteed for all employees through March 31, 2020, as well as new employees or special enrollments that occur during the plan year, through March 31, 2020.

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

f. Rating Regions

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

5. Role of Brokers and Agents

To maximize access to health insurance coverage for residents of New York State, brokers and agents (collectively, "Producers") will be permitted to assist both small groups and individuals in purchasing coverage through the Marketplace.

a. Producer Certification

Producers who have successfully completed the training certification program for each applicable market and entered into an agreement with the Marketplace, will be deemed certified to conduct business in the Marketplace. Such agreements will require Producers to be licensed and in good standing with the DFS.

b. Producer Compliance

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

c. Producer Compensation

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

APPENDIX D



Section III: Essential Plans

APPENDIX D

A. Essential Plan Participation Requirements

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

To be eligible for the Essential Plan, individuals must meet the following requirements:

- Be less than age 65 at the beginning of the plan year;
- Reside in New York State;
- Not be eligible for Medicaid or Child Health Plus ("CHP");
- Not be eligible for affordable Minimum Essential Coverage ("MEC"); and
- Have incomes between 138%-200% of the Federal Poverty Level ("FPL") or less than 138% of the FPL and be ineligible for Medicaid due to immigration status.

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

1. Licensure and Solvency

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

Be licensed as an insurer under Articles 42 or 43 of New York State Insurance Law or certified under Article 44 of NY Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or

Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to November 1, 2018 and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by November 1, 2018.

2. Choice of Participation

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

3. Service Area

EP Applicants must apply to participate in their entire service area as approved by the Department of Financial Services ("DFS") or the DOH at the time of application, provided all requirements of this Invitation are met. EP Applicants may apply to the DOH for an exception to this requirement by

submitting a written request to the DOH explaining the facts that justify the exception. The DOH reserves the right to grant exceptions to this requirement, on a case-by-case basis, when it determines that granting such exception is necessary, non-discriminatory and in the best interest of the Marketplace. EP Applicants seeking participation must cover geographic areas that are established without regard to racial, ethnic, language, or health status-related factors, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

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

4. Benefits, Cost-Sharing and Individual Premium Contributions

a. Standard Essential Plans

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

All Standard EPs below are based on the essential health benefits benchmark plan specified by DOH for calendar year 2019, with the following exceptions: pediatric dental will not be included in the benefit, the wellness benefit may be substituted for a different wellness benefit or benefits in accordance with federal and state regulations, guidance and DOH review and approval.

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

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

(ii) For individuals with incomes greater than 138% and less than or equal to 150% of FPL ("Essential Plan 2" in Attachment "H"), EP Applicants must provide the Standard EP. Enrollees will not have a monthly premium for Essential Plan 2 coverage. EP Applicants must also offer a version of this product for the AI/AN population with no cost-sharing for any services.

(iii) For individuals with incomes greater than 100% and less than or equal to 138% of FPL, who are not eligible for Federal Medicaid due to immigration status ("Essential Plan 3" in Attachment "H"), EP Applicants must provide the Standard EP. As required under Section 369-gg of the NY Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 138% of federal poverty, and who

previously qualified for NY Medicaid benefits, EP Applicants must include the following additional benefits: non-prescription drugs, orthotic devices, orthopedic footwear, adult vision care, adult dental. Non-emergency transportation will be covered but administered by DOH. Individuals will not pay any monthly premium for Essential Plan 3 coverage.

(iv) For individuals with incomes at or below 100% of FPL, who are not eligible for Federal Medicaid due to immigration status ("Essential Plan 4", in Attachment "H)", EP Applicants must provide the Standard EP. As required under Section 369-gg of the NY Social Services Law, in order to maintain coverage for legally present non-citizens who have an income at or below 138% of federal poverty, and who previously qualified for NY Medicaid benefits, EP Applicants must include the following additional benefits: non-prescription drugs, orthotic devices, orthopedic footwear, adult vision care, adult dental. Non-emergency transportation will be covered but administered by DOH. Individuals will not pay any monthly premium for Essential Plan 4 coverage and will have no cost-sharing on benefits.

b. Standard Essential Plan Plus Adult Vision/Dental Benefits

For individuals who qualify for Essential Plan 1 and Essential Plan 2, above, EP Applicants may also elect to offer **one** additional EP product that offers the same benefits and cost-sharing as the Standard EP, but that also includes coverage for adult dental and vision benefits as defined in Attachment "H" ("Standard EP Plus Adult Vision/Dental"). These are the only additional benefits that may be added and both benefits **must** be added.

Individual enrollees will pay the applicable Standard EP premium per individual, per month, plus any additional costs for the dental and vision coverage.

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

c. Standard Essential Plan and Stand-Alone Dental Products

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

d. Additional Features of Essential Plans

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

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

chronic health conditions;

(ii) Foster patient involvement in their health care decision-making, including the use of incentives for appropriate health care utilization and patient choice of provider;

(iii) Incentives for the use of preventive services.

e. Essential Plan Naming Conventions

To assist consumers in easily identifying the EP Plans, all EP Applicants must use the same names for their products, and the Marketplace will attach the insurer logo and/or company name on it's website to identify the insurer. The EPs must be labeled as follows (*see* Attachment "H"):

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

Optional EP 1 and 2 Product Variations:

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

f. Effective Dates

Individuals who enroll in the Essential Plan in 2019 will have the following effective dates:

(i) For individuals who have incomes at or below 138% of the FPL, and do not qualify for Federal Medicaid due to immigration status, the effective date of Essential Plan coverage will be the first of the month in which they selected an EP plan. For example, an individual who enrolls in an Essential Plan on February 15, 2019, will have coverage starting February 1, 2019.

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

g. Compensation

EP Applicants who contract with the DOH to offer the Essential Plan on the NY State of Health Marketplace will receive from DOH, a monthly capitation payment for each member that has enrolled in its EP, and will separately collect the applicable premium payment made from enrollees. The capitation payments made to the insurer must be used in accordance with federal and state laws and regulations, including 42 CFR Part 600. EP Applicants will be informed of their monthly capitation payment amount around August 31, 2018.

Essential Plans are subject to the MLR provisions at 85% (*See* Patient Protection and Affordable Care Act § 1331(b)(3); 45 CFR § 158.210(c), 45 CFR § 158.240(b)). The EP Applicant will have ten (10) business days following the determination of its capitation rate to notify the DOH of its final determination on whether to participate in the Essential Plan in 2019.

h. Premium Payment

EP Applicants must accept premium and cost-sharing payments made from third party entities on behalf of a member, including payment from the Ryan White HIV/AIDS Programs under title XXVI of the Public Health Service Act, Indian tribes and tribal organizations, and State and Federal Government Programs.

i. Rating Regions and Risk Adjustment

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

j. Subscriber Agreements and Template Submissions

EP Applicants must use the subscriber agreements that will be provided to them shortly after the release of this Invitation. Revisions to the model language contained in the subscriber agreements will be limited to the bracketed sections of the subscriber agreements. EP Applicants can include their logos and numerical contract-identifying information on agreements. The subscriber agreements must be submitted to the DOH by the due date shown in the 2019 Schedule of Key Events.

EP Applicants must submit the required EP templates to DOH that provide, prescription drug information, links to plan information, service area information, plan rates and contact information. The templates must be submitted to DOH by the due date shown in the 2019 Schedule of Key Events.

k. Non-Discrimination

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

APPENDIX D

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The Official Health Plan Marketplace

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

APPENDIX D

A. Administrative Requirements

1. Enrollment and Member Services

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

QHP Applicants and SADP Applicants must adhere to the open enrollment periods and special enrollment periods established under applicable law and guidance. Enrollment is not effectuated until receipt of initial payment of premium from the prospective enrollee. However, once payment is received, the Applicant must adhere to the grace period standards set forth in federal regulation and DFS guidance for those enrollees receiving advanced premium tax credit assistance. For enrollees in the individual market that do not receive advanced premium tax credit assistance, once the initial premium is paid, the Applicant must provide a thirty (30) day grace period to pay premiums in accordance with DFS guidance.

b. Enrollment Period for the Essential Plan

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

The EP Applicant must provide a ten (10) day initial grace period and a thirty (30) day grace period thereafter to pay the premium. If an enrollee fails to pay their premium within the grace period, the enrollee will lose coverage on the first of the following month. The EP Applicant will continue to receive a capitation payment for the grace period month and EP Applicant will be obligated to cover claims for services incurred during the grace period.

c. Enrollment/Disenrollment Transactions

Applicants must be able to send and receive HIPAA Compliant 834 and 999 transactions in accordance with the 834 and 999 Companion Guide, developed by the DOH and CMS pursuant to law, regulation and guidance. In addition, the NYSOH provides these transactions to insurers on a daily basis and Applicants must process these transactions regularly, and more specifically in accordance with the following timeframes:

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

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

(iii) Effectuation transactions must be sent within five (5) business days of receipt of payment, and must include the insurer-assigned member identification number;

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

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

d. Member Services General Functions

The Applicant must agree to operate a Member Services Department during regular business hours, which must be accessible to Marketplace enrollees via a toll-free telephone line. Personnel must also be available via a toll-free telephone line (which can be the member services toll-free line or separate toll-free lines), not less than during regular business hours, to address complaints and utilization review inquiries.

In addition, the Applicant must have a telephone system capable of accepting, recording or providing instruction in response to incoming calls regarding complaints and utilization review during other than normal business hours and measures in place to ensure a response to those calls the next business day after the call was received.

The DOH may require the Applicant to periodically report member services call statistics such as the number of calls received related to the Marketplace, the number of calls answered and caller wait times.

Applicants must be prepared to adjust member services staff to meet expected performance levels on peak Marketplace volume days.

e. Subscriber Contracts

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

f. Accessibility

Information must be provided to prospective enrollees and enrollees in plain language and in a manner that is accessible and timely to individuals with limited English proficiency ("LEP") and individuals with disabilities, including accessible websites and the provision of auxiliary aids and services at no cost to the individual, in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

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The Applicant and its contractors must:

(i) Provide written materials in a prose that is understood by an eighth-grade reading level and must be printed in at least ten (10) point font type;

(ii) Make available written materials and other informational materials in a language other than English, whenever at least five (5%) of the applicants and/or enrollees of the issuer in any county of the service area speak that particular language and do not speak English as a first language; or, alternatively, in any county of the service area where the applicants and/or enrollees of the issuer speak a common non-English language, the issuer must provide taglines in those languages indicating the availability of written translation of materials in any language the prospective or current enrollee speaks;

(iii) Pursuant to 45 CFR § 155.205(c)(2)(iii), before the beginning of the 2019 open enrollment period, documents and website content that are considered critical (see HHS Technical Guidance, March 30, 2016 at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Language-access-guidance.pdf) for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees or enrollees must include taglines in the top 15 language spoken by the LEP population as determined by the Secretary of HHS (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf);

(iv) Make verbal interpretation services available in any language to current or potential enrollees who speak a language other than English as a primary language. Interpreter services must be offered in person, where practical, but otherwise may be offered by telephone;

(v) Have in place appropriate alternative mechanisms for communicating effectively with persons with visual, hearing, speech, physical or developmental disabilities. These alternative mechanisms include assistive technologies for the visually impaired, TTY access for those with certified speech or hearing disabilities, and use of American Sign Language and/or integrative technologies; and

(vi) To the extent HHS establishes standards on written materials and/or verbal materials for the Marketplace that provides greater protections than the standards set forth above, Applicant shall adhere to such HHS standards.

g. Consumer Complaints

Consumer complaints received through the Marketplace and sent to the Applicant require a response from the Applicant no later than three (3) business days from the day the Marketplace sends the complaint.

If the matter involves an urgent coverage issue, the Applicant must respond and act upon the complaint within twenty-four (24) hours of issuance by the Marketplace.

These timeframes apply regardless of whether the complaint is generated as a result of technical problems with the Applicant's system or technical problems with the Marketplace system.

In the event the complaint involves a technical error by the Marketplace or the Applicant needs a technical transaction to resolve the complaint, the Applicant will work cooperatively and diligently with the Marketplace to ensure the consumer's coverage is not delayed in any way as a result of waiting for the technical issues to be resolved.

B. Marketing Standards

1. New York State of Health Marketing and Outreach

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

2. QHP and EP Applicant Responsibilities

Applicant may conduct advertising campaigns, including but not limited to television, radio, digital, billboards, subway and bus posters. The Applicant may distribute marketing materials in local community centers, health fairs and other areas where potential enrollees are likely to gather.

The Applicant shall use the NY State of Health logo and branding designated by the DOH in referring to Marketplace products in marketing and outreach activities including any printed materials. Such materials must prominently display the Marketplace website and toll-free telephone number. Applicant will cooperate in good faith with DOH's marketing and outreach activities, including the development of advertising materials and descriptive literature for its Marketplace products.

Applicant may not employ marketing practices that will have the effect of discouraging the enrollment of individuals or small businesses with significant health needs in their Marketplace products.

The Applicant shall comply with all provisions of federal and state law regulating advertising material and marketing practices. The Applicant's advertising materials must accurately reflect general information that would be applicable to a Marketplace enrollee. Materials must not contain false or misleading information. Applicants may not offer incentives to potential enrollees to enroll in a Marketplace product or renew their coverage.

The Applicant is prohibited from door-to-door solicitations of potential enrollees or distribution of material, and may not engage in "cold calling" inquiries or solicitation. The Applicant may not require participating providers to distribute Applicant-prepared communications to their patients. Marketing may not take place in patient rooms or treatment areas.

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

C. Network Adequacy

Applicants will establish and maintain a network of participating providers that is consistent with 45 CFR § 156.230 and existing DOH managed care network adequacy standards. Specifically, Applicants must adhere to the following:

1. General Standards

In establishing the network, the Applicant must consider the following: anticipated enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services covered in each product, the number of providers who are not accepting new patients and the geographic location of the providers and enrollees.

To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the enrollee population and to assure that all services will be accessible without undue delay. This includes being geographically accessible (i.e., meeting time/distance standards) and being accessible for people with disabilities.

2. Specific Standards for QHP Applicants and EP Applicants

a. Network Composition

The QHP Applicant's and EP Applicant's network must contain all of the provider types necessary to furnish the Marketplace products, including but not limited to: hospitals, physicians (primary care and specialists), mental health and substance use providers, allied health professionals, ancillary providers, durable medical equipment ("DME") providers, home health providers, and pharmacies. Specifically, the Applicant's network must meet the following minimum standards:

(i) Each county network must include at least one (1) hospital; however, for the following counties and boroughs, the network must include at least three (3) hospitals: Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, Manhattan and Queens;

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

(iii) Provide a choice of three (3) primary care physicians ("PCPs") in each county, but more may be required based on enrollment and geographic accessibility;

(iv) Include at least two (2) of each required specialist provider types in each county, but more may be required based on enrollment and geographic accessibility;

(v) Meet the following time and distance standards:

Primary Care Providers

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

Dental Providers

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

Other Provider Types

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

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

(vii) QHP Applicants and EP Applicants are required to have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in QHP Applicants' and EP Applicants' service area;

(viii) The QHP Applicant and EP Applicant must make every good faith effort to include in its network the essential community providers defined under federal regulation, and at a

minimum, must include in each county network a federally qualified health center and a tribal operated health clinic, to the extent such providers are available;

(ix) QHP Applicants and EP Applicants are required to include individual providers, outpatient facilities, residential treatment facilities, and inpatient facilities in its behavioral health network. The network must include facilities that provide inpatient and outpatient mental health and inpatient and outpatient alcohol and substance use services. Facilities providing inpatient alcohol and substance use services must be capable of providing detoxification and rehabilitation services.

b. Specific Standards for Dental Benefits and Stand-Alone Dental Carriers

The Applicant's dental network shall include geographically accessible general dentists sufficient to offer each enrollee a choice of two (2) primary dentists in their service area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 enrollees. Networks must also include at least two (2) orthodontists, one (1) pediatric dentist and at least one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders ("TMD") and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral.

The network must include dentists with expertise serving special needs populations (e.g. HIV+ and developmentally disabled patients).

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

3. Sanctioned Providers Applicable to All Applicants

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

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

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

4. Method of Review

Network adequacy shall be reviewed by the DOH on a county-by-county basis. For some network adequacy purposes, however, the county may be extended by the DOH in the event the Applicant demonstrates a lack of health care resources or demonstrates that utilization patterns of consumers typically reside outside the county. In such cases, and for rural areas in particular, Applicants may contract with providers in adjacent counties to fulfill the network adequacy requirements, as determined by the DOH.

5. Frequency of Review

The DOH shall review the adequacy of an Applicant's network upon submission of the application, and on a quarterly basis thereafter. Pursuant to NY Insurance Law § 3217-1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), Applicants must update their online directory, as well as their PNDS submission(s) within fifteen (15) days of becoming aware of the addition or termination of a provider from its network, or a change in a physician's hospital affiliation.

6. Submission of the Network

The Applicant shall submit its network through the Provider Network Data System, https://pnds.health.ny.gov, in accordance with instructions issued by the DOH and the Provider Network Submission Instructions set forth in Attachment "Q". Submissions must include out-of-state providers within the Applicant's network and must include arrangements with specialty centers and centers of excellence. The DOH reserves the right to ask for further explanations and/or details in the event the system is not able to capture or accurately identify particular service providers.

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

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

D. Enhancements to Network Information.

In addition to the Network Adequacy requirements set forth in Section IV(C), all Applicants shall adhere to the following, unless otherwise specified:

1. Provider Directories

The Applicant shall maintain an up-to-date listing of providers, including facilities and specialty providers, participating in the products offered through the Marketplace (the "Marketplace Provider Directory"). The Marketplace Provider Directory must include names, office addresses, telephone numbers, board certification for physicians, any affiliations with participating hospitals, information on language capabilities and wheelchair accessibility of participating providers. The Marketplace Provider Directory should also identify providers that are considered Primary Care Physicians and identify providers that are not accepting new patients. Consistent with NY Insurance Law § 3217-1(a)17, NY Insurance Law § 4324(a)(17) and NY Public Health Law § 4408(r), such directories shall be updated within fifteen (15) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

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The Applicant must make available to DOH, a URL link that provides access to the Applicant's Marketplace Provider Directory. The directory must clearly identify the network of providers participating in the Marketplace QHPs, SADPs or EPs. If multiple network configurations are offered by the Applicant, the directories must clearly identify the network(s) for the particular Marketplace product(s). For example, if one network is used for an Applicant's standard QHP products, but a different network is used for one particular non-standard QHP product, the provider directory for the standard product and non-standard product must be distinct and identifiable to a consumer. The directories must distinguish individual network(s) offered by the Applicant so a consumer using the directory can clearly and easily access the correct network via the URL link provided to the Marketplace. For tiered networks, the directory must clearly identify the tier in which the provider participates.

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

2. Verification of Networks and Appointment Availability Standards/Monitoring

a. The Applicant shall provide upon request a process to periodically verify the accuracy of its reported Marketplace provider network(s). Such process may include, but not be limited to, direct outreach to providers listed by the Applicant as participating in Marketplace networks. The Applicant shall provide to the DOH, the method and frequency with which it will carry out such verifications and report to the DOH the results of such verification efforts within a timeframe specified by DOH. The goals of such processes are to validate participation by providers and to make sure providers are aware of their participation in Marketplace networks.

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

3. Addressing Provider Directory Disputes

Applicants must develop and implement protocols to effectively address inquiries and complaints concerning provider directories. Applicants shall provide to the DOH the protocols developed within a timeframe specified by DOH.

4. Treatment Cost Calculators for Participating Providers

The QHP Applicant and EP Applicant must have in place a treatment cost calculator available through an internet website and such other means for individuals without access to the internet. Such treatment cost calculators must be able to demonstrate enrollee cost-sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual.

E. Consumer Network Protections

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

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

(i) QHP Applicants and EP Applicants must hold its members harmless from liability for all out-of-network emergency ("ER") bills. In addition, QHP Applicants and EP Applicants must hold their member harmless from liability for non-emergency ("non-ER") surprise out-of-network bills: (a) for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center where an in-network provider is unavailable, or a non-participating physician renders services without a member's knowledge, or unforeseen medical circumstances arise (unless a participating physician is available and the member chose to obtain services from a non-participating physician); or (b) whenever a participating physician refers a member to an out-of-network provider without the member's written consent.

(ii) QHP Applicants and EP Applicants shall allow their members to request a referral to an out-of-network provider, or request prior authorization to have a service provided by an out-of-network provider, when there is not an appropriate in-network provider available to the member.

(iii) QHP Applicants and EP Applicants must allow members to request:

- A standing referral to a specialist provider when the enrollee's condition requires ongoing care from the specialist provider;
- A referral to a specialist responsible for providing or coordinating the member's care when the member has a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which may require specialized medical care for a prolonged period of time; and
- Direct access to primary care services and preventive obstetric and gynecologic

services within the network of providers without having to obtain a referral.

(iv) QHP Applicants and EP Applicants will provide its members with all grievance, utilization review and external appeal rights, including the ability to appeal a denial for an out-of-network referral and external appeal rights to denials for an out-of-network referral.

(v) QHP Applicants and EP Applicants will provide to its members and to DOH, information on cost-sharing and payments to providers with respect to any out-of-network coverage pursuant to 45 CFR § 156.220(a)(7) and consistent with Part H of Chapter 60 of the Laws of 2014 (the "Out-of-Network Law").

QHP Applicant and EP Applicant may use a treatment cost calculator to provide estimates of out of pocket expenses for receiving services at an out-of-network provider, provided such calculators provide the information required by the Out-of-Network Law. Upon request, QHP Applicant and EP Applicant will provide a URL link to its out-of-network treatment cost calculator.

F. Prescription Drug Benefits

1. Formulary Requirements

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

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

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

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

QHP Applicants and EP Applicants must comply with NY Public Health Law § 4406-c, and NY Insurance Law § 3216(i)(27), § 3221(a)(16) and § 4303(jj). Formularies will be reviewed to ensure the intent of the state law is being followed. QHP Applicants and EP Applicants should not place all prescription drugs to treat a specific condition on the highest tier, or should provide information to DOH or DFS to demonstrate that they are otherwise in compliance with 45 CFR §156.125 which prohibits discriminatory benefit designs.

2. Pharmacy and Therapeutics Committee

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

3. Pharmacy Rules

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

G. Quality and Enrollee Satisfaction

1. QHP Applicant Requirements

a. Quality Rating System

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

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

b. Quality Improvement Strategy ("QIS") or Quality Strategy ("QS")

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

i. Quality Improvement Strategy ("QIS")

QHP Applicants that offered QHP coverage through the Marketplace in 2016 and 2017, and had more than 500 QHP enrollees in a "product" (defined by CMS for this purpose as insurer model, including HMO, EPO, PPO, POS, etc.) as of July 1, 2017, must submit at least one initial QIS **Implementation Plan** and **Progress Report Form for the 2019 Plan Year.**

Applicants must:

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

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

- Activities for improving health outcomes;
- Activities to prevent hospital readmissions;
- Activities to improve patient safety and reduce medical errors;

- Activities for wellness and health promotion; and/or
- Activities to reduce health and health care disparities.

(iii) Adhere to guidelines, including the QIS Technical Guidance and User Guide for the 2019 coverage year, established by Health and Human Services ("HHS"), in consultation with experts in health care quality and stakeholders.

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

QHP Applicants must submit the required QIS information as part of their participation proposal for the 2019 coverage year by completing the required parts of the QIS Implementation Plan and Progress Report forms.

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

ii. Quality Strategy ("QS")

QHP Applicants that did not offer QHP coverage through the Marketplace in 2016 and 2017, or did not have more than 500 enrollees enrolled in a product as of July 1, 2017, must develop a **Quality Strategy ("QS")** that encompasses all the requirements set forth in 1311 (g) of the Affordable Care Act ("ACA"). This strategy must be implemented and updated annually with progress reported to the designated office of the DOH. The quality strategy should describe how the Applicant will address the following:

(i) The implementation of quality improvement activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(ii) The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post discharge reinforcement by an appropriate health care professional;

(iii) The implementation of activities to improve health outcomes, and patient safety, as well as to reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

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

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

(vi) A description of any current or proposed innovative programs to expand access to mental health services including, but not limited to, telepsychiatry or consultative services for co-management of common behavioral health conditions in children and adults.

iii. Quality Reporting System ("QRS")

QHP Applicants must submit quality data collected as part of the Quality Reporting System ("QRS") and QHP enrollee survey requirements to NYS DOH. QHP Applicants should follow the 2018 Quality Rating System Measure Set Technical Specifications. These quality indicators are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance's ("NCQA") Health Care Effectiveness Date and Information Set ("HEDIS").

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

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

iv. Enrollee Satisfaction Survey

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

2. EP Applicant Requirements

a. Quality Strategy ("QS")

EP Applicants must comply with the **Quality Strategy ("QS"),** as outlined above, in Section IV(G)(1)(B)(2).

b. Quality Reporting ("QR")

EP Applicants will be required to participate in the NYS DOH Quality Assurance Reporting Requirements ("QARR"). The quality indicators in QARR are comprised of quality of care and utilization of service measures, largely adopted from the National Committee for Quality Assurance ("NCQA") and the Health Care Effectiveness Data and Information Set ("HEDIS") with New York State specific measures added to address health issues of importance to the state.

QARR data will be used as a major component of plan issuer quality rankings that will appear on the Marketplace website and will also be used in identifying clinical best practices, as well as areas of concern with respect to quality of care and administering the health plan benefit package. The QARR data collected from the plan issuer will also be posted on the DOH website in eQARR and related publications.

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

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

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

c. Satisfaction Survey ("CAHPS")

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

For EP, this information will be collected using a national satisfaction survey methodology called

Consumer Assessment of Healthcare Providers and Systems ("CAHPS").

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

d. Accreditation

The DOH will not require Applicants to be accredited as a condition of participation in 2019.

H. Reporting

1. General

The Applicant will maintain a health information system that collects, analyzes and reports data. The system must be able to report on utilization, claims payment policies and practices, periodic financial disclosures, enrollment and disenrollment information, claim denials, customer service information, rating of provider practices, cost-sharing and payments with respect to out-of-network coverage, prescription drug distribution and cost reporting, quality and customer satisfaction reporting pursuant to the DOH reporting requirements, and any other information requested by the DOH and/or required under applicable federal and state laws or regulations.

2. Timing and Instructions for Reporting

The Applicant must submit required reports to the DOH in a manner consistent with federal requirements under Section 45 CFR Part 156, or as otherwise instructed by the DOH.

3. Encounter Data

Applicants will be required to submit encounter data for all contracted services obtained by each of their members. Encounters are records of each face-to-face interaction a member has with the health care system and includes outpatient visits, inpatients admissions, dental care, emergency room and urgent care visits. Encounters for ordered services, such as pharmacy and labs, shall also be submitted. An encounter is comprised of the procedure(s) or service(s) rendered during the contact and includes information on the site of service and may also include diagnosis information. Each encounter must be recorded in an information system as each unique occurrence between recipient and provider. Encounters must be submitted on at least a monthly or more frequent basis through the DOH designated vendor in a format and manner to be prescribed by the DOH.

4. Financial Reporting

Applicant shall submit financial reports, including certified annual financial statements, and make available documents relevant to its financial condition to the DOH and DFS in a timely manner as

required by state and federal laws and regulations. Applicant must also agree to also submit separate premium and expenditure reports, and any additional relevant financial reports and documents related to its financial condition, in a manner and form required by the DOH.

I. Certification, Recertification and Decertification Processes

1. Certification

The Marketplace will grant certification through SERFF and/or email notice. All Applicants that meet the requirements set forth in this Invitation, will have their health plans certified to be offered through the Marketplace.

2. Decertification

A plan issuer certified by the Marketplace may be decertified if it fails to adhere to the certification standards set forth in this application, fails to resolve state agency sanctions, fails to comply with any applicable corrective action plan, or fails to recertify, and for any other reason set forth in the Agreement between DOH and the issuer applicable law. Decertification of individual products shall occur in accordance with all applicable laws and regulations governing the removal of a product from the market, including notification to enrollees.

3. Non-Renewal

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

4. Suspension

The DOH may suspend enrollment in a health plan in the event a state agency requires suspension, or in the event the DOH determines it is in the best interest of the public. Notification of such suspension shall occur in accordance with applicable laws and regulations.

J. Federal and State Laws and Regulations

1. Federal Laws, Regulation and Guidance

The Applicant shall at all times strictly adhere to all applicable federal laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted, including the following:

- The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, as amended. The two laws are collectively referred to as the Affordable Care Act ("ACA");
- 45 C.F.R. Parts 155 and 156 Marketplace Establishment Standards and Other Related Standards Under the Affordable Care Act, Insurance Standards Under the Affordable Care Act, Including Standards Related to Exchanges;
- Health Information Technology for Economic and Clinical Health Act of 2009;
- Health Insurance Portability and Accountability Act of 1996;
- The Privacy Act of 1974; and
- 42 CFR Part 600 and other related guidance and instruction;

2. State Laws and Regulations

The Applicant shall at all times strictly adhere to all applicable state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted. Applicant acknowledges that such laws include, but are not limited to the following:

Contracts/Insurance Companies and Non-Profit Medical and Dental Indemnity Corporations

- The Privacy Act of 1974;
- N.Y. Insurance Law § 3201, 11 N.Y.C.R.R. 52.1, et. seq. (Approval of Policy Forms);
- N.Y. Insurance Law § 3231 (Rating of Individual and Small Group Health Insurance Policies; Approval of Superintendent);
- N.Y. Insurance Law § 4308 (Supervision of Superintendent);
- N.Y. Insurance Law § 4235, 11 N.Y.C.R.R. 52.2 (Group Accident and Health Insurance);

Access to Care

- N.Y. Public Health Law § 4403(5)(a), 10 N.Y.C.R.R. 98-1.13(b) (Health Maintenance Organizations, Network Adequacy);
- N.Y. Public Health Law § 4403(6)(a), 10 N.Y.C.R.R. 98-1.13(a) (Health Maintenance Organizations, Access to Appropriate Providers);
- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.13(j) (Health Maintenance Organizations, Emergency Health Services);
- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.6, 10 N.Y.C.R.R. 98-1.12 (Health Maintenance Organizations, Quality Management Program);
- N.Y. Insurance Law § 4325 (Prohibitions);
- N.Y. Insurance Law § 3224-a (Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments of Health Care Services);
- The Out-of-Network Law, Chapter 60 of the Laws of 2014;
- Health Insurance Coverage for the Treatment of Gender Dysphoria, DFS Insurance Circular - Letter No. 7 (2014) (found here:

http://www.dfs.ny.gov/insurance/circltr/2014/cl2014_07.pdf);

- Changes in Utilization Review Standards for Substance Use Disorder Treatment Pursuant to Chapter 41 of the Laws of 2014;
- Updated FAQs Regarding 18 Approved Forms of Contraception Issued by CMS May 11, 2015 (found here: http://www.dol.gov/ebsa/faqs/faq-aca26.html);

Access to Information

- N.Y. Public Health Law § 4403(2), 10 N.Y.C.R.R. 98-1.16 (Disclosure and Filing);
- N.Y. Public Health Law § 4405-b (Duty to Report);
- N.Y. Public Health Law § 4408 (Disclosure of Information);
- N.Y. Public Health Law § 4910 (Right to External Appeal);
- N.Y. Insurance Law § 4323 (Marketing Material); and
- N.Y. Insurance Law §§ 3217-a and 4324 (Disclosure of Information).

3. Medicaid and Child Health Plus Programs

Applicants that also participate in the Medicaid Managed Care Program and the Child Health Plus Program shall adhere to the requirements of the respective programs. Nothing contained herein shall be interpreted to supersede the laws, regulations, guidance or instructions issued under the Medicaid Managed Care Program and Child Health Plus Program.

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Section V: Application Process

APPENDIX D

A. Issuing Agency

As stated in Section I (A), this Invitation is issued by the DOH. DOH is responsible for the requirements specified herein and for processing all Applications in partnership with the DFS. This Invitation has been posted on the DOH Marketplace informational website.

DOH shall review Applications in an objective, comprehensive manner designed to benefit both the Marketplace and Applicants. The DOH intends that all Applications will be reviewed uniformly and consistently. For the purpose of its review, the DOH may seek assistance from any person, other than one associated with an Applicant.

B. Letters of Interest

Applicants are requested to submit non-binding Letters of Interest as soon as possible, but no later than the date set forth in the 2019 Schedule of Key Events, via electronic or regular mail at the addresses set forth in paragraph "C" below. Submission of the Letter of Interest does **not** bind a prospective Applicant to submit an Application.

If an Applicant would like to receive e-mail notification of updates/modifications to the Invitation, including the issuance of DOH responses to questions raised regarding the Invitation, the Applicant may include such request in their Letter of Interest.

A form Letter of Interest is attached to this Invitation as Attachment "F" for QHP Applicants, EP Applicants, SADP Applicants and Small Business Market (SHOP) Applicants. Please indicate which offerings you are interested in participating in for 2019.

C. Inquiries

All responses and requests for information concerning this Invitation by a prospective Applicant, or an Applicant, or a representative or agent of a prospective Applicant, or Applicant, should be directed to the contact listed below.

In order for DOH to address questions efficiently, prospective Applicants are requested to send their inquiry in writing by email to the address below.

Inquiries of a technical nature may result in either a written response or a referral to the appropriate individual for a verbal response. To the extent possible, written questions concerning a specific requirement of the Invitation should cite the relevant section of the Invitation for which clarification is sought.

Questions of this nature will be responded to by the DOH in writing and such questions and answers will be posted on the NY State of Health website (nystateofhealth.ny.gov), unless the party

submitting a question demonstrates that the question/answer will contain confidential and/or proprietary information.

NAME: Invitation Administrator

EMAIL: nyhxpm@health.ny.gov

ADDRESS: NY State of Health
NYS Department of Health
Corning Tower, Suite 2378
Albany, New York 12237

D. Changes to the Application

The DOH reserves the right to:

- Withdraw the Invitation at any time, at the DOH's sole discretion;
- Disqualify any Applicant whose conduct and/or Application fails to conform tothe requirements of this Invitation;
- Seek clarifications and revisions of Applications. The DOH may require clarification from individual Applicants to assure a complete understanding of the Application and/or to assess the Applicant's compliance with the requirements in this Invitation; and
- At any time during the Invitation process, amend the Invitation to correct errors or omissions, and to supply additional information. Prospective Applicants are advised that at any time during the course of this application process, pertinent federal and state laws, regulations, and rules may change, and the protocol for using required systems such as SERFF and the PNDS website may change. In addition, scheduled dates may need to be adjusted. All Prospective Applicants and Applicants will be informed of such changes, and Applicants may be directed to supply additional information in response to such amendments.

E. Submission of the Application

1. Application Contents

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

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For QHP Applicants and Stand-Alone Dental Plan Applicants:

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

For EP Applicants:

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

Each of the component parts must be received by the due dates set forth in the 2019 Schedule of Key Events, listed in this Invitation. Late submissions may not be accepted.

2. Instructions

a. Participation Proposals

Applicants shall submit two (2) original, signed copies of the Participation Proposal by mail or hand delivery to the address listed above in Section V (C). Electronic submissions are also required and can be sent to the email address noted in Section V (C). Participation Proposals will not be accepted by fax. The Participation Proposal must be signed and executed by an individual with legal authority to bind the Applicant to the authenticity of the information provided. The Participation Proposal Form to be completed and submitted by Applicants is attached to this Invitation as Attachment "G" (QHP Applicants and SADP Applicants) and Attachment "K1" (EP Applicants).
Applicants). Applicants applying to offer both QHPs and EPs must complete **both** Attachments.

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

As set forth in Section II(B), Marketplace products, rates and policy forms must be submitted to DFS per DFS instruction, which will be available on the DFS website.

c. Submission of Subscriber Agreements and Templates to DOH for EP Applicants

As set forth in Section II (B), EP Applicants will be required to submit EP Subscriber Agreements to DOH. EP Applicants will also be required to submit plan information via DOH required templates. Policy forms and templates must be sent directly to the Applicant's assigned Plan Manager by the due date indicated in the 2019 Schedule of Key Events.

d. Submission of Provider Network Information

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

e. Submission of Quality Improvement Strategy or Quality Strategy

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

f. Vendor Responsibility

On or around the same time that Applicants submit forms and rates, Applicants will be notified of their responsibility to complete the New York State "vendor responsibility" process through the New York State VendRep System. The VendRep system instructions are available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at https://portal.osc.state.ny.us. For questions about the VendRep Systemcontact 866-370-4672 or 518-408-4672 or ITServiceDesk@osc.state.ny.us

g. Submission of HHS Form 690, Assurance of Compliance

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

F. Public Information

Disclosure of information related to this Invitation process and resulting contracts shall be permitted consistent with the laws of the State of New York and specifically the Freedom of Information Law (FOIL) contained in Article 6 of the NY Public Officers Law. Information constituting trade secrets or information that if disclosed would cause substantial injury to the competitive position of the subject enterprise, for purposes of FOIL, shall be clearly marked and identified as such by the Applicant upon submission. Determinations regarding disclosure will be made when a request for such information is received by the DOH Records Access Office.

G. Agreement with DOH

Following completion of the activities outlined in this Invitation and having been determined to have

met all the requirements, the DOH will provide Applicants with an Agreement. The Agreement resulting from this Invitation will be effective only upon approval by the New York State Office of the Attorney General (OAG) and the Comptroller of the State of New York (OSC). Applicants must enter into an Agreement with the DOH for their products to be certified and offered through the Marketplace.

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Section VI: Attachments

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Attachment Designation	Attachment Name
Attachment "A"	2019 QHP Essential Health Benefits
Attachment "B"	2019 Standard Products Cost-Sharing Chart
Attachment "C"	2019 QHP Standard Product With 3 PCP Visits Cost-Sharing Chart
Attachment "D"	QHP and SADP Rating Regions by County
Attachment "E"	QHP and SADP Rating Regions Map
Attachment "F"	2019 Letter of Interest
Attachment "G (1)"	2019 QHP and SADP Participation Proposal
Attachment "G (2)"	2019 QHP Non-Standard Product Offering Details
Attachment "G (3)"	2019 QHP Products Offered by County and Market
Attachment "G (4)"	2019 SADP Products Offered by County and Market
Attachment "H"	EP Benefits and Cost-Sharing Chart
Attachment "I"	EP Rating Regions
Attachment "J"	EP Rating Regions Map
Attachment "K (1)"	2019 EP Participation Proposal
Attachment "K (2)"	2019 EP Products Offered by County
Attachment "L"	2019 EP Template Instructions
Attachment "M"	2019 EP Admin Template
Attachment "N"	2019 EP Plans Template
Attachment "O"	2019 EP Rates Template
Attachment "P"	2019 EP Service Area Template
Attachment "Q"	2019 Provider Network Submission Instructions

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Section VII: Definitions

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For purposes of this Invitation:

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

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

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

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

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

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

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

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

"Marketplace shall mean NY State of Health, The Official Health Plan Marketplace (formerly known as the New York Health Benefit Exchange or Exchange) established within the New York State Department of Health pursuant to Executive Order Number 42 on April 12, 2012.

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

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

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"Personally Identifiable Information" ("PII") shall mean information that can be used to distinguish or trace a person's identity, such as their name, social security number, etc., alone or when combined with other personal or identifying information that is linked or linkable to a particular individual.

"Protected Health Information" ("PHI") shall refer to individually identifiable health information as defined in 45 CFR 164.402.

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

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

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

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

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

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

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

"Small Business Marketplace" (a/k/a the "Small Business Health Options Program, or SHOP") shall mean the Small Business Health Options Program, as defined at ACA § 1311 (b)(1)(B) and 45 C.F.R. Part 155.
"Small Employer" shall mean an employer with 1-100 FTE employees.

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

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

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

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ATTACHMENT G (1)

2019 PARTICIPATION PROPOSAL
QUALIFIED HEALTH PLANS AND STAND-ALONE DENTAL PLANS

All Applicants must submit the following information to the e-mail address set forth in Section V (C) of the Invitation. Answers should be completed within this Participation Proposal Form, unless otherwise directed.

1. Participation.

Indicate below whether Applicant is participating in the Individual Marketplace, Small Business Marketplace or both, and the type of Applicant. If the Applicant is applying as both a Health Insurer Applicant and a Stand-Alone Dental Applicant, submit two separate participation proposals.

PARTICIPANT TYPE		EXCHANGE	
■	Health Insurer Applicant	☐	Individual
☐	Stand-Alone Dental Applicant	■	SHOP

2. Organization

a) Identify below the legal entity that will be responsible for offering products in each Exchange and its current license or certification. If Applicant anticipates licensure prior to November 1, 2018, identify what type of licensure is anticipated.

Healthfirst Insurance Company, Inc. which is licensed as an accident and health insurer pursuant to Article 42 of the NY Insurance Law.

b) Identify whether the same legal entity currently contracts with the State Department of Health for the Child Health Plus and/or Medicaid Program, and if so, identify the program(s).

Healthfirst Insurance Company, Inc. does not contract with the State Department of Health for Medicaid and Child Health Plus.

c) Identify any entities that will be involved in the administration of the QHPs and briefly describe the roles of such entities. Include in this section any entity the Applicant is using to satisfy coverage of essential health benefits (e.g., pediatric vision), and for Health Insurer Applicants, any entity used to satisfy the provision of offering out-of-network benefits.

The following vendors will be involved in the administration of the Exchange products:

- **HF Management Services, which provides administrative and management services;**
- **American Specialty Health, which administers chiropractic benefits and the fitness incentive program;**
- **Beacon, which provides autism services;**
- **eviCore, which provides utilization management for radiology and radiation therapy services;**
- **Caremark, which administers pharmacy benefits;**
- **Davis Vision, which provides vision services;**
- **DentaQuest, which provides dental services;**
- **Teladoc, which provides general medicine telemedicine services**

3. **Summary of Products Offered**

a) Health Insurer Applicants, indicate the total number of products at each metal level (do not include catastrophic products and child-only products) that you are proposing to offer in the Marketplace:

INDIVIDUAL EXCHANGE		SHOP EXCHANGE	
Metal Tier	Number	Metal Tier	Number
Bronze		Bronze	4
Silver		Silver	4
Gold		Gold	4
Platinum		Platinum	2

b) Identify whether Health Insurer Applicant will be offering an additional Bronze product in 2019 with HSA eligibility that was offered in 2018:

☐ Yes ■ No

c) Identify whether the Health Insurer Applicant will be offering the Standard with 3 PCP Visits products in 2019:

☐ Yes ■ No

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

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

4. **Proposal Attachment Submissions**

a. <u>Health Insurer Applicants:</u>

(i) Provide the following information:

- ***Attachment G (2)*** - For each Non-standard product, regardless of whether it was offered in 2018, complete Addendum G (2), 2019 Non-Standard Product Descriptions and describe how the benefit is being modified per Section II (A)(4)(h) of the Invitation.

  Attachment G (3) - For <u>each</u> Standard and Non-Standard Product offered through the Individual Marketplace, provide the Name of the Applicant and place an x in each box indicating each product you will offer in each county. If you are proposing to enter a new county in 2019, highlight the row in yellow indicating the new county. If you are proposing to offer a new product for 2019 (i.e. a new non-standard product), highlight the column(s) containing the new product(s) in yellow. If you are proposing to leave a county in 2019, highlight the corresponding cells for each product and county in red.

- Provide a list of each standard and non-standard product offered in the Marketplace by using the Product Name (including the naming convention outlined in the Invitation) and the 14 digit HIOS ID. The listing must be provided in excel spreadsheet format and one tab must be used for the Individual Marketplace and a separate tab for the Small Business Marketplace as applicable.

(ii) DOH reserves the right to request a copy of all final documents submitted through SERFF and approved by DFS as part of the Rate and Form Filings.

Copies may be needed by the DOH for review of consistency with this Application, archival purposes, and to ensure that benefit and rate information is displayed accurately and timely on the Marketplace.

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

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

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

d) Stand-Alone Dental Applicants

(i) Provide the following information:

- ***Attachment G (4)*** - Provide the name of Applicant and place an x in each box indicating which product(s) you will offer in each county. If you are proposing to enter a new county in 2019, highlight the cell in yellow indicating the new county. If you are proposing to offer (a) new product(s) for 2019 (i.e. offering EP for the first time, or offering a new non-standard product), highlight the column(s) with the new product(s) in yellow. If you are proposing to leave a county in 2019, highlight the cell in red, indicating a product removal.

- Provide a list of each standard and non-standard product offered in the Marketplace by using the Product Name and the 14 digit HIOS ID. The listing must be provided in excel spreadsheet format and one tab must be used for the Individual Marketplace and a separate tab for the Small Business Marketplace as applicable. Clearly identify the products as Pediatric only or Adult/Family.

5. **URL links**

Provide URL links for the following areas:

- Plan Brochures/QHP Descriptions (if applicable)

  Product descriptions can be found at: http://www.healthfirst.org/healthfirst-qualified-health-plans.html.

- Summary(ies) of Benefits

  Summaries of Benefits & Coverage (SBC) can be found at: http://healthfirst.org/healthfirst-summary-of-benefits/.

- Provider Directory

  The provider directory can be accessed at www.hfdocfinder.org.

- Pharmacy Formulary

  The Pharmacy Formulary can be accessed at www.healthfirst.org/formulary.

- Treatment Cost Calculator

  The Treatment Cost Calculator can be accessed at http://hfcostlookup.org/.

6. **Plan Contacts**

Provide a contact who will be responsible for each of the areas identified below. Include their name, title, telephone number and email address:

- **Product/form submissions**
  Shawn Nowicki
  Director, Regulatory Affairs
  (212) 801-6210
  snowicki@healthfirst.org

- **Network adequacy**
  Shpresa Basha
  Manager, Provider Data Reporting
  (212) 401-8457
  sbasha@healthfirst.org

- **Provider Directories**
  Nancy Famiglietti
  Director, Credentialing
  (212) 801-1450
  NFamiglietti@healthfirst.org

- **Quality submissions**
  Rebecca Schwietz
  Senior Vice President, Clinical Services
  (212) 801-1667
  Rschwietz@healthfirst.org

- **Customer Service/Call Center Issues**
  Kimberly O'Connor
  VP, Call Center Operations & Member Services
  (212) 801-1639
  koconnor@healthfirst.org

- **Pharmacy submissions**
  Bhavesh Modi
  VP, Pharmacy
  (212) 209-6442
  BModi@Healthfirst.org

- **Enrollment Transactions**
  Rachel Sylvester
  VP, Enrollment & Billing
  (212) 453-7772
  RSylvester@Healthfirst.org

- **Billing issues**
  Rachel Sylvester
  VP, Enrollment & Billing
  (212) 453-7772
  RSylvester@Healthfirst.org

- **Encounter submissions**
  Uday Joshi
  AVP, Encounters & DA
  (212) 823-2419
  ujoshi@healthfirst.org

APPENDIX D-1

ATTESTATION TO PARTICIPATION PROPOSAL

The following must be signed and executed by an individual with the capacity and legal authority to bind the Applicant to the authenticity of the information provided.

I, ____Linda V. Tiano_____, hereby attest that I have been duly authorized to execute this Participation Proposal on behalf of Applicant, and to the best of my knowledge, the information and data provided by Applicant in response to the Invitation and Requirements for Participation in the NY State of Health, the Official Health Plan Marketplace (the "Invitation") is accurate, true, and complete. I understand that the NY State of Health will rely on my statements above in reviewing the Participation Proposal and the related information and data submitted in response to the Invitation. In completing the certification process set forth in the Invitation, Applicant shall, at all times, strictly adhere to all applicable federal and state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted.

_Linda V. Tiano_____
Print Name

_Chief Legal Officer_____
Print Title

Linda V Tiano
Signature

5/25/18
Date

APPENDIX D-1

nystate of health
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ATTACHMENT G (1)

2019 PARTICIPATION PROPOSAL
QUALIFIED HEALTH PLANS AND STAND-ALONE DENTAL PLANS

All Applicants must submit the following information to the e-mail address set forth in Section V (C) of the Invitation. Answers should be completed within this Participation Proposal Form, unless otherwise directed.

1. Participation.

Indicate below whether Applicant is participating in the Individual Marketplace, Small Business Marketplace or both, and the type of Applicant. If the Applicant is applying as both a Health Insurer Applicant and a Stand-Alone Dental Applicant, submit two separate participation proposals.

PARTICIPANT TYPE		EXCHANGE	
■	Health Insurer Applicant	☐	Individual
☐	Stand-Alone Dental Applicant	■	SHOP

2. Organization

a) Identify below the legal entity that will be responsible for offering products in each Exchange and its current license or certification. If Applicant anticipates licensure prior to November 1, 2018, identify what type of licensure is anticipated.

Healthfirst Insurance Company, Inc. which is licensed as an accident and health insurer pursuant to Article 42 of the NY Insurance Law.

b) Identify whether the same legal entity currently contracts with the State Department of Health for the Child Health Plus and/or Medicaid Program, and if so, identify the program(s).

Healthfirst Insurance Company, Inc. does not contract with the State Department of Health for Medicaid and Child Health Plus.

c) Identify any entities that will be involved in the administration of the QHPs and briefly describe the roles of such entities. Include in this section any entity the Applicant is using to satisfy coverage of essential health benefits (e.g., pediatric vision), and for Health Insurer Applicants, any entity used to satisfy the provision of offering out-of-network benefits.

The following vendors will be involved in the administration of the Exchange products:

- **HF Management Services, which provides administrative and management services;**
- **American Specialty Health, which administers chiropractic benefits and the fitness incentive program;**
- **Beacon, which provides autism services;**
- **eviCore, which provides utilization management for radiology and radiation therapy services;**
- **Caremark, which administers pharmacy benefits;**
- **Davis Vision, which provides vision services;**
- **DentaQuest, which provides dental services;**
- **Teladoc, which provides general medicine telemedicine services**

3. **Summary of Products Offered**

a) Health Insurer Applicants, indicate the total number of products at each metal level (do not include catastrophic products and child-only products) that you are proposing to offer in the Marketplace:

INDIVIDUAL EXCHANGE		SHOP EXCHANGE	
Metal Tier	**Number**	**Metal Tier**	**Number**
Bronze		**Bronze**	4
Silver		**Silver**	4
Gold		**Gold**	4
Platinum		**Platinum**	2

b) Identify whether Health Insurer Applicant will be offering an additional Bronze product in 2019 with HSA eligibility that was offered in 2018:

☐ Yes ■ No

c) Identify whether the Health Insurer Applicant will be offering the Standard with 3 PCP Visits products in 2019:

☐ Yes ■ No

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

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

4. **Proposal Attachment Submissions**

a. Health Insurer Applicants:

(i) Provide the following information:

- ***Attachment G (2)*** - For each Non-standard product, regardless of whether it was offered in 2018, complete Addendum G (2), 2019 Non-Standard Product Descriptions and describe how the benefit is being modified per Section II (A)(4)(h) of the Invitation.

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d) Stand-Alone Dental Applicants

(i) Provide the following information:

- ***Attachment G (4)*** - Provide the name of Applicant and place an x in each box indicating which product(s) you will offer in each county. If you are proposing to enter a new county in 2019, highlight the cell in yellow indicating the new county. If you are proposing to offer (a) new product(s) for 2019 (i.e. offering EP for the first time, or offering a new non-standard product), highlight the column(s) with the new product(s) in yellow. If you are proposing to leave a county in 2019, highlight the cell in red, indicating a product removal.

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- **Quality submissions**
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- **Customer Service/Call Center Issues**
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_Linda V. Tiano_____
Print Name

_Chief Legal Officer_____
Print Title

Linda V Tiano
Signature

5/25/18
Date

:RIPTIONS
be offered in 2019)

[redacted]								FILL OUT THESE TWO DEDUCTIBLE DIFFERS I PROI
Premium Amount - Higher or Lower than Standard	Benefit/Service addition(s) Y/N	Description of benefit addition(s)	Benefit/Service substitution(s) Y/N	Description of benefit substitution(s)	Benefit/Service alteration(s) Y/N	Description of benefit/service alteration(s)	Deductible same as standard? Y/N	Individual deductible for standard product
Higher	Y	Telemedicine, Adult Dental, Adult Vision	N	NONE	N	NONE	N	$4,000
Higher	Y	Telemedicine, Adult Dental, Adult Vision	N	NONE	N	NONE	N	$4,000
Higher	Y	Telemedicine, Adult Dental, Adult Vision	N	NONE	N	NONE	N	$1,700
Higher	Y	Telemedicine, Adult Dental, Adult Vision	N	NONE	N	NONE	N	$1,700
Higher	Y	Telemedicine, Adult Dental, Adult Vision	N	NONE	N	NONE	N	$600
Higher	Y	Telemedicine, Adult Dental, Adult Vision	N	NONE	N	NONE	N	$600
Higher	Y	Telemedicine, Adult Dental, Adult Vision	N	NONE	N	NONE	Y	
Higher	Y	Telemedicine, Adult Dental, Adult Vision	N	NONE	N	NONE	Y	

N-STANDARD DESCRIPTIONS ndard products to be offered in 2019)	

				COST SHARING AMOUNTS (list amount if different from standard product; if same write "same")								
e as Y/N	Individual MOOP for standard product	Individual MOOP for proposed non-standard product	Description of Network (if not offering entire available network; e.g., tiered network)	PCP visit	Specialist visit	Prescription drug Tier 1	Prescription drug Tier 2	Prescription drug Tier 3	Inpatient svcs	ER visit	Urgent care visit	DME
	$7,600	$8,000	Same as standard products	$30	same	$8	$60	$95	same	same	same	same
	$7,600	$8,000	Same as standard products	$30	same	$8	$60	$95	same	same	same	same
	$7,500	$7,900	Same as standard products	same	same	$7	$50	$100	same	same	same	same
	$7,500	$7,900	Same as standard products	same	same	$7	$50	$100	same	same	same	same
	$4,000	$5,000	Same as standard products	$20	same	$7	$50	$100	same	$175	same	same
	$4,000	$5,000	Same as standard products	$20	same	$7	$50	$100	same	$175	same	same
	$2,000	$2,000	Same as standard products	$10	$40	$5	$50	$85	same	same	same	same
	$2,000	$2,000	Same as standard products	$10	$40	$5	$50	$85	same	same	same	same

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NON-STANDARD DESCRIPTIONS n-standard products to be offered in 2019)	

COST SHARING AMOUNTS (list amount if different from standard product; if same write "same")							
Diagnostic & Routine Imaging	Outpatient Surgery Physician/Surgical Services	Home Health Care	O/P Behavioral Health	Pediatric Basic Dental Care (if offered)	Pediatric Vision Care (Routine eye exam for children)	Wellness	Offered in entire service area? (If no, please provide details in the additional description field)
same	same	same	same	same	same	same	
same	same	same	same	same	same	same	
same	same	same	same	same	same	same	
same	same	same	same	same	same	same	
same	same	$20	$20	$20	$20	same	
same	same	$20	$20	$20	$20	same	
$40	same	$10	$10	$10	$10	same	
$40	same	$10	$10	$10	$10	same	

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***Additional description - please use narrative to describe how NS plan differs from standard, if not already captured by previous columns
Telemedicine, Adult Dental and Vision, lower generic Rx copay, Reduce mail order copay from
Telemedicine, Adult Dental and Vision, lower generic Rx copay, Reduce mail order copay from
Telemedicine, Adult Dental and Vision, lower generic Rx copay, all PCP copays are not subject
Telemedicine, Adult Dental and Vision, lower generic Rx copay, all PCP copays are not subject
Telemedicine, Adult Dental and Vision, lower generic Rx copay, lower PCP copay, all PCP copa
Telemedicine, Adult Dental and Vision, lower generic Rx copay, lower PCP copay, all PCP copa
Telemedicine, Adult Dental and Vision, lower generic Rx copay, lower PCP copay, Reduce mai
Telemedicine, Adult Dental and Vision, lower generic Rx copay, lower PCP copay, Reduce mai

APPENDIX D-1

APPENDIX D-1

APPENDIX D-1

ATTACHMENT G [3]

2019 Qualified Health Plan Product Offerings by County - Individual Market

Gold Standard w Child Dental	Platinum Standard w Child Dental	Chiropractic w Child Dental	Silver Standard with 3 PCP Visits	Gold Standard with 3 PCP Visits	Bronze Child Only	Silver Child Only	Gold Child Only	Platinum Child Only	Bronze 851	Silver 851	Gold 851	Platinum 851	Bronze 851 w Child Dental	Silver 851 w Child Dental	Gold 851 w Child Dental	Platinum 851 w Child Dental	Bronze 852	Silver 852	Gold 852	Platinum 852	Bronze 852 w Child Dental	Silver 852 w Child Dental	Gold 852 w Child Dental	Platinum 852 w Child Dental	Bronze 853	Silver 853	Gold 853	Platinum 853	Bronze 853 w Child Dental	Silver 853 w Child Dental	Gold 853 w Child Dental	Platinum 853 w Child Dental

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nystate

ATTACHMENT G (3)

2019 Qualified Health Plan Product Offerings by County - Small Business ("SHOP") Market

Gold Standard w Child Dental	Platinum Standard w Child Dental	Silver Standard with 3 PCP Visits	Gold Standard with 3 PCP Visits	Bronze N52	Silver N51	Gold N51	Platinum N51	Bronze N51 w Child Dental	Silver N51 w Child Dental	Gold N51 w Child Dental	Platinum N52 w Child Dental	Bronze N52	Silver N52	Gold N52	Platinum N52	Bronze N52 w Child Dental	Silver N52 w Child Dental	Gold N52 w Child Dental	Platinum N52 w Child Dental	Bronze N53	Silver N53	Gold N53	Platinum N53	Bronze N53 w Child Dental	Silver N53 w Child Dental	Gold N53 w Child Dental	Platinum N53 w Child Dental
				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	

county. If you are proposing to enter a new
proposing to offer a new product for 2019 (i.e. a
s) in yellow. If you are proposing to leave a county

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ATTACHMENT G (3)
2019 Qualified Health Plan Product Offerings by County - Small Business ("SHOP") Market

Silver Standard w Child Dental	Gold Standard w Child Dental	Platinum Standard w Child Dental	Silver Standard with 3 PCP Visits	Gold Standard with 3 PCP Visits	Bronze NS1	Silver NS1	Gold NS1	Platinum NS1	Bronze NS1 w Child Dental	Silver NS1 w Child Dental	Gold NS1 w Child Dental	Platinum NS1 w Child Dental	Bronze NS2	Silver NS2	Gold NS2	Platinum NS2	Bronze NS2 w Child Dental	Silver NS2 w Child Dental	Gold NS2 w Child Dental	Platinum NS2 w Child Dental	Bronze NS3	Silver NS3	Gold NS3	Platinum NS3	Bronze NS3 w Child Dental	Silver NS3 w Child Dental	Gold NS3 w Child Dental	Platinum NS3 w Child Dental
					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	
					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	
					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	

NYSOH INDIVIDUAL QHP PRODUCT LISTINGS - 2019
HealthFirst PHSP, Inc.

Product Name	HIOS Plan ID
Healthfirst Bronze Leaf, ST, INN, Pediatric Dental, Dep25, Fitness & Wellness Rewards	91237NY0020003
Healthfirst Bronze Leaf, ST, INN, Pediatric Dental, Dep29, Fitness & Wellness Rewards	91237NY0020004
Healthfirst Silver Leaf, ST, INN, Pediatric Dental, Dep25, Fitness & Wellness Rewards	91237NY0020007
Healthfirst Silver Leaf, ST, INN, Pediatric Dental, Dep29, Fitness & Wellness Rewards	91237NY0020008
Healthfirst Gold Leaf, ST, INN, Pediatric Dental, Dep25, Fitness & Wellness Rewards	91237NY0020011
Healthfirst Gold Leaf, ST, INN, Pediatric Dental, Dep29, Fitness & Wellness Rewards	91237NY0020012
Healthfirst Platinum Leaf, ST, INN, Pediatric Dental, Dep25, Fitness & Wellness Rewards	91237NY0020015
Healthfirst Platinum Leaf, ST, INN, Pediatric Dental, Dep29, Fitness & Wellness Rewards	91237NY0020016
Healthfirst Green Leaf, Catastrophic, ST, INN, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020018
Healthfirst Bronze Leaf, Child-Only, ST, INN, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020020
Healthfirst Silver Leaf, Child-Only, ST, INN, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020022
Healthfirst Gold Leaf, Child-Only, ST, INN, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020024
Healthfirst Platinum Leaf, Child-Only, ST, INN, Pediatric Dental, Fitness & Wellness Rewards	91237NY0020026
Healthfirst Bronze Leaf Premier, NS, INN, Dep25, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020052
Healthfirst Bronze Leaf Premier, NS, INN, Dep29, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020053
Healthfirst Silver Leaf Premier, NS, INN, Dep25, Family Dental, Family Vision, No Deductible PCP Visits, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020054
Healthfirst Silver Leaf Premier, NS, INN, Dep29, Family Dental, Family Vision, No Deductible PCP Visits, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020055
Healthfirst Gold Leaf Premier, NS, INN, Dep25, Family Dental, Family Vision, No Deductible PCP Visits, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020056
Healthfirst Gold Leaf Premier, NS, INN, Dep29, Family Dental, Family Vision, No Deductible PCP Visits, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020057
Healthfirst Platinum Leaf Premier, NS, INN, Dep25, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020058
Healthfirst Platinum Leaf Premier, NS, INN, Dep29, Family Dental, Family Vision, Free Telemedicine, Fitness & Wellness Rewards	91237NY0020059

NYSOH SHOP QHP PRODUCT LISTINGS - 2019 Healthfirst Insurance Company, Inc.	
Product Name	HIOS Plan ID
Healthfirst Bronze Pro Plus EPO, NS, INN, Dependent Age 25, DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030001
Healthfirst Bronze Pro Plus EPO, NS, INN, Dependent Age 29, DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030002
Healthfirst Bronze Pro Plus EPO, NS, INN, Dependent Age 25, No DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030033
Healthfirst Bronze Pro Plus EPO, NS, INN, Dependent Age 29, No DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030034
Healthfirst Silver Pro Plus EPO, NS, INN, Dependent Age 25, DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030003
Healthfirst Silver Pro Plus EPO, NS, INN, Dependent Age 29, DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030004
Healthfirst Silver Pro Plus EPO, NS, INN, Dependent Age 25, No DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030035
Healthfirst Silver Pro Plus EPO, NS, INN, Dependent Age 29, No DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030036
Healthfirst Gold Pro Plus EPO, NS, INN, Dependent Age 25, DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030005
Healthfirst Gold Pro Plus EPO, NS, INN, Dependent Age 29, DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030006
Healthfirst Gold Pro Plus EPO, NS, INN, Dependent Age 25, No DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030037
Healthfirst Gold Pro Plus EPO, NS, INN, Dependent Age 29, No DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030038
Healthfirst Platinum Pro Plus EPO, NS, INN, Dependent Age 25, DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030007
Healthfirst Platinum Pro Plus EPO, NS, INN, Dependent Age 29, DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030008
Healthfirst Platinum Pro Plus EPO, NS, INN, Dependent Age 25, No DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030039
Healthfirst Platinum Pro Plus EPO, NS, INN, Dependent Age 29, No DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030040
Healthfirst Bronze 6650 Pro Plus EPO, NS, INN, Dependent Age 25, DP, FP, Family Dental, Family Vision, Acupuncture, Free Telemedicine, Fitness & Wellness Rewards	61405NY0030065
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APPENDIX I
TRADING PARTNER AGREEMENT

All trading partners who will be participating in electronic transactions with the NY State of Health, The Official Health Plan Marketplace must first have a fully executed Trading Partner Agreement (TPA) with the NY State of Health. The TPA form is available on the following pages.

TRADING PARTNER AGREEMENT

This Trading Partner Agreement ("***Agreement***") is made and entered into on this 20 day of August, 2018 (the "***Effective Date***"), by and between Healthfirst PHSP, Inc. ("***Trading Partner***"), and the **State of New York Department of Health** (STATE).

WITNESSETH

WHEREAS, by Executive Order dated April 12, 2012 Governor Andrew M. Cuomo established within the New York State Department of Health, in conformity with the Patient Protection and Affordable Care Act (the "Affordable Care Act"), the NY State of Health, The Official Health Plan Marketplace ("NYSOH"); and

WHEREAS, the NYSOH shall, among other things, facilitate enrollment in health insurance coverage and the purchase and sale of qualified health plans ("QHPs") in the individual market in New York, and enroll individuals in health coverage for which they are eligible under federal law; and

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

(i) benefit enrollment and maintenance for qualified individuals enrolling in coverage ("834 Transactions");
(ii) health care premium payments for qualified employers who duly initiated or renewed coverage through the Small Business Marketplace ("820 Transactions");
(iii) encounter / health care claim transactions ("837 Transactions");

together with such other healthcare transactions that may be necessary in accordance with the QHP Contract; and

WHEREAS, STATE and Trading Partner seek to address certain requirements that are applicable to the parties under regulations issued pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (as the same may be amended from time to time, "*HIPAA*") including, without limitation, the Standards for Electronic Transactions, which were issued in their final form on August 17, 2002 (as the same may be amended from time to time, the "*Transaction Regulations*"), and the Security Standards, which were issued in their final form on February 20, 2003 (as the same may be amended from time to time, the *"Security Standards"*); and

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants and agreements herein contained, Trading Partner and STATE agree to the foregoing and as follows:

1. General Obligations.

1.1 Compliance With Transaction Regulations. Each party shall, and shall cause its applicable subcontractors and agents to, comply with the applicable requirements of the Transaction Regulations and any applicable Implementation Specifications issued therein. STATE shall provide, and shall update from time to time, a HIPAA compliant (i) Trading Partner Information Companion Guide (the "TPI Guide"), (ii) an 834 Companion Guide; (iii) an 820 Companion Guide; (iv) an 837 Post Adjudicated Claims Data Reporting (PACDR) Companion Guide; (v) an Interface Control Document for Group Set Up File, and such other guides that may be necessary to provide specific instructions, where applicable, to assist Trading

Partners in appropriately filling out their transactions for STATE (collectively referred to herein as "Trading Partner Guides"). These Trading Partner Guides will be distributed by the NYSOH's Plan Management department.

1.2 No Changes. With respect to each transaction, each party agrees that it will not change any definition, data condition or use of a data element or segment as proscribed in the Transaction Regulations and/or the applicable Implementation Specifications. Further, neither party will take any action to change the meaning or intent of the Implementation Specifications.

1.3 No Additions. With respect to each transaction, each party agrees that it will not add any data elements or segments to the maximum defined data set as proscribed in the Transaction Regulations and/or the applicable Implementation Specifications.

1.4 No Use. With respect to each transaction, each party agrees that it will not use any code or data elements that either are marked "not used" or are not in the Transaction Regulations and/or the applicable Implementation Specifications.

1.5 Testing Requirements. The Trading Partner Guides set forth the testing requirements that Trading Partner and/or its contractors and/or agents must implement and/or complete prior to submitting any live, production transactions to STATE. Trading Partner agrees to satisfy these requirements.

1.6 Communications. The Trading Partner Guides set forth specifications for establishing connectivity with, and transmitting transactions to, STATE. Trading Partner agrees to satisfy these requirements.

1.7 Supplementary Specifications. The Trading Partner Guides set forth the current supplementary specifications ("*Supplementary Specifications*") of STATE with respect to the Transaction Regulations and any applicable Implementation Specifications. STATE shall have the right to amend the Supplementary Specifications and/or to provide additional supplementary specifications to Trading Partner from time to time (all of which shall constitute Supplementary Specifications for purposes of this Agreement). Trading Partner will be expected to implement such amendments and additions within sixty (60) calendar days following STATE publication of same, unless a shorter period is necessary to conform to applicable laws and/or regulations or otherwise required by STATE to ensure effective transactions.

1.8 Security Requirements.
(a) Each party will take reasonable care to ensure that the information submitted in each transaction is timely, complete, accurate and secure, and will take reasonable precautions to prevent unauthorized access to: (i) its own and the other party's transmission and processing systems; (ii) the transmissions themselves; and (iii) the control structure applied to transmissions between them.

(b) Each party is solely responsible for the preservation, privacy and security of data in its possession, including data in transmissions received from the other party and other persons. If either party receives from the other data not intended for it, the receiving party will immediately notify the sender to arrange for its return, re-transmission, or destruction, as the other party directs.

(c) Under the final HIPAA Security Regulations, parties entering into a Business Associate agreement relating to the electronic exchange of data will implement additional requirements as specified in the Security Regulations including, without limitation, requirements relating to encryption, Public Key Infrastructure (PKI) and other similar technologies

(d) Each party and its Business Associates shall be prohibited from: (i) transmitting healthcare transactions covered under this Agreement directly to STATE from outside of the U.S. or its territories, and (ii) from

providing IP addresses or other information to STATE that would allow for transmission of healthcare transactions covered under this Agreement directly from STATE to a location outside the U.S. or its territories.

2. Costs and Expenses. Each party shall be responsible for any and all costs and expenses related to such party's compliance with the Transaction Regulations, any applicable Implementation Specifications and the terms of this Agreement. Further, each party shall be responsible for all costs, charges and fees it may incur in connection with transmitting and receiving transactions.

3. Term and Termination.

3.1 Term; Effect of Termination. This Agreement shall remain in effect until one party provides written notice of termination to the other, which termination shall be effective thirty (30) days following the other party's receipt of the notice. Termination or expiration of this Agreement or any other contract between the parties does not relieve either party of its obligations under this Agreement and under federal and State laws and regulations pertaining to the privacy and security of Individually Identifiable Health Information nor its obligations regarding the confidentiality of proprietary information.

4. Miscellaneous.

4.1 Defined Terms. Capitalized terms used in this Agreement but not defined herein shall have the meanings ascribed to them in the Transaction Regulations and/or in HIPAA.

4.2 Interpretation. Any ambiguity in any term or condition of this Agreement shall be resolved in favor of a meaning that permits the parties to comply with HIPAA.

4.3 ***Standard Clauses***. Appendix A, Standard Clauses for NYS Contracts, January 2014, is incorporated into this Trading Partner Agreement by reference.

IN WITNESS WHEREOF, STATE and Trading Partner have caused this Agreement to be signed and delivered by their duly authorized representatives as of the date set forth above.

On behalf of STATE and Trading Partner:

STATE OF NEW YORK DEPARTMENT OF HEALTH

By: Donna Frescatore

Print Name: Donna Frescatore

Title: Executive Director

TRADING PARTNER: _____

By: Linda Tiano

Print Name: LINDA TIANO

Title: CHIEF LEGAL OFFICER, GENERAL COUNSEL

EXHIBIT 9

2022 Gold Leaf Premier Plan Member Contract

healthfirst

This is Your

HEALTH MAINTENANCE ORGANIZATION CONTRACT

Issued by

HEALTHFIRST PHSP, INC.

This is Your individual direct payment Contract for health maintenance organization coverage issued by Healthfirst PHSP, Inc. This Contract, together with the attached Schedule of Benefits, applications and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

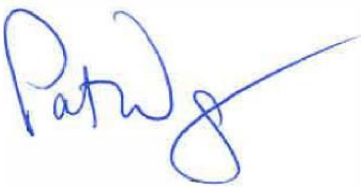
You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract. We will refund any Premium paid including any Contract fees or other charges.

Renewability. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Contract or by the Subscriber upon 30 days' prior written notice to Us.

In-Network Benefits. This Contract only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers and Participating Pharmacies in Our Network. Except for care for an Emergency Condition described in the Emergency Services and Urgent Care section of this Contract, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

This Contract is governed by the laws of New York State.



Pat Wang
CEO & President

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SECTION I

Definitions

Defined terms will appear capitalized throughout this Contract.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Contract for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Contract.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Contract: This Contract issued by Healthfirst PHSP, Inc., including the Schedule of Benefits and any attached riders.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cost-Sharing Reductions: Discounts that lower cost-sharing for certain services covered by individual coverage purchased through the NYSOH. You may get a discount if Your income is below a certain level and You choose a silver level plan. If You are a member of a federally recognized tribe, You can qualify for Cost-Sharing Reductions on certain services covered by individual coverage purchased through the NYSOH at any metal level and You may qualify for additional Cost-Sharing Reductions depending upon Your income.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Contract.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible

applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28(or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Contract.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to New York Public Health Law Article 40 or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Medically Necessary: See the How Your Coverage Works section of this Contract for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Network: The Providers We have contracted with to provide health care services to You.

New York State of Health ("NYSOH"): The New York State of Health, the Official Health Plan Marketplace. The NYSOH is a marketplace where individuals, families and small businesses can learn about their health insurance options; compare plans based on cost, benefits and other important features; apply for and receive financial help with premiums and cost-sharing based on income; choose a plan; and enroll in coverage. The NYSOH also helps eligible consumers enroll in other programs, including Medicaid, Child Health Plus, and the Essential Plan..

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide health care services to You. The services of Non-Participating Providers are Covered only for Emergency Services or when authorized by Us.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide health care services to You. A list of Participating Providers and their locations is available on Our website at www.healthfirst.org or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: A calendar year ending on December 31 of each year.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Contract.

Premium: The amount that must be paid for Your health insurance coverage.

Premium Tax Credit: Financial help that lowers Your taxes to help You and Your family pay for private health insurance. You can get this help if You get health insurance through the NYSOH and Your income is below a certain level. Advance payments of the tax credit can be used right away to lower Your monthly Premium.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating nurse practitioner or Physician who typically is an

internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Contract that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member. Except as provided in the Access to Care and Transitional Care section of this Contract or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Contract that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, Referral requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: New York, Queens, Richmond, Bronx, Kings, Westchester, Nassau, and Suffolk Counties.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Subscriber: The person to whom this Contract is issued.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a participating Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility that provides Urgent Care.

Us, We, Our: Healthfirst PHSP, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Contract.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II

How Your Coverage Works

A. Your Coverage Under this Contract.

You have purchased a HMO Contract from Us. We will provide the benefits described in this Contract to You and Your covered Dependents. You should keep this Contract with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Contract only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Contract; and
- Received while Your Contract is in force.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at www.healthfirst.org.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

D. The Role of Primary Care Physicians.

This Contract does not have a gatekeeper, usually known as a Primary Care Physician (“PCP”). This Contract requires that You select a Primary Care Physician (“PCP”). Although You are encouraged to receive care from Your PCP, You do not need a Referral from a PCP before receiving Specialist care from a Participating Provider.

You may select any participating PCP who is available from the list of PCPs in the HMO Healthfirst Leaf Network. Each Member may select a different PCP. Children covered under this Contract may designate a participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Contract for more information about designating a Specialist. To select a PCP, visit Our website at www.healthfirst.org and log into the member portal. If You do not select a PCP, We will assign one to You.

E. Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the PCP to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a Healthfirst Leaf Member , and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

You may change Your PCP by visiting Our website at www.healthfirst.org and logging into the member portal. This can be done once per week.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve an authorization to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our Network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

F. Services Subject to Preauthorization.
Our Preauthorization is required before You receive certain Covered Services. Your Participating Provider is responsible for requesting Preauthorization for the in-network services listed in the Schedule of Benefits section of this Contract.

G. Preauthorization / Notification Procedure.
If You seek coverage for services that require Preauthorization or notification, Your Provider must call Us at the number on Your ID card.

Your Provider must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

H. Medical Management.
The benefits available to You under this Contract are subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

I. Medical Necessity.
We Cover benefits described in this Contract as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:
- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:
- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and External Appeal sections of this Contract for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

J. Protection from Surprise Bills.
1. **Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:

- For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
  - A participating Physician is unavailable at the time the health care services are performed;
  - A non-participating Physician performs services without Your knowledge; or
  - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
  - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
  - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
  - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Contract.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Copayment, Deductible or Coinsurance if You assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.healthfirst.org/idr for a copy of the form. You need to mail a copy of the assignment of benefits form to Us at the address on Our website and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

K. Delivery of Covered Services Using Telehealth.

If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Contract that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies, including telephone or video using smart phones or other devices, by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

L. Early Intervention Program Services.

We will not exclude Covered Services solely because they are Early Intervention Program services

for infants and toddlers under three years of age who have a confirmed disability or an established developmental delay. Additionally, if Early Intervention Program services are otherwise covered under this Contract, coverage for Early Intervention Program services will not be applied against any maximum annual or lifetime dollar limits if applicable. Visit limits and other terms and conditions will continue to apply to coverage for Early Intervention Program services. However, any visits used for Early Intervention Program services will not reduce the number of visits otherwise available under this Contract.

M. Important Telephone Numbers and Addresses.

- **CLAIMS**
  212-801-3250

  Healthfirst, Inc.
  P.O. Box 5165
  New York, NY 10274-5165
  (Submit claim forms to this address)

  claimsubmission@healthfirst.org
  (Submit electronic claim forms to this e-mail address)

  Pharmacy Claims:
  800-364-6331

  Submit pharmacy claim forms to this address:

  Claims: CVS Caremark
  P.O. Box 52136
  Phoenix, AZ 85072-2136

  www.caremark.com
  (Submit electronic claim forms to this website)

- **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**
  888-250-2220
  Expedited appeals: 877-779-2959

- **ASSIGNMENT OF BENEFITS FORM**
  Healthfirst, Inc.
  P.O. Box 5165
  New York, NY 10274-5165
  (Submit assignment of benefits forms for surprise bills to this address.)

- **MEDICAL EMERGENCIES AND URGENT CARE**
  888-394-4327
  24 hours per day including evenings, weekends and holidays

- **MEMBER SERVICES**
  888-250-2220
  (Member Services Representatives are available Monday - Friday, 8:00 a.m. – 8:00 p.m.)

- **PREAUTHORIZATION**
  888-394-4327

- **BEHAVIORAL HEALTH SERVICES**
  888-250-2220

- **OUR WEBSITE**
  www.healthfirst.org

SECTION III

Access to Care and Transitional Care

A. Authorization to a Non-Participating Provider. If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will not be Covered.

B. When a Specialist Can Be Your Primary Care Physician.
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCP. We will consult with the Specialist and Your PCP and decide whether the Specialist should be Your PCP. Any authorization will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. We will not approve a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing.

C. Standing Authorization to a Participating Specialist.
If You need ongoing specialty care, You may receive a "standing authorization" to a Specialist who is a Participating Provider. This means that You will not need a new authorization from Your PCP every time You need to see that Specialist. We will consult with the Specialist and Your PCP and decide whether You should have a standing authorization. Any authorization will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide Your PCP with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing authorization to a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a standing authorization to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

D. Specialty Care Center.
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may request a authorization to a specialty care center with expertise in treating Your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government or a national health organization as having special expertise to treat Your disease or condition. We will consult with Your PCP, Your Specialist, and the specialty care center to decide whether to approve such an

authorization. Any authorization will be pursuant to a treatment plan developed by the specialty care center, and approved by Us in consultation with Your PCP or Specialist and You. We will not approve an authorization to a non-participating specialty care center unless We determine that We do not have an appropriate specialty care center in Our network. If We approve an authorization to a non-participating specialty care center, Covered Services rendered by the non-participating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a participating specialty care center. You will be responsible only for any applicable in-network Cost-Sharing.

E. When Your Provider Leaves the Network.
If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered Services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care and obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

F. New Members In a Course of Treatment.
If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Contract becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Contract. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Contract becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care and obtaining Preauthorization, Referrals and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.
Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Contract for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Contract. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Contract collectively total the family Deductible amount in the Schedule of Benefits section of this Contract in a Plan Year, no further Deductible will be required for any person covered under this Contract for that Plan Year.

The Deductible runs from January 1 to December 31 of each calendar year.

B. Copayments.
Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Contract for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance.
Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Contract.

D. Out-of-Pocket Limit.
When You have met Your Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Contract, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits section of this Contract, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Contract have collectively met the family Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Contract, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family.

Cost-Sharing for out-of-network services, except for Emergency Services, and out-of-network services approved by Us as an in-network exception and out-of-network dialysis, does not apply toward Your Out-of-Pocket Limit.

E. Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Contract, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider, or the Participating Provider's charge, if less.

See the Emergency Services and Urgent Care section of this Contract for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Contract for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

SECTION V

Who is Covered

A. Who is Covered Under this Contract.
You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live or reside in Our Service Area to be covered under this Contract. If You are enrolled in Medicare, You are not eligible to purchase this Contract. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.
We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.

3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. **Family.** If You selected family coverage, then You, Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Contract.
If You selected parent and child/children or family coverage, Children covered under this Contract include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, intellectual disability (as defined in the New York Mental Hygiene Law), or physical disability and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child qualifies and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Contract at any time.

D. Special Enrollment Periods.
Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child can enroll for coverage within 60 days prior to or after the occurrence of one (1) of the following events:

1. You, Your Spouse or Child involuntarily loses minimum essential coverage, including COBRA or state continuation coverage; including if You are enrolled in a non-calendar year group health plan or individual health insurance coverage, even if You have the option to renew the coverage;
2. You, Your Spouse or Child are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate existing coverage;
3. You, Your Spouse or Child loses eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that do not provide coverage for primary and specialty care;
4. You, Your Spouse or Child become eligible for new qualified health plans because of a permanent move and You, Your Spouse or Child had minimum essential coverage for one (1) or more days during the 60 days before the move; or
5. You, Your Spouse or Child are no longer incarcerated.

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child can enroll for coverage within 60 days after the occurrence of one (1) of the following events:

1. You, Your Spouse or Child's enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the NYSOH, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the NYSOH;
2. You, Your Spouse or Child adequately demonstrate to the NYSOH that another qualified health plan in which You were enrolled substantially violated a material provision of its contract;
3. You gain a Dependent or become a Dependent through birth, adoption or placement for adoption or foster care, or through a child support order or other court order, however, foster Children are not covered under this Contract;
4. You gain a Dependent or become a Dependent through marriage and You or Your Spouse had minimum essential coverage for one (1) or more days during the 60 days before the marriage;
5. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents;
6. If You are an Indian, as defined in 25 U.S.C. 450b(d), You and Your Dependents may enroll in a qualified health plan or change from one (1) qualified health plan to another one (1) time per month;
7. You, Your Spouse or Child demonstrate to the NYSOH that You meet other exceptional circumstances as the NYSOH may provide;
8. You, Your Spouse or Child were not previously a citizen, national, or lawfully present individual and You gain such status;
9. You, Your Spouse or Child are determined newly eligible or newly ineligible for advance payments of the Premium Tax Credit or have a change in eligibility for Cost-Sharing Reductions;
10. You are a victim of domestic abuse or spousal abandonment, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage, and You and

Your Dependents seek to enroll in coverage separate from the perpetrator of the abuse or abandonment;

11. You, Your Spouse or Child apply for coverage during the annual open enrollment period or due to a qualifying event, are assessed by the NYSOH as potentially eligible for Medicaid or Child Health Plus, but are determined ineligible for Medicaid or Child Health Plus after open enrollment has ended or more than 60 days after the qualifying event; or
12. You, Your Spouse or Child adequately demonstrate to the NYSOH that a material error related to plan benefits, service area, or premium influenced Your decision to purchase a qualified health plan through the NYSOH.

The NYSOH must receive notice and We must receive any Premium payment within 60 days of one (1) of these events.

If You, Your Spouse or Child are applying due to a permanent move or marriage, You, Your Spouse or Child can meet the requirement to demonstrate coverage in the 60 days prior to the permanent move or marriage by having minimum essential coverage for one (1) or more days during the 60 days before the move or marriage; or living in a foreign country or in a United States territory for one (1) or more days during the 60 days before the move or marriage; You are an Indian as defined in 25 U.S.C. 450b(d); or You lived for one (1) or more days during the 60 days before the move or marriage in a service area where no qualified health plan was available through the NYSOH.

E. Plan Selection Limitations for Certain Special Enrollment Periods.

1. Cost-Sharing Reductions and Silver Level Plans. If You, Your Spouse or Child become newly eligible for Cost-Sharing Reductions and are not enrolled in a silver level qualified health plan, You, Your Spouse or Child can only change to a silver level qualified health plan.

2. Gain a Dependent. If You gain a Dependent, You must add the Dependent to Your current qualified health plan, or, if the current qualified health plan's rules do not allow the Dependent to enroll, You and Your Dependents may change to another qualified health plan within the same level of coverage (or to one (1) metal level higher or lower if no qualified health plan is available at Your current metal level). Your Dependent may also enroll in any separate qualified health plan.

3. Metal Level Plan Selection Limitations for Special Enrollment Periods. In addition to the plan selection limitations described above, if You qualify for a special enrollment period, You may only make enrollment changes in the same qualified health plan or change to another qualified health plan within the same metal level of coverage (or to one (1) metal level higher or lower if no qualified health plan is available at Your current metal level) for any special enrollment triggering event listed above except the following:

1. You, Your Spouse or Child's enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the NYSOH, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the NYSOH;
2. You are an Indian, as defined in 25 U.S.C. 450b(d);
3. You, Your Spouse or Child demonstrate to the NYSOH that You meet other exceptional circumstances as the NYSOH may provide;
4. You are a victim of domestic abuse or spousal abandonment, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage, and You and Your Dependents seek to enroll in coverage separate from the perpetrator of the abuse or abandonment; or

5. You, Your Spouse or Child adequately demonstrate to the NYSOH that a material error related to plan benefits, service area, or premium influenced Your decision to purchase a qualified health plan through the NYSOH.

   Additionally, if Your Dependent qualifies for any of these same special enrollment periods, You must add the Dependent to Your current qualified health plan, or, if the current qualified health plan's rules do not allow the Dependent to enroll, You and Your Dependents may change to another qualified health plan within the same level of coverage (or to one (1) metal level higher or lower if no qualified health plan is available at Your current metal level). Your Dependent may also enroll in any separate qualified health plan.

F. Effective Dates of Coverage for Special Enrollment Periods.

If You, Your Spouse or Child enroll because You are losing minimum essential coverage within the next 60 days, You are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, or You gain access to new qualified health plans because You are moving, and Your selection is made on or before the triggering event, then Your coverage will begin on the first day of the month following Your loss of coverage.

If You, Your Spouse or Child enroll because You got married, Your coverage will begin on the first day of the month following Your selection of coverage. If You, Your Spouse or Child enroll because You gain a Dependent through adoption or placement for adoption, Your coverage will begin on the date of the adoption or placement for adoption. If You, Your Spouse or Child enroll because of a court order, Your coverage will begin on the date the court order is effective.

If You have a newborn or adopted newborn Child and the NYSOH receives notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which the NYSOH receives notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify the NYSOH of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which the NYSOH receives notice, provided that You pay any additional Premium when due.

If You, Your Spouse or Child enroll because of the death of You or Your Dependents, Your coverage will begin on the first day of the month following Your selection.

Advance payments of any Premium Tax Credit and Cost-Sharing Reductions are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

In all other cases, the effective date of Your coverage will depend on when the NYSOH receives Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is

received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then.

G. Special Enrollment Period for Pregnant Women

If You are pregnant as certified by a Health Care Professional, You may enroll in coverage at any time during Your pregnancy. You must provide Us with the certification from Your Health Care Professional that You are pregnant. Coverage will be effective on the first day of the month in which You received the certification from Your Health Care Professional that You are pregnant, unless You elect for coverage to be effective on the first day of the month following certification. You must pay all Premiums due from the first day of the month in which You received the certification that You are pregnant for Your coverage to begin. However, if You elect for coverage to be effective on the first day of the month following certification, You must pay all Premiums due from the first day of the month in which Your coverage is effective.

If You are eligible, advance payments of any Premium Tax Credit and Cost-Sharing Reductions will apply on the first day of the month following Your enrollment with NYSOH.

H. Domestic Partner Coverage.

This Contract covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Contract also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

- Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists; or

- For partners residing where registration does not exist, by:

  a. An alternative affidavit of domestic partnership.
     The affidavit must be notarized and must contain the following:
     - The partners are both 18 years of age or older and are mentally competent to consent to contract;
     - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
     - The partners have been living together on a continuous basis prior to the date of the application; and
     - Neither individual has been registered as a member of another domestic partnership within the last six (6) months;
  b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
  c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
     - A joint bank account;
     - A joint credit card or charge card;
     - Joint obligation on a loan;
     - Status as an authorized signatory on the partner's bank account, credit card or charge card;
     - Joint ownership of holdings or investments;
     - Joint ownership of residence;

- Joint ownership of real estate other than residence;
- Listing of both partners as tenants on the lease of the shared residence;
- Shared rental payments of residence (need not be shared 50/50);
- Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
- Shared household budget for purposes of receiving government benefits;
- Status of one (1) as representative payee for the other's government benefits;
- Joint ownership of major items of personal property (e.g., appliances, furniture);
- Joint ownership of a motor vehicle;
- Joint responsibility for child care (e.g., school documents, guardianship);
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other's life insurance policy;
- Designation as beneficiary under the other's retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI

Preventive Care

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care.
We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your ID card or visit Our website at www.healthfirst.org for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. **Well-Baby and Well-Child Care.** We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per calendar year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

B. **Adult Annual Physical Examinations.** We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

   Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website at www.healthfirst.org, or will be mailed to You upon request.

   You are eligible for a physical examination once every calendar year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

   This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with

an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

C. Adult Immunizations. We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. Well-Woman Examinations. We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.healthfirst.org, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

E. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member’s Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds, and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

F. Family Planning and Reproductive Health Services. We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of this Contract, patient education and counseling on use of contraceptives and related topics, follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal,; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

G. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Contract. Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by Participating Provider and in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices.

H. Screening for Prostate Cancer. We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

SECTION VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. Pre-Hospital Emergency Medical Services. We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance.

In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the FAIR Health rate at the 80th percentile.

2. Emergency Ambulance Transportation. In addition to Pre-Hospital Emergency Medical Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

B. Non-Emergency Ambulance Transportation.

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

SECTION VIII

Emergency Services and Urgent Care

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Emergency Services.
We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**. If You are uncertain whether a Hospital emergency department is the most appropriate place to receive care, You can call Us before You seek treatment.

We do not Cover follow-up care or routine care provided in a Hospital emergency department. You should contact Us to make sure You receive the appropriate follow-up care.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number listed in this Contract and on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

   We Cover inpatient Hospital services following Emergency Department care at a non-participating Hospital at the in-network Cost-Sharing. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer.

3. **Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Participating Provider for Emergency Services will be the amount We have negotiated with the Non-Participating Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge and will be at least the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare.

   If a dispute involving a payment for physician or Hospital services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for physician or Hospital services.

   You are responsible for any Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. Additionally, if You assign benefits to a Non-Participating Provider in writing, the Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your Copayment, Deductible or Coinsurance, You should contact Us.

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions, or visit an Urgent Care Center.

If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. **Urgent Care is Covered in Our Service Area**.

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.

2. **Out-of-Network.** We do not Cover Urgent Care from non-participating Urgent Care Centers or Physicians.

If Urgent Care results in an emergency admission, please follow the instructions for emergency

Hospital admissions described above.

SECTION IX

Outpatient and Professional Services

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Advanced Imaging Services.
We Cover PET scans, MRI, nuclear medicine, and CAT scans.

B. Allergy Testing and Treatment.
We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

C. Ambulatory Surgical Center Services.
We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

D. Chemotherapy and Immunotherapy.
We Cover chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Contract.

E. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Contract.

F. Clinical Trials.
We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Contract.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Contract for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

G. Dialysis.
We Cover dialysis treatments of an Acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than 10 dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

H. Habilitation Services.
We Cover Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition per Plan Year. The visit limit applies to all therapies combined. For the purpose of this benefit, "per condition" means the disease or injury causing the need for the therapy.

I. Home Health Care.
We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 40 visits per Plan Year. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is

considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

J. Infertility Treatment.
We Cover services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.
   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultrasound;
   - Hysterosalpingogram;
   - Sono-hystogram;
   - Testis biopsy;
   - Blood tests; and
   - Medically appropriate treatment of ovulatory dysfunction.

   Additional tests may be Covered if the tests are determined to be Medically Necessary.

2. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;
   - Pelvic ultrasound;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **Fertility Preservation Services.** We Cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

4. **Exclusions and Limitations.** We do not Cover:
   - In vitro fertilization;
   - Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs associated with an ovum or sperm donor, including the donor's medical expenses;
   - Cryopreservation and storage of sperm and ova except when performed as fertility preservation services;
   - Cryopreservation and storage of embryos;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for services relating to surrogate motherhood that are not otherwise Covered Services under this Contract;
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

   All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

K. Infusion Therapy.
We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.

L. Interruption of Pregnancy.
We Cover medically necessary abortions including abortions in cases of rape, incest or fetal malformation. We Cover elective abortions for one (1) procedure per Member, per calendar year.

M. Laboratory Procedures, Diagnostic Testing and Radiology Services.
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

N. Maternity and Newborn Care.
We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Contract for Coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of the purchase of one (1) breast pump per pregnancy for the duration of breast feeding from a Participating Provider or designated vendor.

O. Office Visits.
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

P. Outpatient Hospital Services.
We Cover Hospital services and supplies as described in the Inpatient Services section of this Contract that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

Q. Preadmission Testing.
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

R. Prescription Drugs for Use in the Office.
We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Contract.

S. Retail Health Clinics.
We Cover basic health care services provided to You on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered Services are typically provided by a physician's assistant or nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common illnesses. Retail health clinics are not a replacement for your PCP. Your PCP should be Your first choice for care and for regular visits.

T. Rehabilitation Services.
We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per condition per Plan Year. The visit limit applies to all therapies combined. For the purpose of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- The therapy is ordered by a Physician; and
- You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond 365 days after such event.

U. Second Opinions.

1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis when Your attending Physician provides a written Referral to a non-participating Specialist.

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
   - The second opinion must be given by a board certified Specialist who personally examines You.
   - If the first and second opinions do not agree, You may obtain a third opinion.

4. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

V. Surgical Services.

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

Sometimes two (2) or more surgical procedures can be performed during the same operation.

1. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest Allowed Amount.

2. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
   - For the procedure with the highest Allowed Amount; and
   - 50% of the amount We would otherwise pay for the other procedures.

W. Oral Surgery.

We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

X. Reconstructive Breast Surgery.
We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

Y. Other Reconstructive and Corrective Surgery.
We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Z. Telemedicine Program.
In addition to providing Covered Services via telehealth, We Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition.

Healthfirst offers the telemedicine program through Teladoc. Teladoc will provide You with unlimited 24 hours per day/7 days-a-week toll-free access to Teladoc providers available through their telemedicine program. You can also access these Teledoc providers through the Teladoc mobile application. Teladoc will connect you with a state licensed physician associated with their program. Please note that Healthfirst does not distribute a directory of telemedicine program providers. To access the Teledoc telemedicine program, go to www.healthfirst.org.

The Teladoc telemedicine program is for non-emergent medical problems. If you are experiencing a medical emergency, call 911. Please note: cost-sharing for Covered Services are different between the Teledoc program and those provided via telehealth from our network of Participating Providers.

AA. Transplants.
We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency

disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

SECTION X

Additional Benefits, Equipment and Devices

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Autism Spectrum Disorder.
We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

1. **Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

2. **Assistive Communication Devices.** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop, or tablet computers. We Cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

   We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We Cover one (1) repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

3. **Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and

include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

4. **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

5. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Contract.

6. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Contract.

7. **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under New York Public Health Law Section 2545, an individualized education plan under New York Education Law Article 89, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Contract for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

   You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Contract for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Contract for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

   Nothing in this Contract shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to New York Insurance Law Section 3235-a or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities.

B. Diabetic Equipment, Supplies and Self-Management Education.
We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. **Equipment and Supplies.**
   We Cover the following equipment and related supplies for the treatment of diabetes when

prescribed by Your Physician or other Provider legally authorized to prescribe:

- Acetone reagent strips
- Acetone reagent tablets
- Alcohol or peroxide by the pint
- Alcohol wipes
- All insulin preparations
- Automatic blood lance kit
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose kit
- Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
- Glucose reagent tape
- Glucose test or reagent strips
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

2. **Self-Management Education.**
Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:
   - By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
   - Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
   - Education will also be provided in Your home when Medically Necessary.

3. Limitations.
The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

Step Therapy for Diabetes Equipment and Supplies. Step therapy is a program that requires You to try one type of diabetic Prescription Drug, supply or equipment unless another Prescription Drug, supply or equipment is Medically Necessary. The diabetic Prescription Drugs, supplies and equipment that are subject to step therapy include:

- Diabetic glucose meters and test strips;
- Diabetic supplies (including but not limited to syringes, lancets, needles, pens);
- Insulin;
- Injectable anti-diabetic agents; and
- Oral anti-diabetic agents.

These items also require Preauthorization and will be reviewed for Medical Necessity. For diabetic Prescription Drugs, refer to the step therapy provisions in the Prescription Drug section and the Step Therapy Protocol Override Determination provisions in the Utilization Review section of this Contract.

C. Durable Medical Equipment and Braces.
We Cover the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.
Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. Braces.
We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

D. Hearing Aids.
1. External Hearing Aids.

We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years.

2. Cochlear Implants

We Cover bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Contract. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

E. Hospice.

Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

F. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Contract. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Contract. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

G. Prosthetics.

1. External Prosthetic Devices.

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or

disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this section of the Contract and are only Covered under the Vision Care section of this Contract.

We do not Cover shoe inserts.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. **Internal Prosthetic Devices.**
We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

SECTION XI

Inpatient Services

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Hospital Services.
We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Contract apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days for the same or related causes.

B. Observation Services.
We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Contract.

D. Inpatient Stay for Maternity Care.
We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care

provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Contract and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Contract that apply to home care benefits.

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

E. Inpatient Stay for Mastectomy Care.
We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

F. Autologous Blood Banking Services.
We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Habilitation Services.
We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit limit applies to all therapies combined.

H. Rehabilitation Services.
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:
1. Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. The therapy is ordered by a Physician; and
3. You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

I. Skilled Nursing Facility.
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Contract). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 200 days per Plan Year for non-custodial care.

J. End of Life Care.
If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Contract until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:
1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

K. Limitations/Terms of Coverage.
1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

SECTION XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Contract. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:
    - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
    - A state or local government run psychiatric inpatient Facility;
    - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
    - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

and in other states, to similarly licensed or certified Facilities.

We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental, health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health, and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of additional experience in psychotherapy; a licensed nurse practitioner; or a professional corporation or a university faculty practice corporation thereof.

B. Substance Use Services. We Cover the following substance use services to treat a substance use

disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes Coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Addiction Services and Supports ("OASAS"); and, in other states, to those Facilities that are licensed certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs.

   We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

   Additional Family Counseling. We also Cover up to 20 outpatient visits per Plan Year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from a substance use disorder; and 2) is covered under the same family Contract that covers the person receiving, or in need of, treatment for substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

SECTION XIII

Prescription Drug Coverage

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Prescription Drugs.
We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On Our Formulary; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders, include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Contract.
- Off-label cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex

DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.

- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at www.healthfirst.org/formulary.html. You may inquire if a specific drug is Covered under this Contract by contacting Us at the number on Your ID card.

B. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail, mail order or designated pharmacy as ordered by an authorized Provider. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Contract.

C. Benefit and Payment Information.

1. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Contract when Covered Prescription Drugs are obtained from a retail, mail order or designated pharmacy.

   You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

   You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not

be available to You.

2. **Participating Pharmacies.** For Prescription Drugs purchased at a retail or mail order or designated Participating Pharmacy, You are responsible for paying the lower of:

   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the number on Your ID card to request approval.

3. **Non-Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

4. **Designated Pharmacies.** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

   Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

   If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have coverage for that Prescription Drug.

   Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

   - Age related macular edema;
   - Anemia, neutropenia, thrombocytopenia;
   - Crohn’s disease;
   - Cystic fibrosis;
   - Cytomegalovirus;
   - Endocrine disorders/neurologic disorders such as infantile spasms;
   - Enzyme deficiencies/liposomal storage disorders;
   - Gaucher's disease;
   - Growth hormone;
   - Hemophilia;
   - Hepatitis C;
   - Hereditary angioedema;
   - Immune deficiency;
   - Immune modulator;
   - Infertility;

- Iron overload;
- Iron toxicity;
- Multiple sclerosis;
- Oncology;
- Osteoarthritis;
- Osteoporosis;
- Pulmonary arterial hypertension;
- Respiratory condition;
- Rheumatologic and related conditions (rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis).

5. **Mail Order.** Certain Prescription Drugs may be ordered through Our mail order pharmacy. You are responsible for paying the lower of:

   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You may be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days' supply written on the Prescription Order or Refill.

   Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

   We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy, when that retail pharmacy has a participation agreement with Us or Our vendor in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

   You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.healthfirst.org or by calling the number on Your ID card.

6. **Tier Status.** The tier status of a Prescription Drug may change periodically, but no more than four (4) times per calendar year or when a Brand-Name Drug becomes available as a Generic Drug as described below, based on Our tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier or is being removed from Our Formulary We will notify You at least 30 days before the change is effective. When such changes occur, Your Cost-Sharing may change. You may also request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this Contract. You may access the most up to date tier status on Our website at www.healthfirst.org or by calling the number on Your ID card.

7. **When a Brand-Name Drug Becomes Available as a Generic Drug.** When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which

the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded or placed on a higher tier due to a Generic Drug becoming available, You will receive 30 days' advance written notice of the change before it is effective. You may request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this Contract.

8. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of this Contract. Visit Our website at www.healthfirst.org or call the number on Your ID card to find out more about this process.

   Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 72 hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

   Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 24 hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

9. **Supply Limits.** Except for contraceptive drugs, devices, or products. We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply. However, for Maintenance Drugs We will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for up to three (3) Cost-Sharing amounts for a 90-day supply at a retail pharmacy.

   You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices or products are not subject to Cost-Sharing when provided by a Participating Pharmacy.

   Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of two and a half (2.5) Cost-Sharing amounts for a 90-day supply.

Specialty Prescription Drugs may be limited to a 30-day supply when obtained at a retail or mail order pharmacy. You may access Our website at www.healthfirst.org or by calling the number on Your ID card for more information on supply limits for specialty Prescription Drugs.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at www.healthfirst.org or by calling the number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Contract.

10. **Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be prorated. If You receive an additional supply of the Prescription Drug within the 30-day period in which You received the seven (7) day supply, Your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than Your Copayment for a 30-day supply.

11. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You as the Cost-Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of this Contract.

D. Medical Management.

This Contract includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. Preauthorization is not required for Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

   For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.healthfirst.org or call the number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Contract. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one (1) or more types of Prescription Drugs before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check

certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Contract.

E. Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

3. Compounded Prescription Drugs will be Covered only when they contain at least one (1) ingredient that is a Covered legend Prescription Drug, and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs over $250 require Your Provider to obtain Preauthorization.

4. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Contract.

6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician’s office are Covered under the Outpatient and Professional Services section of this Contract.

7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an “A” or “B” rating from USPSTF, or as otherwise provided in this Contract. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may

be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.

8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Contract.

11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

F. General Conditions.

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

2. Drug Utilization, Cost Management and Rebates. We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the Premiums for Your coverage.

We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

G. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Contract).

1. **Brand-Name Drug:** A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as

"brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.

2. **Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Contract. This list is subject to Our periodic review and modification (no more than four (4) times per calendar year or when a Brand-Name Drug becomes available as a Generic Drug). To determine which tier a particular Prescription Drug has been assigned, visit Our website at www.healthfirst.org/formulary.html or call the number on Your ID card.

4. **Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as "generic" by the manufacturer, pharmacy, or Your Physician may not be classified as a Generic Drug by Us.

5. **Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.

6. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

7. **Participating Pharmacy:** A pharmacy that has:
   - Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
   - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
   - Been designated by Us as a Participating Pharmacy.

   A Participating Pharmacy can be either a retail or mail-order pharmacy.

8. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

9. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, as contracted between Us and Our pharmacy benefit manager for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Contract includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

10. **Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

11. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by the New York Education Law.

SECTION XIV

Wellness Benefits

A. Exercise Facility Reimbursement.
We will partially reimburse the Subscriber and the Subscriber's covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities that We have an agreement with and which maintain equipment and programs that promote cardiovascular wellness.

Reimbursement is limited to actual workout visits. We do not reimburse:

- Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities;
- Lifetime memberships;
- Equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.); or
- Services that are amenities, such as a gym, that are included in Your rent or homeowner's association fees.

In order to be eligible for reimbursement, You must:

- Be an active member of the exercise facility or attend classes at the exercise facility, and
- Complete 50 visits in a six (6)-month period.

In order to obtain reimbursement, at the end of the six (6)-month period, You must submit:

- A completed reimbursement form. Each time You visit the exercise facility, a facility representative must sign and date the reimbursement form.
- A copy of Your current facility bill which shows the fee paid for Your membership.

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of $200 for the Subscriber and $100 for the Subscriber's covered Spouse or the actual cost of the membership per six (6)-month period. Reimbursement must be requested within 120 days of the end of the six (6)-month period. Reimbursement will be issued only after You have completed each six (6)-month period even if 50 visits are completed sooner.

SECTION XV

Vision Care

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits and any Preauthorization requirements that apply to these benefits.

A. Pediatric Vision Care.
We Cover emergency, preventive and routine vision care for Members through the end of the month in which the Member turns 19 years of age.

B. Pediatric Vision Examinations.
We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any 12-month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

C. Pediatric Prescribed Lenses and Frames.
We Cover standard prescription lenses or contact lenses one (1) time in any 12-month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic.

We also Cover standard frames adequate to hold lenses one (1) time in any 12-month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. If You choose a non-standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non-standard frame. The difference in cost does not apply toward Your Out-of-Pocket Limit.

D. Vision Examinations for Adults.
We Cover vision examinations for Members over age 18 for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any 12-month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and

- Summary findings and recommendation for corrective lenses.

E. Prescribed Lenses and Frames for Adults.
We Cover standard prescription lenses or contact lenses one (1) time in any 12-month period; unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. If You choose non-standard lenses, We will pay the amount that We would have paid for standard lenses and You will be responsible for the difference in cost between the standard lenses and the non-standard lenses. The difference in cost does not apply toward Your Out-of-Pocket Limit.

We also Cover standard frames adequate to hold lenses one (1) time in any 12-month period;, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. If You choose a non-standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non-standard frame. The difference in cost does not apply toward Your Out-of-Pocket Limit.

You have a separate allowance of $100 towards the purchase of frames and contacts. If You choose frames or contacts that cost more than Your allowance, You will be responsible for the difference in cost. The difference in cost does not apply toward Your In-Network Out-of-Pocket Limit.

SECTION XVI

Dental Care

Please refer to the Schedule of Benefits section of this Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following dental care services:

A. Emergency Dental Care. We Cover emergency dental care, which includes emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

B. Preventive Dental Care. We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

C. Routine Dental Care. We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-rays, full mouth x-rays or panoramic x-rays at 36-month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

D. Endodontics. We Cover routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

E. Periodontics. We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics that are otherwise Covered under this Contract.

F. Prosthodontics. We Cover prosthodontic services as follows:

- Removable complete or partial dentures, for Members 15 years of age and above including six (6) months follow-up care;
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate; and
- Interim prosthesis for Members five (5) to 15 years of age.

We do not Cover implants or implant related services.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Oral Surgery. We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of, or leading to orthodontics that are otherwise Covered under this Contract

H. Orthodontics. We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions, such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

SECTION XVII

Exclusions and Limitations

No coverage is available under this Contract for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Contract. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Contract unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services.
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Dental Care sections of this Contract.

G. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Contract, or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Contract for non-investigational treatments. See the Utilization Review and External Appeal sections of this Contract for a further explanation of Your Appeal rights.

H. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

I. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

K. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Contract.

L. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, We will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

M. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

N. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

O. Services Not Listed.
We do not Cover services that are not listed in this Contract as being Covered.

P. Services Provided by a Family Member.
We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

Q. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services with No Charge.
We do not Cover services for which no charge is normally made.

S. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Vision Care section of this Contract;

T. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

U. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION XVIII

Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Contract. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Contract. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Contract.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within 180 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 180-day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Contract.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Contract.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.
A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period if We deny the claim in whole or in part.

H. Payment of Claims.
Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION XIX

Grievance Procedures

A. Grievances.
Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance. You can contact Us by phone at 888-250-2220, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

You may ask that We send You electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card. You can opt out of electronic notifications at any time.

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances (A request for a service or a treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of Your Grievance.

D. Assistance.
If You remain dissatisfied with Our Grievance determination, or at any other time You are dissatisfied,

You may:

Call the New York State Department of Health at 1-800-206-8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
E-mail: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XX

Utilization Review

A. Utilization Review.
We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

We have developed guidelines and protocols to assist Us in this process. We will use evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card. You can opt out of electronic notifications at any time.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45 day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and

provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

4. **Inpatient Rehabilitation Services Reviews.** After receiving a Preauthorization request for coverage of inpatient rehabilitation services following an inpatient Hospital admission provided by a Hospital or skilled nursing facility, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information.

5. **Crisis Stabilization Centers.** Coverage for services provided at participating crisis stabilization centers licensed under New York Mental Hygiene Law section 36.01 is not subject to Preauthorization. We may review the treatment provided at crisis stabilization centers retrospectively to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS or approved by OMH. If any treatment at a participating crisis stabilization center is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your treatment.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews**. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously

approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

5. **Inpatient Mental Health Treatment for Members under 18 at Participating Hospitals Licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed Hospital notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary, and We will use clinical review tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

6. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

7. **Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28

visits, if the OASAS-certified Facility notifies Us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. Retrospective Reviews.
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Step Therapy Override Determinations.
You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

1. **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:
   - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;
   - The required Prescription Drug(s) is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;
   - You have tried the required Prescription Drug(s) while covered by Us or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or

with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- You are stable on a Prescription Drug(s) selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB-rated generic equivalent; or
- The required Prescription Drug(s) is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review.** We will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your Health Care Professional, within 72 hours of receipt of the supporting rationale and documentation.

3. **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination and provide notification to You (or Your designee) and Your Health Care Professional within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or Your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours or one (1) business day of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 24 hours of Our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If We do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

G. Reconsideration.
If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration

will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

H. Utilization Review Internal Appeals.
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
    - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
    - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
    - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
    - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

I. Standard Appeal.
1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide

the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 days of receipt of the Appeal. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

   Our failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

J. Full and Fair Review of an Appeal.
We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

K. Appeal Assistance.
If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates

633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XXI

External Appeal

A. Your Right to an External Appeal.
In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Contract; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.
If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.
If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**
2. There does not exist a more beneficial standard service or procedure Covered by Us; **or**
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or

3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your Right to Appeal a Determination that a Service is Out-of-Network.
If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.
If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. Your Right to Appeal a Formulary Exception Denial.
If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Contract for more information on the formulary exception process.

G. The External Appeal Process.
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 72 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 24 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within 72 hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug

while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Contract. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Contract for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

H. Your Responsibilities.
It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XXII

Termination of Coverage

This Contract may be terminated as follows:

A. Automatic Termination of this Contract.
This Contract shall automatically terminate upon the death of the Subscriber, unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, this Contract will terminate as of the last day of the month for which the Premium had been paid.

B. Automatic Termination of Your Coverage.
Coverage under this Contract shall automatically terminate:

1. For Spouses in cases of divorce, the date of the divorce.

2. For Children, the end of the month in which the Child turns 26 years of age.

3. For all other Dependents, the end of the month in which the Dependent ceases to be eligible, except that We shall not terminate Your Dependent if Your Dependent becomes eligible for or enrolls in Medicare.

Eligibility or enrollment in Medicare is not a basis for termination under this Contract.

C. Termination by You.
The Subscriber may terminate this Contract at any time by giving the NYSOH at least 14 days' prior written notice.

D. Termination by Us.
We may terminate this Contract with 30 days' written notice (unless longer notice is provided below) as follows:

1. Non-Payment of Premiums.
Premiums are to be paid by the Subscriber to Us by each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:

- If the Subscriber does not receive advanced payments of the Premium Tax Credit for coverage in the NYSOH and fails to pay the required Premium within a 30-day grace period, this Contract will terminate retroactively back to the last day Premiums were paid. The Subscriber will be responsible for paying any claims submitted during the grace period if this Contract terminates.
- If the Subscriber receives advanced payments of the Premium Tax Credit and has paid at least one (1) full month's Premium, this Contract will terminate one (1) month after the last day Premiums were paid. That is, retroactive termination will not exceed 61 days. We may pend claims incurred during the 61-day grace period. The Subscriber will be responsible for paying any claims incurred during the 61-day grace period if this Contract terminates.

2. Fraud or Intentional Misrepresentation of Material Fact.
If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or

the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, this Contract will terminate immediately upon a written notice to the Subscriber and/or the Subscriber's Dependent, as applicable, from the NYSOH. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, We will rescind this Contract if the facts misrepresented would have led Us to refuse to issue this Contract and the application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to the issuance of this Contract. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

3. If the Subscriber no longer lives or resides in Our Service Area.

4. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide the Subscriber with at least 90 days' prior written notice.

5. The date the Contract is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this State. We will provide the Subscriber with at least 180 days' prior written notice.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Conversion Right to a New Contract after Termination section of this Contract for Your right to conversion to another individual Contract.

SECTION XXIII

Extension of Benefits

When Your coverage under this Contract ends, benefits stop. But, if You are totally disabled on the date the Contract terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this section, "total disability" means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

A. When You May Continue Benefits.
If You are totally disabled on the date Your coverage under this Contract terminates, We will continue to pay for Your care under this Contract during an uninterrupted period of total disability until the first of the following:

- The date You are no longer totally disabled; or
- 12 months from the date this Contract terminated.

B. Limits on Extended Benefits.
We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Contract ends; or
- Beyond the extent to which We would have paid benefits under this Contract if coverage had not ended.

SECTION XXIV

Temporary Suspension Rights for Armed Forces' Members

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than five (5) years of active duty.

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned Premiums will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the Premium within 60 days of the termination of active duty.

The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XXV

Conversion Right to a New Contract after Termination

A. Circumstances Giving Rise to Right to Conversion.
The Subscriber's Spouse and Children have the right to convert to a new Contract if their coverage under this Contract terminates under the circumstances described below.

1. **Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Contract because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.

2. **Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Contract because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.

3. **On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Contract because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

B. When to Apply for the New Contract.
If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of Your coverage under this Contract. You must also pay the first Premium of the new Contract at the time You apply for coverage.

C. The New Contract.
We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the four (4) Contracts offered by Us.

SECTION XXVI

General Provisions

1. Agreements Between Us and Participating Providers.
Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Contract does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. Assignment.
You cannot assign any benefits under this Contract to any person, corporation or other organization. You cannot assign any monies due under this Contract to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill or to a Hospital for Emergency Services, including inpatient services following Emergency Department Care. See the How Your Coverage Works section of this Contract for more information about surprise bills. Any assignment of benefits by You other than for monies due for a surprise bill or an assignment of monies due to a Hospital for Emergency Services, including inpatient services following Emergency Department Care, will be void and unenforceable.

You may request Us to make payment for services directly to Your Provider instead of You, including a payment for a surprise bill or to a Hospital for Emergency Services and inpatient services following Emergency Department Care. See the How Your Coverage Works section of this Contract for more information about surprise bills

Assignment means the transfer to another person, corporation or other organization of Your right to the services provided under this Contract or Your right to collect money from Us for those services.

3. Changes in this Contract.
We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.

4. Choice of Law.
This Contract shall be governed by the laws of the State of New York.

5. Clerical Error.
Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.
Any term of this Contract which conflicts with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Contract may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Entire Agreement.
This Contract, including any endorsements, riders and the attached applications, if any, constitutes the entire Contract.

9. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

10. Furnishing Information and Audit.
All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

11. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Contract. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

12. Incontestability.
No statement made by the Subscriber in an application for coverage under this Contract shall avoid the Contract or be used in any legal proceeding unless the application or an exact copy is attached to this Contract.

13. Independent Contractors.
Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's Facility.

14. Input in Developing Our Policies.
Subscribers may participate in the development of Our policies by contacting Us directly. If you have any ideas or suggestions, please let us know. You can write to us at Healthfirst, Member Services, 100 Church Street, New York, NY 10007. Or call Member Services at 888-250-2220. Our Senior Management will review all suggestions we receive.

15. Material Accessibility.
We will give You ID cards , Contracts, riders, and other necessary materials.

16. More Information about Your Health Plan.
You can request additional information about Your coverage under this Contract. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.

- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Contract.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Contract.

17. Notice.
Any notice that We give You under this Contract will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: Member Services, Healthfirst Leaf Plans, 100 Church Street, New York, NY 10007.

18. Premium Payment.
The first month's Premium is due and payable when You apply for coverage. Coverage will begin on the effective date of the Contract as defined herein. Subsequent Premiums are due and payable on the first of each month thereafter.

19. Premium Refund.
We will give any refund of Premiums, if due, to the Subscriber.

20. Recovery of Overpayments.
On occasion, a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

21. Renewal Date.
The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Contract or by the Subscriber upon 30 days' prior written notice to Us.

22. Reinstatement after Default.
If the Subscriber defaults in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract.

23. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Contract. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Contract. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Contract.

24. Right to Offset.
If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

25. Severability.
The unenforceability or invalidity of any provision of this Contract shall not affect the validity and enforceability of the remainder of this Contract.

26. Significant Change in Circumstances.
If We are unable to arrange for Covered Services as provided under this Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

27. Subrogation and Reimbursement.
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Contract. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law Section 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

28. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Contract and nothing in this Contract shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Contract. No other party can enforce this Contract's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Contract, or to bring an action or pursuit for the breach of any terms of this Contract.

29. Time to Sue.
No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Contract. You must start any lawsuit against Us under this Contract within two (2) years from the date the claim was required to be filed.

30. Translation Services.
Translation services are available free of charge under this Contract for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

31. Venue for Legal Action.
If a dispute arises under this Contract, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

32. Waiver.
The waiver by any party of any breach of any provision of this Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

33. Who May Change this Contract.
This Contract may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Contract in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

34. Who Receives Payment under this Contract.
Payments under this Contract for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Contract for more information about surprise bills.

35. Workers' Compensation Not Affected.
The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

36. Your Medical Records and Reports.
In order to provide Your coverage under this Contract, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Contract, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

37. Your Rights.
You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

As a Member, You should also take an active role in Your care. We encourage You to:

- Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
- Follow the treatment plan that You have agreed on with Your doctors or Providers;
- Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Contract. This may include information about other health insurance benefits You have along with Your coverage with Us; and
- Inform Us if You have any changes to Your name, address or Dependents covered under Your Contract.

SECTION XXVII

HEALTHFIRST SCHEDULE OF BENEFITS
Gold Leaf Premier
Non-Standard

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	$850 $1,700	Non-Participating Provider services are not covered except as required for emergency care.	
Out-of-Pocket Limit • Individual • Family Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.	$6,000 $12,000		
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$20 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)	$40 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Well Child Visits and Immunizations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Adult Immunizations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Sterilization Procedures for Women*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Vasectomy	See surgical services Cost Sharing	Non-Participating Provider services are not covered	

		and You pay the full cost	
• Bone Density Testing*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Screening for Prostate Cancer	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• All other preventive services required by USPSTF and HRSA.	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Non-Participating Provider services are not covered and You pay the full cost	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$150 Copayment after Deductible	$150 Copayment after Deductible	See benefit for description
Non-Emergency Ambulance Services	$150 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Emergency Department	$175 Copayment after Deductible Copayment / Coinsurance waived if admitted to Hospital	$175 Copayment after Deductible Copayment / Coinsurance	See benefit for description

	Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	waived if admitted to Hospital Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	
Urgent Care Center	$60 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services			See benefit for description
• Performed in a Specialist Office	$40 Copayment Not Subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	$40 Copayment Not Subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$40 Copayment Not Subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Allergy Testing and Treatment			See benefit for description
• Performed in a PCP Office	$20 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	

• Performed in a Specialist Office	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Ambulatory Surgical Center Facility Fee	$100 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings)	Covered in full **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Cardiac and Pulmonary Rehabilitation			See benefit for description
• Performed in a Specialist Office	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Inpatient Hospital Services	Included as part of inpatient Hospital Cost Sharing **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Chemotherapy and Immunotherapy			See benefit for description
• Performed in a PCP Office	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	

• Performed in a Specialist Office	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Chiropractic Services	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Clinical Trials	Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures) **Preauthorization Required**	Use Cost-Sharing for appropriate service **Preauthorization Required**	See benefit for description
Diagnostic Testing			See benefit for description
• Performed in a PCP Office	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	

Dialysis • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services • Performed at Home	$20 Copayment after Deductible **Preauthorization Required** $20 Copayment after Deductible **Preauthorization Required** $20 Copayment after Deductible **Preauthorization Required** $20 Copayment after Deductible **Preauthorization Required** $20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See benefit for description Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information.
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	60 visits per condition, per Plan Year; combined therapies
Home Health Care	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	40 visits per Plan Year
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

Infusion Therapy • Performed in a PCP Office	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
• Performed in Specialist Office	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Home Infusion Therapy	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	Home infusion counts toward home health care visit limits
Inpatient Medical Visits	$0 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Interruption of Pregnancy • Medically Necessary Abortions	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	Unlimited
• Elective Abortions • Inpatient Hospital Surgery	$100 Copayment after Deductible per admission	Non-Participating Provider services are not covered	One (1) procedure per

		and You pay the full cost	Plan Year
• Outpatient Hospital Surgery	$100 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment after Deductible per admission	Non-Participating Provider services are not covered and You pay the full cost	
• Office Surgery	$20 Copayment after Deductible when performed by PCP $40 Copayment after Deductible when performed by Specialist	Non-Participating Provider services are not covered and You pay the full cost	
Laboratory Procedures			See benefit for description
• Performed in a PCP Office	$20 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	$40 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Freestanding Laboratory Facility	$40 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	

• Performed as Outpatient Hospital Services	$40 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Maternity and Newborn Care • Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Non-Participating Provider services are not covered and You pay the full cost	
• Inpatient Hospital Services and Birthing Center	$1,000 Copayment after Deductible per admission **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for delivery	$100 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	

• Breast Feeding Support, Counseling and Supplies, Including Breast Pump • Postnatal Care	Covered in full **Preauthorization Required** Covered in full Included in physician and midwife services for delivery Cost Sharing	Non-Participating Provider services are not covered and You pay the full cost	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	$100 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preadmission Testing	$0 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office • Performed in a PCP Office • Performed in a Specialist Office	 Included as part of the PCP office visit Cost Sharing **Preauthorization Required** Included as part of the Specialist office visit Cost Sharing **Preauthorization Required**	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Diagnostic Radiology Services • Performed in a PCP Office	 $20 Copayment not subject to Deductible **Preauthorization Required**	 Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

• Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	$40 Copayment not subject to Deductible **Preauthorization Required** $40 Copayment not subject to Deductible **Preauthorization Required** $40 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	 $20 Copayment after Deductible **Preauthorization Required** $20 Copayment after Deductible **Preauthorization Required** $20 Copayment after Deductible **Preauthorization Required**	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Rehabilitation Services (Physical Therapy,	$30 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered	60 visits per condition, Per

Occupational Therapy or Speech Therapy)		and You pay the full cost	Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery
Retail Health Clinic Care	$20 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$40 Copayment after Deductible	Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants) • Inpatient Hospital Surgery	$100 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description All transplants must be performed at designated Facilities

• Outpatient Hospital Surgery	$100 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Office Surgery	$20 Copayment after Deductible when performed by PCP; $40 Copayment after Deductible when performed by Specialist **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Telemedicine Program (Teledoc)	$0 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	No Limit
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$20 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	$20 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
• Diabetic Equipment, Supplies and Insulin	$20 Copayment not subject to Deductible. Diabetic insulin cost-sharing is no more than	Non-Participating Provider services are not covered	See Prescription

(30-day; Up to a 90-day supply) • Diabetic Education	$100 (including before deductible based on the plan) for a 30-day supply. **Preauthorization Required** $20 Copayment not subject to Deductible	and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	Drug benefit
Durable Medical Equipment and Braces	20% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
External Hearing Aids	20% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants	20% Coinsurance after Deductible **Preauthorization Required** See Surgical Services; Internal Prosthetic Devices Cost-Sharing	Non-Participating Provider services are not covered and You pay the full cost	One (1) per Ear per time Covered
Hospice Care • Inpatient • Outpatient	 $1,000 Copayment after Deductible per admission **Preauthorization Required** $20 Copayment after Deductible **Preauthorization Required**	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	210 days per Plan Year five (5) visits for family bereavement counseling
Medical Supplies	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Prosthetic Devices			One (1) prosthetic

• External • Internal	20% Coinsurance after Deductible **Preauthorization Required** Included as part of Inpatient Hospital service cost sharing **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	device, per limb, per lifetime with coverage for repairs and replacements. Unlimited; See benefit for description
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Autologous Blood Banking	20% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	$1,000 Copayment after Deductible per admission **Preauthorization Required. However, Preauthorization is Not Required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Observation Stay	$150 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	$1,000 Copayment after Deductible per admission **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	200 days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy	$1,000 Copayment after Deductible per admission **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	60 days per Plan Year combined

			therapies.
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	$1,000 Copayment after Deductible per admission **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	60 days per plan year, combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery.
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)	$1,000 Copayment after Deductible per admission **Preauthorization Required** **However, Preauthorization is Not Required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$20 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	$1,000 Copayment after Deductible per admission **Preauthorization Required** **However, Preauthorization is Not Required for emergency admissions or for Participating OASAS-certified Facilities.**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	$20 Copayment not subject to Deductible **Preauthorization Required** **However, Preauthorization is not required for Participating OASAS-certified Facilities**	Non-Participating Provider services are not covered and You pay the full cost	Unlimited; Up to 20 visits per calendar year may be used for family counseling
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy 30-day supply Tier 1 Tier 2 Tier 3 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or	 $7 Copayment not subject to Deductible $50 Copayment not subject to Deductible $100 Copayment not subject to Deductible The Deductible does not apply to certain Prescription Drugs. Visit Our website at Healthfirst.org to review Our formulary or call the number on Your ID card to learn more.	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

stabilization and for opioid overdose reversal.			
Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3	 $21 Copayment not subject to Deductible $150 Copayment not subject to Deductible $300 Copayment not subject to Deductible The Deductible does not apply to certain Prescription Drugs. Visit Our website at Healthfirst.org to review Our formulary or call the number on Your ID card to learn more.	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $14 Copayment not subject to Deductible $100 Copayment not subject to Deductible $200 Copayment not subject to Deductible The Deductible does not apply to certain Prescription Drugs. Visit Our website at	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

	Healthfirst.org to review Our formulary or call the number on Your ID card to learn more.		
Enteral Formulas Tier 1 Tier 2 Tier 3	 $7 Copayment not subject to Deductible $50 Copayment not subject to Deductible $100 Copayment not subject to Deductible	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Spouse	Non-Participating Provider services are not covered and You pay the full cost	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Spouse
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental Care • Routine Dental Care	 $20 Copayment $20 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered	One (1) dental exam and cleaning per six (6) month period Full mouth x-rays or

• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)	$20 Copayment after Deductible **Preauthorization Required**	and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	panoramic x-rays at 36 month intervals and bitewing x-rays at 6 month intervals
• Orthodontics	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Adult Dental Care			One (1) dental exam and cleaning per six (6) month period
• Preventive Dental Care	$20 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
• Routine Dental Care	$20 Copayment	Non-Participating Provider services are not covered and You pay the full cost	Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 month intervals
• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Orthodontics	$20 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Pediatric Vision Care			
• Exams	$20 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	One (1) exam per 12-month period
• Lenses	20% Coinsurance after Deductible	Non-Participating Provider	One (1) prescribed

		services are not covered and You pay the full cost	lenses and frames per 12-month period
• Frames	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	$100 Allowance for frames and contacts
• Standard Contact Lenses	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
Adult Vision Care			
• Exams	$20 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	One (1) exam per 12-month period
• Lenses	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	One (1) prescribed lenses and frames per 12-month period
• Frames	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	$100 Allowance for frames or contacts
• Standard Contact Lenses	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	

Eligible American Indians, as determined by the NYSOH, are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Contract, You will be responsible for the full cost of the services.

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No Surprises Act Rider

This rider amends the sections listed below of Your Contract to provide the consumer protections required under the Federal No Surprises Act.

1. Paragraph C from How Your Coverage Works section is replaced with the following:

C. Participating Providers.
To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at www.healthfirst.org.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

You are only responsible for any Copayment, Deductible or Coinsurance that would apply to the Covered Services, and You are not responsible for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance, if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:

- The Provider is listed as a Participating Provider in Our online Provider directory;
- Our paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;
- We give You written notice that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider; or
- We do not provide You with a written notice within one business day of Your telephone request for network status information.

2. Paragraph J from How Your Coverage Works section is replaced with the following:

J. Protection from Surprise Bills.

1. **Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:
   - For services performed by a non-participating Provider at a participating Hospital or Ambulatory Surgical Center, when:
     - A participating Provider is unavailable at the time the health care services are performed;
     - A non-participating Provider performs services without Your knowledge; or
     - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Provider is available and You elected to receive services from a non-participating Provider.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
  - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
  - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
  - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Contract.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Copayment, Deductible or Coinsurance. The Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance. You can sign a form to let Us and the Non-Participating Provider know You received a surprise bill.

The form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.healthfirst.org/idr for a copy of the form. You need to mail a copy of the form to Us at the address on Our website and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

3. Paragraph E from the Access to Care section is replaced with the following:

E. When Your Provider Leaves the Network.
If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care and obtaining Preauthorization, Referrals, and a treatment plan approved by Us. You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable Copayment, Deductible

or Coinsurance. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

4. A new Paragraph D is added to the Ambulance and Pre-Hospital Emergency Medical Services as follows:

D. Payments for Air Ambulance Services. We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the air ambulance service, an amount We have determined is reasonable for the air ambulance service, or the Non-Participating Provider's charge. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity, We will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any Cost-Sharing. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your Copayment, Deductible or Coinsurance, You should contact Us. Visit Our website at www.healthfirst.org or www.dfs.ny.gov for more information on the independent dispute resolution process for air ambulance bills.

5. Item 3 under Paragraph A titled "Emergency Services" in the Emergency Services and Urgent Care section is replaced with the following:

3. Payments Relating to Emergency Services. We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the Emergency Service, an amount We have determined is reasonable for the Emergency Service, or the Non-Participating Provider's charge. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

If a dispute involving a payment for Emergency Services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for the services.

You are responsible for any Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. The Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your Copayment, Deductible or Coinsurance, You should contact Us.

6. Controlling Contract.
All of the terms, conditions, limitations, and exclusions of Your Contract to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

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Health Insurance for New Yorkers

Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. Healthfirst does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Healthfirst at **1-866-305-0408**. For TTY services, call 1-888-542-3821.

If you believe that Healthfirst has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Healthfirst by:

- **Mail:** Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- **Phone:** **1-866-305-0408** (for TTY services, call 1-888-542-3821)
- **Fax:** 1-212-801-3250
- **In person:** 100 Church Street, New York, NY 10007
- **Email:** **http://healthfirst.org/members/contact/**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- **Web:** Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- **Phone:** **1-800-368-1019** (TTY 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-305-0408 (TTY: 1-888-542-3821).	Chinese
ملحوظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408 (TTY: 1-888-542-3821).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY: 1-888-542-3821).번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408 (TTY: 1-888-542-3821).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408 (TTY: 1-888-542-3821).	Italian
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408 (TTY: 1-888-542-3821).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY: 1-888-542-3821).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון 1-866-305-0408 (TTY: 1-888-542-3821). רופט אפצאל.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY: 1-888-542-3821).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-305-0408 (TTY: 1-888-542-3821).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-866-305-0408 (TTY: 1-888-542-3821).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408 (TTY: 1-888-542-3821).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408 (TTY: 1-888-542-3821).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-305-0408 (TTY: 1-888-542-3821).	Urdu

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EXHIBIT 10

Excerpts, first page from Qualified Health Plan Member Contracts:

- **2023 Gold Leaf Premier Plan Member Contract**
- **2024 Gold Leaf Premier Plan Member Contract**
- **2024 Silver Leaf Premier Plus Plan Member Contract**
- **2025 Silver Leaf Premier Plus Plan Member Contract**
- **2026 Bronze Leaf Premier Plan Member Contract**

healthfirst

This is Your

HEALTH MAINTENANCE ORGANIZATION CONTRACT

Issued by

HEALTHFIRST PHSP, INC.

This is Your individual direct payment Contract for health maintenance organization coverage issued by Healthfirst PHSP, Inc. This Contract, together with the attached Schedule of Benefits, applications and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract. We will refund any Premium paid including any Contract fees or other charges.

Renewability. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Contract or by the Subscriber upon 30 days' prior written notice to Us.

In-Network Benefits. This Contract only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers and Participating Pharmacies in Our Network. Except for care for an Emergency Condition described in the Emergency Services and Urgent Care section of this Contract, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

This Contract is governed by the laws of New York State.



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