SECTION VI: DRAFT CONTRACT

AGREEMENT NO. C000XXX

THIS Agreement is entered into by and between the New York State Department of Civil Service ("Department" or DCS), having its principal office at the Empire State Plaza, Agency Building #1, Albany, New York 12239 and _____ ("Contractor"), a corporation authorized to do business in the State of New York with a principal place of business located at _____, and collectively referred to as the "Parties."

WITNESSETH

WHEREAS, Civil Service Law Article XI authorizes and directs the President of the State Civil Service Commission and New York State Department of Civil Service (President) to establish a health benefit plan for the benefit of State Employees, Retirees, and their Dependents, and for the benefit of Participating Employers, Retirees, and their Dependents; and

WHEREAS, Civil Service Law Article XI authorizes and directs the President to purchase a contract or contracts to provide the benefits under the plan of health benefit; and

WHEREAS, New York State, through the Department, oversees the New York State Health Insurance Program (NYSHIP) for New York State Employees and Retirees and their Dependents; and

WHEREAS, on April 23, 2015, the Department of Civil Service issued Specifications for Health Maintenance Organizations entitled "2016 HMO Specifications" to secure the services of qualified Health Maintenance Organizations for participation in the New York State Health Insurance Program (NYSHIP); and

WHEREAS, after thorough review by the State and the New York State Joint Labor Management Committees on Health Benefits of Proposals received in response to the Specifications, the Contractor represented its ability to deliver a Program Services for NYSHIP; and

WHEREAS, the Department, in reliance upon the expertise of the Contractor, desires to engage the Contractor to deliver a Program Services, pursuant to the terms and conditions set forth in this Agreement;

THEREFORE, the Parties agree as follows:

ARTICLE I: DEFINITION OF TERMS

1.1.0 **Affiliate** means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent.

1.2.0 **Agreement** means the contract that results from these Specifications between the Department and the Contractor.

1.3.0 **Business Day(s)** means every Monday through Friday, except for days designated as Business Holidays.

1.4.0 **Business Holiday(s)** means legal holidays observed by the State. For Medicare Advantage Plan and Medicare Advantage Plans with Prescription Drug Plan, Business Holidays must additionally comply with Chapter 3, section 80.1 of the Medicare Managed Care Manual.

1.5.0 **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.

1.6.0 **Centers for Medicare and Medicaid Services (CMS)** means the Federal Agency within the United States Department of Health and Human Services that is responsible for administration and oversight of various Medicare programs.

1.7.0 **Child(ren)** means children under 26 years of age, including natural children, legally adopted children, children in a waiting period prior to finalization of adoption, Enrollee stepchildren and children of the Enrollee's domestic partner. Other children who reside permanently with the Enrollee in the Enrollee's household and are chiefly dependent on the Enrollee are also eligible, subject to a statement of dependence and documentation.

1.8.0 **Clinical Manager –** means licensed PhD, clinical psychologist, licensed professional registered nurse, or licensed master's level certified social worker with a minimum of three to five years of previous position-related clinical experience.

1.9.0 **Commercial Plan** means the Plan submitted by the Contractor pursuant to this Agreement through which each Enrollee is entitled to receive comprehensive health benefits not obtained through a Medicare Advantage Plan.

1.10.0 **Coverage** means the health services and insurance benefits provided by the Contractor pursuant to this Agreement.

1.11.0 **Creditable Coverage** means prescription drug coverage that is deemed equivalent to Medicare Part D.

1.12.0 **Day(s)** means calendar day(s) unless otherwise noted in this Agreement.

1.13.0 **DCS or Department** means the New York State Department of Civil Service.

1.14.0 **Dependent** means the spouse, domestic partner, and children under twenty-six (26) years of age of an Enrollee. Young adult dependent children age twenty-six (26) or over are also eligible if they are incapable of supporting themselves due to mental or physical disability acquired before termination of their eligibility for coverage under the New York State Health Insurance Program.

1.15.0 **Dependent Survivor** means the unremarried spouse, dependent child, or domestic partner who has not acquired another domestic partner, of an Enrollee who died after having had at least ten (10) years of service, who was covered as a dependent of the deceased Enrollee at the time of the Enrollee's death and who elects to continue coverage under NYSHIP following the three (3) month extended benefits period.

1.16.0 **Disabled Lives Benefit** means the benefits provided to an Enrollee who is Totally Disabled on the date coverage ends. The benefits are provided on the same basis as if coverage had continued with no change until the day the Enrollee is no longer Totally Disabled or for ninety (90) days after the date the coverage ended, whichever is earlier.

1.17.0 **Employee** means any person defined as an Employee as defined in 4 NYCRR Part 73, as amended, or as modified by collective bargaining agreement.

1.18.0 **Employer** means Employer as defined in 4 NYCRR Part 73, as amended.

1.19.0 **Enrollee(s)** means those Employees and Retirees eligible for NYSHIP coverage as set forth in the regulations of the President of the Civil Service Commission at 4

NYCRR Part 73, and who have elected to receive HMO coverage under the terms and conditions of this Agreement.

1.20.0 **Enrollee Certificate of Insurance (Certificate)** means a comprehensive description of benefits provided through the HMO plan by the Contractor pursuant to this Agreement.

1.21.0 **ET** means prevailing Eastern Time.

1.22.0 **Health Maintenance Organization (HMO)** means any person, natural or corporate, or any groups of such persons who enter into an arrangement, agreement or plan, or any combination of arrangements or plans, which proposes to provide or offer, or which does provide or offer, a comprehensive health service plan for which the Contractor has current certification or licensure in accordance with the statutes and regulations of the State of New York and/or may operate outside the State of New York by federal qualification subject to appropriate jurisdiction for certification and oversight.

1.23.0 **HMO Member** means the Enrollee or any Dependent that is eligible, enrolled and covered by the HMO Plan.

1.24.0 **Joint Labor Management Committee (JLMC)** means a committee consisting of representatives of the State's collective bargaining units, the Department of Civil Service, and the Governor's Office of Employee Relations (GOER) which is charged with the responsibility to cooperatively develop and oversee administration of health care programs for State-represented Employees and to make mutually agreed upon changes to health insurance plan benefits.

1.25.0 **Key Subcontractor(s)** means those vendors with whom the Contractor subcontracts to provide Program Services and incorporated as a part of the Contractor's Program Team. Key Subcontractors include all vendors who will provide $100,000 or more in Program Services over the term of the Agreement that results from these Specifications, as well as any vendor who will provide Program Services in an amount lower than the $100,000 threshold and who is a part of the Contractor's Program Team.

1.26.0 **Medicare Advantage Plan (MAP)** means health benefits coverage offered under a policy or contract by an Medicare Advantage organization that includes a specific package of health benefits offered at a uniform premium and uniform level of cost-

sharing to all Medicare beneficiaries residing in the Service Area (or segment of the Service Area) of the MAP.

1.27.0 **Medicare Advantage with Prescription Drug (MAPD) Plan** means health benefits coverage offered under a policy or contract by a Medicare Advantage organization that includes a specific package of health benefits, as well as qualified prescription drug coverage, as defined at 42 CFR 423.100 and in section 20.1 of Chapter 5 of the Prescription Drug Benefit Manual, under Part D of the Social Security Act, as amended.

1.28.0 **MMCM** means the Centers for Medicare and Medicare Services Medicare Managed Care Manual.

1.29.0 **MAPD Evidence of Coverage (EOC)** means a comprehensive description of services and benefits provided to MAPD Members through the MAPD Plan. The EOC also defines the rights and responsibilities of the Member and the MA Organization under the MAPD Plan.

1.30.0 **MAPD Member(s)** means the MAPD Enrollee(s) or any Dependent that is eligible, enrolled and covered by the MAPD Plan.

1.31.0 **MAPD Enrollee(s)** means the eligible Employee or Retiree who is eligible to receive MAPD benefits under the rules, regulations and conditions of the NYSHIP and CMS, and is enrolled in the MAPD Plan.

1.32.0 **NYS** means New York State.

1.33.0 **NYSHIP** means the New York State Health Insurance Program.

1.34.0 **Offeror** means a person or entity that submits a Proposal in response to these Specifications.

1.35.0 **Option Transfer Period** means the period of time established by the Employer during which an Employee may transfer enrollment from one available health benefit plan (either an HMO or indemnity plan) to a different available plan.

1.36.0 **Participating Employer (PE)** means a public authority, public benefit corporation, or other public agency, subdivision, or quasi-public organization of the State which elects,

with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

1.37.0 **Periodic Recruitment** means the State's reserved right to consider additional HMOs starting on the one year anniversary of the award start date or at any time deemed to be in the best interests of the State. Potential additional HMOs shall be required to submit an original bid document and, where applicable, bids shall be evaluated under the original "Specifications For Health Maintenance Organizations Participation in the New York State Health Insurance Program" requirements. An addendum containing additional applicable statutory requirements currently in effect at the time of the periodic recruitment may be added to the recruitment. The State is not required to award on offers under Periodic Recruitment.

1.38.0 **Plan** means the proposed health plan submitted by the Contractor for NYSHIP.

1.39.0 **Plan Year** means the period from January 1st to December 31st in each year covered by the Agreement, unless specified otherwise.

1.40.0 **President** means the President of the New York State Civil Service Commission and the Commissioner of the DCS.

1.41.0 **Program Services** means all of the services to be provided by the Contractor as set forth in these Specifications.

1.42.0 **Proposal or Submission** means the Contractor response to the 2016 HMO Specification including all responses to supplemental requests for clarification, information, or documentation submitted during the course of the Procurement.

1.43.0 **Regulations of the President of the Civil Service Commission** means those regulations promulgated by the DCS pursuant to Civil Service Law, Article XI, as amended, including but not limited to those rules and regulations found at 4 New York Code of Rules and Regulations (NYCRR) Part 73, as amended.

1.44.0 **Required Annual Submission** means the Contractor's response to program requirements in years 2 – 5 of the Agreement that results from these Specifications, including all responses to supplemental requests for clarification, information or documentation during the term of the Agreement.

1.45.0 **Retiree** means any person defined as a Retiree pursuant to the terms of 4 NYCRR Part 73, as amended.

1.46.0 **Service Area** means the approved counties in which an Contractor is authorized to offer services.

1.47.0 **Specifications** means the document entitled "2016 HMO Specifications for the New York Health Insurance Program (NYSHIP)" dated April 23, 2015.

1.48.0 **State** means New York State as a whole.

1.49.0 **Summary of Benefits and Coverage (SBC) :** means a federally mandated document that accurately describes the NYSHIP group benefits and coverage.

1.50.0 **SERFF** means the System for Electronic Rate and Form Filing system used by the DFS for rate filings.

1.51.0 **Total Disability and Totally Disabled** means that because of a medical or mental health/substance abuse condition, the Enrollee, cannot perform his/her job or the Dependent cannot perform the normal activities of a person that age.

1.52.0 **Vestee** means a former Employee who is entitled to continue benefits under NYSHIP because he/she has met all the requirements for NYSHIP coverage as a Retiree, except for age eligibility for pension, at the time employment terminates.

ARTICLE II AGREEMENT DURATION AND AMENDMENTS

2.1.0 This Agreement shall be subject to the approval of the New York State Attorney General's Office ("AG") and the NYS Office of the State Comptroller ("OSC"). The term of the Agreement is for the period starting January 1, 2016 through and including December 31, 2020, and subject to the termination provisions contained herein.

2.2.0 This Agreement is subject to amendment(s) only upon consent of the Parties, reduced to writing and approved by the AG and OSC.

2.3.0 The Contractor's continued participation in NYSHIP for each year subsequent to the initial year of the term is contingent upon the Department and the JLMC's review and approval of the following documents. The Contractor shall submit Required Annual Submission documents to the Department by the established deadline, including, but not limited to:

2.3.1 New York State (NYS) Department of Health Certification for HMOs to operate within an approved Service Area and the ability to provide comprehensive hospital, medical and prescription drug benefits for covered Enrollees;

2.3.2 Current HMO status based on the National Committee on Quality Assurance (NCQA);

2.3.3 Key Subcontractors listing;

2.3.4 Service Area expansion requests, if any;

2.3.5 Submission to offer or discontinue a Medicare Advantage Plan;

2.3.6 Most recent annual filing of Schedule M (Complaints); and

2.3.7 Coverage and benefit documents, including but not limited to:

2.3.7a Enrollee Certificate of Insurance

2.3.7b MAP and MAPD Evidence of Coverage

2.3.7c Choices - HMO e-page

2.3.7d Schedule of Benefits

2.3.7e Side by Side comparison of changes in benefits from current year to upcoming year

2.3.7f Coverage Riders and Addendums

2.3.7g Annual communication materials to Enrollees

2.3.7h Summary of Benefits and Coverage (SBC)

2.3.7i Other required submission material

2.4.0 The Required Annual Submission, listed in Section 2.30 of this Agreement shall be the basis of the Contractor's continuation in NYSHIP unless the Department chooses to amend any of the Required Annual Submission documents. Should the requirements be amended, the Department shall notify the Contractor in writing no later than thirty (30) days prior to the requested due date of the Required Annual Submission. Contractor's failure to submit the Required Annual Submission for the JLMC's review or failure to obtain the JLMC's approval by the Department's established deadlines may result in the Department's termination of the Agreement or placement of restrictions on the Contractor's participation in NYSHIP.

2.5.0 If the JLMC approves continuation, the Contractor shall be required to enter into such annual renewal at a premium rate to be specified in accordance with Article XIV, of this

Agreement entitled, "Determination of Rate Basis, Payment of Premiums and Grace Period."

2.6.0 During years 2 – 5 of the term of the Agreement, the JLMC, at its sole discretion, may determine that a geographic region is underserved by HMO coverage. In such circumstances, the Department will request current NYSHIP participating HMOs to submit expansion requests into the designated underserved area as part of the Required Annual Submission. All expansion requests into underserved areas must be contiguous to the HMO's approved NYSHIP Service Area.

2.7.0 This Agreement is subject to amendment(s) only upon the mutual consent of the Parties, reduced to writing and approved by the Office of the Attorney General and the Office of the State Comptroller of the State of New York.

Article III: INTEGRATION

3.1.0 This Agreement, including all Exhibits, copies of which are attached hereto and incorporated by reference, constitutes the entire Agreement between the Parties. All prior Agreements, representations, statements, negotiations, and undertakings are superseded hereby.

3.2.0 All statements made by the Department shall be deemed to be representations and not warranties.

ARTICLE IV: DOCUMENT INCORPORATION AND ORDER OF PRECEDENCE

4.1.0 The Agreement consists of:

4.1.1 The body of this Agreement (that portion preceding the signatures of the Parties in execution) and any amendments thereto;

4.1.2 Appendix A - Standard Clauses for all New York State Contracts;

4.1.3 Appendix B - Standard Clauses for All Department Contracts;

4.1.4 Appendix C - Third Party Connection and Data Sharing Agreement;

4.1.5 Appendix D - Participation by Minority Group Members and Women with Respect to State Contracts: Requirements and Procedures; Appendix D-1: Minority and Women-Owned Business Enterprises – Equal Employment Opportunity Policy Statement; and Appendix D-2: MWBE Utilization Reporting Responsibilities under Article 15-A; and

4.1.6 The following Exhibits attached and incorporated by reference to the body of the Agreement:

4.1.6a Exhibit A: The MacBride Act Statement and the Non-Collusive Bidding Certification;

4.1.6b Exhibit B: 2016 HMO Specifications dated April 23, 2015; and Exhibit B-1 – Official Department Response to Questions Raised Concerning the 2016 HMO Specifications, dated (*insert Date*); and

4.1.6c Exhibit C: Contractor's Proposal dated *(insert Date)*; Exhibit C-1: Written responses to clarifying questions regarding Contractor's Proposal.

4.1.7 In the event of any inconsistency in or conflict among the document elements of the Agreement identified above, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

4.1.7a First, Appendix A - Standard Clauses for All New York State Contracts;

4.1.7b Second, Appendix B - Standard Clauses for All Department Contracts;

4.1.7c Third, Appendix C - Third Party Connection and Data Sharing Agreement;

4.1.7d Fourth, Appendix D - Participation by Minority Group Members and Women with Respect to State Contracts: Requirements and Procedures; Appendix D-1: Minority and Women-Owned Business Enterprises – Equal Employment Opportunity Policy Statement; and Appendix D-2: MWBE Utilization Reporting Responsibilities under Article 15-A;

4.1.7e Fifth, any Amendments to the body of this Agreement;

4.1.7f Sixth, the body of this Agreement;

4.1.7g Seventh, Exhibit A the MacBride Act Statement and the Non-Collusive Bidding Certification;

4.1.7h Eighth, Exhibit B – the 2016 HMO Specifications dated April 23, 2015; and Exhibit B-1 – the official Department response to questions raised concerning the 2016 HMO Specifications, dated (*insert Date*); and

4.1.7i Ninth, Exhibit C – the Contractor's Proposal; and, Exhibit C-1 – Written responses to clarifying questions regarding Contractor's Proposal.

4.2.0 The terms, provisions, representations and warranties contained in the Agreement shall survive performance hereunder.

ARTICLE V: LEGAL AUTHORITY TO PERFORM

5.1.0 The Contractor shall maintain appropriate corporate and/or legal authority, which shall include but is not limited to the maintenance of an administrative organization capable of delivering the Program Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which the Program Services are to be delivered.

5.2.0 Contractor agrees that it shall perform its obligations under this Agreement in accordance with all applicable federal and NYS laws, rules and regulations, policies and/or guidelines now or hereafter in effect.

5.3.0 The Contractor shall provide the Department with immediate notice in writing of the initiation of any legal action or suit which relates in any way to the Agreement, or which may affect the performance of Contractor's duties under the Agreement.

ARTICLE VI: PROGRAM SERVICES

6.1.0 The Contractor shall submit for the JLMC's review and approval a Plan in accordance with the Specifications (Exhibit B) and the Contractor's Proposal (Exhibit C). No aspect of Contractor's performance of Program Services under the Plan in accordance with the terms and conditions of the Agreement and the Specifications, shall be contingent upon State personnel or the availability of State resources with the exception of all proposed actions of the Contractor specifically identified in the Agreement as requiring Department approval. The Department shall act promptly and in good faith with respect to its approval or disapproval of the Plan.

6.2.0 **Commercial Plan Benefits***:* Any changes in benefits and/or Coverage in years subsequent to the first year of the Agreement shall be presented to the Department and JLMC in response to the Required Annual Submission. The Commercial Plan Benefits must:

6.2.1 Be fully ACA compliant;

6.2.2 Specify copayments or coinsurance, as part of the benefit package; however, copayments or coinsurance for inpatient hospital care and annual deductibles are not permitted;

6.2.3 Comply with all services required by Federal and NYS laws and/or regulations in addition to the following enhanced coverage:

6.2.3a ***Prosthetic Devices****:* Medically necessary prosthetic devices that aid body functioning or replace a limb or body part in order to correct a defect of body form or function must be covered. Examples of prosthetic devices include but are not limited to: artificial limbs, pacemakers, heart valve replacements, artificial joints, external breast prostheses and ostomy supplies. Replacements, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement must be covered when functionally necessary;

6.2.3b ***Durable Medical Equipment****:* Medically necessary Durable Medical Equipment (DME) that can withstand repeated use and is primarily used to serve a medical purpose must be covered. Examples of DME include but are not limited to: wheelchairs, walkers, respiratory equipment, and oxygen supplies. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement must be covered when functionally necessary;

6.2.3c ***Orthotic Devices****:* Medically Necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot must be covered. Orthopedic shoes and other supportive devices for treatment of weak, strained, flat, unstable or unbalanced feet should not be included for coverage. Replacements, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement must be covered when functionally necessary;

6.2.3d ***Prescription Drugs****:* Medically necessary federal legend and state restricted drugs, compounded medications and injectable and self-injectable medications, contraceptive drugs and devices, fertility drugs and enteral formulas must be covered. (The copayment for self-

injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs, except drugs limited to 30-day supply at dispensing.) No annual or lifetime maximum permitted; and

6.2.3e ***Gender Identity Disorder Services****:* Diagnosis and treatment of Gender Dysphoria must be covered.

6.2.4 Benefits for services not listed as minimum benefit requirements pursuant to this Section 6.2.0, such as routine/preventive dental services and/or the provision of eyeglasses for routine vision correction may be included in the Contractor's standard package. However, riders that include an additional charge for such benefits will not be accepted. Exclusions and other limiting language are subject to modification by the Department in consultation with the JLMC.

6.3.0 Use of Standard Contracts and Riders*:* Contractors may propose to meet the minimum benefit requirements set forth in these Specifications through the use of a standard contract, or through a combination of a standard contract and riders.

6.3.1 A rider shall be accepted by the Department in consultation with the JLMC only if such rider is necessary to bring the standard Plan proposed by the Contractor into conformity with the minimum benefit requirements. It is <u>not</u> the intent of the Department to purchase from Contractors riders that increase the Plan benefit package to a level above the minimum requirements set forth in the Specifications. Riders that provide benefits not required by the minimum benefit requirements, or that provide benefits in excess of the minimum benefit requirements, may be rejected by the Department in consultation with the JLMC.

6.4.0 Medicare Advantage Plan Benefit Requirements (If Offered): Contractor must comply with CMS guidelines and, in addition, the benefit levels provided, must meet or exceed the minimum benefits as set forth in Section 6.2.0 above. Other benefits above the minimum benefits must be comparable to those provided to non-Medicare primary Enrollees. Instances where Federal Law and/or regulation preclude a Contractor from complying with this requirement must be clearly identified in the Contractor's Proposal.

6.4.1 Contractor's MA Plan must be CMS approved for all counties in the proposed Service Area.

6.4.2 The Contractor may submit only one Plan for Medicare primary Enrollees, either the Commercial Plan which coordinates with Medicare and includes prescription drug coverage equal to, or better than, Medicare Part D or a Medicare Advantage with Prescription Drug Plan.

6.4.3 The Contractor must provide Medicare Part D coverage in the coverage gap at a level equal to the Commercial Plan.

6.4.4 If the Contractor's Medicare ranking falls below 3 stars and has its enrollment frozen by CMS the Contractor must keep an Enrollee that otherwise would have aged-into the Medicare Advantage Plan in the Commercial Plan until CMS lifts the enrollment freeze.

6.5.0 Service Accessibility:

6.5.1 The Contractor is required to include in its network various State-run facilities located throughout New York State, (e.g., Roswell Park Cancer Institute, and Helen Hayes Hospital) if such hospitals are within the Contractor's proposed Service Area.

6.5.2 Twenty-four (24) Hour Coverage: Consistent with New York State laws and/or regulations, the Contractor must provide coverage to members, either directly or through their Primary Care Physician (PCP), twenty-four (24) hours a day, seven days a week. Contractors also must instruct their members on what to do to obtain services after regular business hours.

6.5.3 Days to Appointment: Contractor must contract with providers who agree to abide with the following appointment standards:

6.5.3a Emergency medical or mental health and substance abuse problems, immediately;

6.5.3b Urgent medical or mental health and substance abuse problems, within 24 hours of request;

6.5.3c Non-urgent "sick visits," within 48 to 72 hours, as clinically indicated;

6.5.3d In-Plan, non-urgent mental health and substance abuse visits, within two (2) weeks;

6.5.3e Adult baseline and routine physicals and non-urgent or preventive care visits, within twelve (12) weeks;

6.5.3f Initial prenatal visits, within three (3) weeks during the first trimester and two (2) weeks thereafter; and

6.5.3g Initial visit for newborns to their PCP, within two (2) weeks of hospital discharge.

6.6.0 Communication Material Requirements:

6.6.1 All Enrollee material as well as all communications material must be sent to all members of the JLMC and approved by the Department prior to distribution to State Enrollees. This includes both annual benefit plan communications and updated communications distributed by the Contractor throughout the year.

6.6.1a All communication material must present a clear, factually correct, complete and easily understood description of the benefits available through the Contractor. Any incorrect or incomplete communications sent by the Contractor to NYSHIP Enrollees related to required communication materials as set forth in Article XV of the Agreement must be corrected and re-sent at the Contractor's expense. Benefits offered and/or received prior to this correction must be covered until Enrollees receive the correction notification or, at the discretion of the Department in consultation with the JLMC, for the balance of the Plan Year.

6.6.1b Communication materials may promote the Contractor but must not make general or specific comparisons to any other NYSHIP option. The Contractor will not be permitted to make reference to the Empire Plan or Plan specific comparisons to other NYSHIP HMOs. For example, a Contractor may not state that they "serve more NYSHIP members than any other HMO that participates in NYSHIP."

6.6.1c Communication activities may not discriminate on the basis of a potential member's health status, prior use of health service, or need for future health services.

6.6.1d The Contractor may not engage in communication practices or distribute communication materials that mislead or confuse NYSHIP enrollees by promoting benefits for which the NYSHIP Enrollee is not covered.

6.6.1e The premium cost of all NYSHIP health plan options will be communicated to Enrollees by the Employee Benefits Division, Department of Civil Service, and shall not be included in any communication materials distributed by any Contractor, with the exception of rate filing notifications required by the NYS Department of Financial Services.

6.6.1f Visual presentations of Enrollees in the Contractor communication material must be representative of the diversity within the New York State enrollment.

6.6.2 The Contractor is required to timely submit drafts of the Cover Letter, federally mandated Summary of Benefits and Coverage (SBC), Schedule of Benefits, and Side-by-Side Comparison of Benefit Changes in both hard copies and PDF with their Required Annual Submission. The Department may amend the mailing date(s) of communication materials for Retiree groups should it be necessary to coordinate these mailing(s) with Department communications.

6.6.2a The required communication material, after approval by the Department and JLMC, will require that the Cover Letter, Schedule of Benefits, and the applicable Side-by-Side Comparison of Benefit Changes be transmitted to Enrollees in one mailing. Final versions of these mailings must be sent to all JLMC Contact Members one (1) week prior to distribution to Enrollees.

6.6.2b The Contractor may, however, direct NYSHIP Enrollees to rate information provided by the Department. Rate information is provided on the Department's web site at www.cs.ny.gov.

6.6.2c ***Cover letters:*** The Communications Materials mailing to Contractor members must be submitted as part of the Contractor's Required Annual Submission. The Contractor must include the following statement in the Cover Letter, "Your Eligibility Guidelines may be

different from those guidelines listed in the contract. Please refer to your NYSHIP General Information Book for these guidelines or visit the New York State Department of Civil Service's web site at www.cs.ny.gov."

6.6.2d ***Summary of Benefits and Coverage (SBC) :*** The Contractor must comply with ACA to produce, revise, distribute and translate, upon request, an SBC that accurately describes the NYSHIP group benefits and coverage. The SBC must be provided to the Department in an electronic format as a PDF document no later than 30 days before the beginning of each Plan Year for posting to the Department's website. The Contractor must distribute a SBC to any eligible Employee or Retiree contacting the Contractor or the Department to request a copy in accordance with ACA requirements for timely distribution. Annually, at Plan renewal or upon material modification of the SBC, the Contractor must provide notice to all current Enrollees via a postcard, plan materials, or other Federally-compliant means of notification of how to view or obtain a copy of the SBC from the Contractor.

6.6.2e ***Schedule of Benefits:*** The Contractor's Schedule of Benefits must include, but not be limited to, applicable copayments and/or coinsurance levels. The Schedule of Benefits must also include a comprehensive description of limitations and exclusions. A separate Schedule of Benefits is required for the Commercial HMO Plan and the Medicare Advantage Plan, if offered by the Contractor.

6.6.2f ***Side by Side Comparison on Benefits:*** The Contractors is required to submit a Side by Side Comparison of Benefits that lists changes in the benefits offered to Enrollees from the previous year to the current year, if it participated in NYSHIP in the previous year. Such changes include, but are not limited to: copayments; new benefits; number of days of a prescription drug supply; delivery of services; and provider networks. In the event there are no changes in the benefits offered, the Contractor will be required to mail to members an affirmative statement that states that there are no changes in either the benefits offered or delivery of services from the previous year. The Side by Side Comparison of Benefits must

be provided to the Department in an electronic format as a PDF document no later than 30 days before the beginning of each Plan Year for posting to the Department's website.

6.6.3 ***Choices Guide*:** To assist NYSHIP Enrollees in choosing a health insurance plan during the annual Option Transfer Period, the Department will develop the Choices Guide. This Guide contains uniformly formatted pages for each Plan offering (Commercial and Medicare Advantage, if offered) so that Enrollees may easily compare the benefits offered.

6.6.4 ***Optional Marketing Materials and Activities:*** If the Contractor chooses to distribute optional marketing materials and/or participate in optional activities, it must:

6.6.4a Develop and distribute generic marketing materials to NYSHIP Enrollees who live or work in the Contractor's approved NYSHIP Service Area, that are consistent with NYSHIP benefits. The Department will not provide any information to the Contractor regarding the identification of eligible NYSHIP Enrollees or their mailing addresses. Any optional marketing materials mailed by the Contractor, including provider directories and newsletters, must be submitted in advance to all JLMC Contact Members;

6.6.4b Not provide potential NYSHIP members with giveaways as an inducement to enroll in the HMO;

6.6.4c Not permitted to conduct marketing activities at State work sites without prior approval of the Department. Requests for such activities must be submitted to the Department, Attention: Employee Benefits Division, Communications Unit, in writing with a copy to the Governor's Office of Employee Relations, Attention: Employee Benefits Management Unit. Marketing activities include, but are not limited to, participation in health fairs and information booths. The Contractor may only distribute materials that provide specific information regarding the HMO or relate to general health care issues at such approved work site presentations. Items that do not meet these criteria and have no more than a nominal

value may be distributed to NYSHIP Enrollees attending conferences and/or meetings that are not held at the work site; and

6.6.4d Not state how much premiums will decrease or how much savings may be realized, as a result of the Contractor's benefit changes that are expected to reduce premium costs. A notation may be included in the Contractor's Optional Marketing Materials that certain benefit changes are expected to result in decreased premiums or to help limit premium increases.

6.7.0 Reporting

6.7.1 *Complaint/Grievance/External Appeals*

6.7.1a ***Complaints:*** The Contractor must maintain records of all complaints that have been unresolved for more than forty-five days (45) days. Such records shall include the actual complaint, all correspondence related to the complaint, and an explanation of the disposition of the complaint. The Contractor must make these records available to the JLMC Contact Members upon request. All Enrollee identifying information must be redacted.

6.7.1b ***Grievances:*** The Contractor must maintain a report summarizing the number of grievances filed for the most recent Plan Year, sorted by procedure type. The report must include the total number of grievances, the number of grievances upheld, overturned, modified or withdrawn. The Contractor must make these records available to the JLMC Contract Members upon request.

6.7.1c ***External Appeals:*** The Contractor must maintain a report summarizing the number of external appeals filed for the most recent Plan Year, sorted by procedure type. The report must include the total number of external appeals, the number of appeals upheld, overturned, modified or withdrawn. The Contractor must make these records available to the JLMC Contract Members upon request.

6.7.1d The Department reserves the right to seek information immediately from the Contractor pursuant to investigation of a particular member or provider complaint.

6.7.2. ***Member Satisfaction Surveys:*** The Contractor must provide a copy of any member satisfaction survey that includes NYSHIP Enrollees and survey results electronically in searchable format within 30 days upon request from any JLMC Contact Member.

6.7.3. ***Medicare Advantage Plan Enrollments/Disenrollments:*** The Contractor must notify the Department on a monthly basis of any members who are no longer eligible to be enrolled in the Medicare Advantage Plan for reasons identified by the Contractor or CMS, including but not limited to: missing HICN; and no Medicare Parts A and/or B. The Department must also be notified if an Enrollee moved out of the Contractor's Service Area or is deceased.

6.7.4. ***Federal Medical Loss Ratio (MLR):*** The Contractor must file its Medical Loss Ratio (MLR) with the federal government by June 1 each year for the prior Calendar Year. In those instances where the Contractor fails to meet the required MLR threshold for community rated large group contracts during the preceding Calendar Year, rebates must be paid to NYSHIP by August 1 of the current calendar year. In addition, notification must be provided to both Enrollees and the employer group in instances where the MLR threshold has not been met, in accordance with ACA regulations.

6.7.5. ***Low Income Subsidy (LIS):*** The Contactor must submit an LIS report to the Department no later than fifteen (15) Business Days from the date the Contractor receives the subsidy payment from CMS. The report must include the following information regarding payments made by the Contractor to LIS Enrollees: 1) Payment Date; 2) Carrier ID; 3) Benefit Plan; 4) Benefit Program; 5) Last Name; 6) First Name; 7) DOB; 8) HICN; 9) Member ID; 10) SSN; 11) # of Payments; 12) Payment Start Date; 13) Payment End Date; 14) ADJ Reason Code; 15) ADJ Reason Code Description; and 16) LIS Premium Subsidy Amount.

6.7.6. ***Healthcare Effectiveness Data and Information Set (HEDIS) Reports:*** Consistent with State and Federal regulations, The Contractor must complete HEDIS reports on a timely basis.

6.8.0 Submission of Premium Rates: In order to prepare for the annual health insurance Option Transfer Period, NYSHIP premium rate submissions are due to the Department by September 1 of each Calendar Year. The premium rates shall be accompanied by the

Contractor's most recent available year-to-date loss ratio for the community pool in which NYSHIP Enrollees are included. The premiums submitted to the Department shall be guaranteed rates under the NYS Department of Financial Services (DFS) regulation 11 NYCRR 52.42(b). The premium rates guaranteed shall be the presently prevailing approved or filed premiums or the Contractor's best estimate of the expected average filed or approved premium rates for the following year adjusted by any prospective or retrospective adjustments required for guaranteed premium rates under 11 NYCRR 52.42(b). The premium rates for those Enrollees who reside out of state must be the same as NYS premium rates filed with the NYS DFS. Upon request, the Contractor shall provide detailed information to support the quoted premium rates:

6.8.1 ***NYS DFS Rates Filed and Approved:*** The Contractor must provide a complete copy of the NYS DFS's "Prior Approval Rate Change" application along with the printout of the SERFF disposition notice indicating NYSDFS approval of the rates submitted must be submitted to the Department by September 1 of each Calendar Year.

6.8.2. ***Rates Filed and Pending NYS DFS Acknowledgment:*** If the Contractor has a with rate request pending NYS DFS's approval with an effective date no later than January 1, the Contractor must submit a complete copy of the NYS DFS "Prior Approval Rate Change" application and the SERFF application notice indicating submission of the application by September 1 of each Calendar Year. The receipt confirmation from the NYS DFS must be sent to the Department by February 1 of each year.

6.8.3. ***Rates Not Yet Submitted for NYS DFS Approval****:* If the Contractor intends to submit a rate increase or decrease to the NYS DFS but has not made the submission by the Rate Submission Deadline, the Contractor must provide a letter from the Contractor's Chief Executive Officer, by September 1 of each Calendar Year, which states that the Contractor has not yet submitted a request for a rate increase/decrease to the NYS DFS but intends to file a "Prior Approval Rate Change" application for a rate increase/decrease to be effective on or before January 1 and that the rates submitted to NYSHIP are the best estimate of the rates which will be submitted to the NYS DFS. A complete copy of the SERFF application notice indicating submission of the "Prior Approval Rate Change" application and the receipt confirmation from the NYS DFS must be submitted to the Department by February 1 of each Calendar Year. If the

Contractor has not provided rates by September 1 of each Calendar Year it may be excluded by the Department in consultation with the JLMC as a NYSHIP health plan option for the period covered by these Specifications.

6.8.4 ***Premium Rate Billing:*** NYSHIP rates are comprised of (1) the Contractor's Community Rates associated with the JLMC approved benefits for the following Plan Year, as submitted to and approved by the NYS Department of Financial Services (DFS), (2) Medicare Rate Adjustments (if applicable); and (3) Prior Period Adjustments:

6.8.4a ***Community Rates***: The basis for NYSHIP rates are the Contractor's Community Rates (basic contract rates and required benefit rider rates) for Plan Year for the specific Commercial Plan approved by the Department in consultation with the JLMC which have either been approved or are pending approval by DFS.

6.8.4b ***Medicare Rate Adjustments:*** NYSHIP's rate structure and billing system do not differentiate between Medicare and non-Medicare contracts. Regardless of Medicare status, Enrollees/Employers are billed and the Contractor will be paid the same rates. In accordance with CMS guidelines, the Contractor is required to submit Medicare Rates to CMS for each Medicare Plan. The premium rates for the Medicare Plan approved by the JLMC will vary from the Commercial Plan rates; they are typically less than those for the Commercial Plan. The variances between the Commercial Plan rates and the Medicare Rates are recognized in the NYSHIP rate development calculation by means of adjustments to the Community Rates.

6.8.4c ***Prior Period Adjustments:*** The Contractor's NYSHIP premium rate submission will include Community Rates that are pending approval by DFS. The rates eventually approved by DFS may be greater than or less than the Community Rates submitted to the Department and implemented for the Plan Year, resulting in insufficient or excess premiums paid to the Contractor, respectively. As such, the NYSHIP premium rate calculations incorporate prior period adjustment calculations to recognize those differences between the submitted rates and the final approved DFS rates. The prior period adjustment

calculations represent the differences in the initial and final rates multiplied by actual current year enrollment (as provided by the Department, taken from NYBEAS) and are applied as adjustment to the Community Rates.

6.8.4d The Contractor may submit for a rate adjustment to DFS with an effective date of January 1. Such rate adjustment is only applicable until another rate request is made and approved by DFS. For administrative purposes, the Contractor may guarantee the payment of the implemented rate for one year and incorporate any approved mid-year rate changes into the prior period adjustment of the following year's guaranteed rate.

6.8.4e For a Contractor that has withdrawn from NYSHIP, within the first six months following its withdrawal, a prior period calculation will be required for each of administered NYSHIP options. Unlike the active HMO options in which prior period adjustments are applied to a future rate period, an aggregate overpayment/underpayment is calculated for the withdrawn Contractor. An aggregate credit, or negative, dollar amount would represent an overpayment of prior year premium by DCS to the Contractor. An aggregate debit, or positive, dollar amount would represent an underpayment or prior year premium by the Department to the Contractor. The period adjustment calculation is subject to review and approval by the Department. Upon written approval of the prior period adjustment calculation by the Department, any amount due, whether to the Department or the Contractor, shall be paid within thirty days of written approval.

6.9.0 Administrative Requirements

6.9.1 ***Account Management Team:*** The Contractor must have an Account Management Team with a proactive, experienced account leader and team in place who have the authority and expertise to coordinate the appropriate resources to:

6.9.1a Ensure that there is a process in place to gain immediate access to appropriate corporate resources and senior management necessary to

meet all Contractor Program requirements and to address any issues that may arise during the performance of the Agreement;

6.9.1b Ensure the Account Management Team is accessible and sufficiently staffed to provide timely responses (within 1 to 2 Business Days) to concerns and inquiries posed by the Department, or other staff on behalf of the JLMC regarding member-specific claims issues for the duration of the Agreement to the satisfaction of the Department; and

6.9.1c Immediately notify the Department, in writing, of actual or anticipated events impacting the Program requirements and/or delivery of services to Enrollees such as but not limited to: change from not-for-profit status to for-profit status;, applications by another party to acquire control of the Contractor; legislation; class action settlements; and operational issues.

6.9.2 ***Alternate Identification Number:*** The Contractor must use an identification number other than Social Security Number on identification cards and other documents, forms or correspondence provided to users external to the Contractor for its members enrolled through NYSHIP.

6.9.3 ***Hospital and Provider Group Changes:*** The Contractor must advise all JLMC Contact Members of the potential withdrawal of any hospital or hospital group and of any significant provider group from the Contractor's provider network as soon as the potential withdrawal is identified, but no later than thirty (30) days prior to the group's potential withdrawal date.

6.9.4 ***NYSHIP Standing within HMO Customer Base:*** For the initial year of this contract term, the Contractor is required to list its current ten largest employer groups, in descending order, by number of contracts for the organization's HMO business (i.e., large group HMO product) in which NYSHIP is included and indicate where NYSHIP enrollment would rank in the standings. Thereafter, the Contractor must advise the Department and JLMC Contact Members of any change to NYSHIP's position in the standings as part of the Annual Required Submission.

6.9.5 ***Key Subcontractor Changes:*** The Contractor must provide all JLMC Contact Members with notification of changes in Key Subcontractors within thirty (30) days of such changes becoming final.

6.9.6 ***Region Configuration Changes:*** The Contractor must notify the Department, in writing, in advance of all proposed changes in the configuration of Service Area counties, including a shift in counties within rating regions or the establishment of a new rating region(s). This notification must be made to the Department at the time the request is submitted to the regulatory agency and noted as pending. The Contractor must notify the Department of the determination by the regulatory agency, and upon approval, be provided all pertinent information including, but not limited to the effective date of the change. The Contractor must also provide the Department and all JLMC Contact Members with copies of all notification materials for members impacted by the reconfiguration of Service Area prior to distribution to the members.

6.9.7 ***Website Access:*** The Contractor must provide the Department and JLMC Contact Members responsible for administrative oversight of NYSHIP HMOs with access to website applications that are available only to members. The Contractor must also provide the URL of the main website and provide a dummy ID and password so that the Department may view the capabilities and user friendliness of the Contractor's website.

6.9.8 ***Enrollment Data Transmission Requirement:*** The Contractor must use the enrollment data transmission protocol and encryption method stipulated by the Department. The current data transmission protocol must be Secure FTP, and the current encryption methodology must be PGP, or as otherwise specified by the Department. Secure FTP must be compatible with the OpenSSH implementation of Secure FTP. Further, the Contractor must agree to execute the Department's Third Party Connection Agreement and Third Party User Agreement and any amendments, as required as well as any other agreement or protocol required by the Department to ensure the security of its data transmissions.

6.9.9 ***Release of Protected Health Information Requirement:*** The Contractor must accept a signed and valid NYSHIP Authorization for Release of Protected Health Information form, or any alternative form developed during the term of the

Agreement, for the purpose of the release of protected health information to NYSHIP representatives.

6.9.10 ***Medicare Secondary Payer Claim Administration (Applies only to Commercial Plan):*** The Contractor must agree to follow the procedures set forth below in handling Medicare Secondary Payer (MSP) claims for any NYSHIP Enrollees and Dependents:

6.9.10a Upon receipt of a demand letter directly from the Centers of Medicaid and Medicare Services (CMS) or indirectly from the Department for the payment of a claim that was paid primary by Medicare and for which CMS asserts NYSHIP coverage should have been primary, the Contractor shall make its best effort to resolve the claim within the timeframe specified by CMS. This shall include working with the Department to determine the claimant's employment status at the time the claim was incurred, the amount of liability for such claim on the part of the Contractor and the payment of any liability owed by the Contractor to CMS;

6.9.10b In the event an MSP claim is not settled with CMS within the timeframe specified in the demand letter, the Department reserves the right to have CMS reimbursed the full amount of the claim by another NYSHIP plan administrator for the purpose of avoiding any interest charges and/or the offset of other Federal funds payable to the State. The Contractor agrees that if it is determined that there was liability for payment of all or part of such claim including accrued interest, the Contractor shall, upon the direction of the Department, repay to the NYSHIP Plan administrator amounts paid on behalf of the Contractor for MSP claims by the NYSHIP Plan administrator;

6.9.10c The Contractor agrees to periodically report to the Department the status of any unresolved MSP claims, including both claims received directly from CMS or indirectly received from the Department. The timing and information to be included in such reports shall be specified by the Department. In addition, the Contractor shall provide to the Department copies of any correspondence it sends to CMS regarding NYSHIP MSP claims; and

6.9.10d In the event there is an offset of Federal funds payable to a New York State agency by the U.S. Treasury because of an unresolved MSP claim attributable to the Contractor, the Department shall reimburse such agency for the offset using monies from the Health Insurance Fund and shall reduce the next premium payment to the Contractor by the amount of such offset.

6.10.0 Coordination with Medicare: The Contractor must comply with any and all requests from the Department for assistance and such other support as the Department may require to ensure a correct and adequate interface between NYSHIP and the Centers for Medicare and Medicaid Services (CMS). Such services shall include at least the following tasks and such other tasks as may be added in guidance and further regulation by CMS:

6.10.1 ***Retiree Drug Subsidy*:** If the Contractor does not administer an approved Medicare Advantage Plan for NYSHIP, the Contractor shall disclose to CMS, on behalf of the Department, any information received from the Department or within the Contractor's control, necessary for the Department to comply with requirements of the Retiree Drug Subsidy (RDS). This includes providing and maintaining the accounting and enrollment records, as well as reporting documentation in the format and layout required by the Department, necessary to enable the Department to collect and verify the Retiree Drug Subsidy from CMS. The format and layout will be provided to the Contractor and may be revised at the discretion of the Department. If revised, the Department shall provide revised layout documentation to the Contractor. Required RDS tasks shall include, but not be limited to:

6.10.1a Timely submission by the Contractor to the Department all records and reports in a manner, form, and timeliness acceptable to the Department as required support of the Contractor's semi-annually submission of data to CMS in order to permit the Department's receipt of Retiree Drug Subsidy payments on a semi-annually basis. Semi-annually data submission must be received by the Department no later than 45 days following the end of each semi-annual period;

6.10.1b Timely submission by the Contractor to the Department of all records and reports in a manner and form acceptable to the Department as

required support to complete the annual reconciliation process. Such records must be in compliance with CMS and Department requirements, including but are not limited to:

6.10.1b(1) Tracking of final paid claims;

6.10.1b(2) Submitted to the Department all components of the annual RDS Reconciliation Reporting (Detail and Summary Payment files, Detail and Summary Payment file, Record Counts and Cost Report), meeting the Departments' specifications for completeness and accuracy, no later than February 1 of the calendar year in which the Reconciliation is required to be filed with CMS; and;

6.10.1b(3) Agreeing to performance standards for RDS except for those occurrences where a delay is due to a CMS regulation or requirement change impacting file production, as follows: required Reconciliation reporting by the specified due date,

6.10.1b(3)i The Contractor shall remit to the Department $1,000 for each day beyond the due date that the required complete and accurate RDS files are not provided to the Department; and

6.10.1b(3)ii The Contractor shall indemnify the Department, in total, for any and all losses incurred, should the Contractor's failure to provide acceptable files and timely cost reporting to CMS result in any loss of Retiree Drug Subsidy reimbursement to the Department.

6.10.1c Reporting the annual RDS Reconciliation to the CMS/Retiree Drug Subsidy website, once approved, in writing, by the Department;

6.10.1d Assisting the Department to complete the annual attestation of actuarial equivalence for the 2016 Plan Year and subsequent Plan Years. If applicable, the Contractor must also cooperate with the Department to

disclose to CMS and to NYSHIP's Part D-eligible Enrollees if the Department is unable to attest to the requisite actuarial equivalence;

6.10.1e Establishing and implementing proper safeguards against the unauthorized use and disclosure of the data exchanged pursuant to the administration of the NYSHIP Retiree Drug Subsidy as well as other aspects of the interface between NYSHIP and CMS. Such safeguards shall include the adoption of policies and procedures to ensure that the data obtained as a consequence of the NYSHIP Retiree Drug Subsidy application shall be used solely in accordance with applicable federal and State law. The Contractor shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data. The safeguards shall provide a level of security at least comparable to the level of security required of the Department by CMS, as specified by CMS. Any and all Contractor\Personnel interacting with this data must be advised by the Contractor of the confidential nature of the information, the safeguards required to protect the information, and the administrative, civil and criminal penalties for noncompliance contained in applicable federal and State law;

6.10.1f Acknowledging that the information furnished in connection with the administration of the NYSHIP Retiree Drug Subsidy is being provided to obtain federal funds. The Contractor shall require all sub-contractors, including any plan administrators, if applicable, that submit information required by CMS to obtain the Retiree Drug Subsidy on behalf of NYSHIP to acknowledge that information provided in connection with the subcontract is used for the purpose of obtaining federal funds; and

6.10.1g Acknowledging that its provision of services pursuant to this section of this Agreement is subject to audit and evaluation by the Department of Health and Human Services pursuant to 42 CFR Subpart R or other authority as may be cited by the federal government, as well as by the State of New York pursuant to Appendix A and Appendix B of this Agreement. The Contractor shall comply with any record retention requirements required pursuant to 42 CFR SubPart R in this regard.

6.10.2 The Department acknowledges and agrees that it shall be solely responsible for: (1) providing Creditable Coverage notices required with respect to Retiree Drug Subsidy; and (2) determining whether enrolled individuals are qualifying covered Retirees. The Department shall provide to the Contractor a CMS-verified list of qualifying covered Retirees, as will be updated from time to time;

6.10.3 ***Medicare Advantage Plan:*** A Contractor that offers a Medicare Advantage Plan through NYSHIP shall follow the procedures set forth below:

6.10.3a The MA Plan must follow the regulations and requirements set forth in the CMS Medicare Managed Care Manual (MMCM) as amended. The Department is obligated to follow the rules and regulations in the MMCM as applicable to the employer group.

6.10.3b The Contractor shall agree to follow the procedures set forth in Chapter 2 of the MMCM, Additional Enrollment Request Mechanisms for Employer/Union Sponsored Coverage, which allows an Employer to group enroll its Retirees using a group enrollment process that does not require submission of a signed application by the Retiree. The Contractor must agree to work in cooperation with the Department to enroll individuals into the Contractor's Medicare Advantage Plan as each becomes Medicare eligible in accord with the MMCM process. The Department will follow the process required of the employer group for providing information to each eligible Employee/Retiree in the timeframes defined in the MMCM, as follows:

6.10.3b(1) The Department shall provide advance notice to eligible Enrollees and/or their eligible Dependents that Department intends to enroll them in MA Plan;

6.10.3b(2) The Department shall provide eligible Enrollees and/or their eligible Dependents notice that they may affirmatively opt-out of such enrollment; explain the process to opt-out; and explain any consequences to such action;

6.10.3b(3) The Department shall provide eligible Enrollees and/or their eligible Dependents a summary of benefits offered under the MAPD, an explanation of how to get more information about

the MAPD, and an explanation on how to contact Medicare for information on other Medicare health plan options that might be available; and

6.10.3b(4) The Department shall provide eligible Enrollees and/or their eligible Dependents the information contained in the MMCM Chapter 2 Exhibit 2: Model Employer/Union Group Health Plan Enrollment Request Form, under the heading "Please Read & Sign Below."

6.10.3c The Department shall include in the enrollment files submitted to the Contractor all the information required for the Contractor to submit an enrollment request to CMS, as set forth in the MMCM. The Contractor must advise the Department in writing of any changes to the required enrollment data at least 60 days prior to implementation. If the Contractor receives notification of change from CMS less than 60 days in advance of implementation, the Contractor must advise the Department within 2 Business Days from receipt of such notification from CMS.

6.10.3d.The Contractor shall provide health care benefits to MAPD Members who receive covered services under the terms of this Agreement and the EOC. The Contractor shall furnish MAPD identification cards and EOCs to each MAPD Member enrolled for MAPD Plan benefits.

6.10.3e The Contractor shall agree to follow the procedures set forth in Chapter 2 of the MMCM, Optional Employer/Union MA Disenrollment Request Mechanism, which allows MA Plans to accept voluntary disenrollment elections directly from the employer or union without obtaining a MA disenrollment form from each individual and Group Disenrollment for Employer**/**Union Sponsored Plans, which allows an employer to group disenroll its MAPD Members using a group disenrollment process that does not require submission of a signed disenrollment form. The Contractor must agree to work in cooperation with the Department to disenroll individuals out of the Contractor's Medicare Advantage Plan. The Department shall agree to follow the process and timelines required for group disenrollment as stated in the MMCM including notification of

the group's intention to disenroll the MAPD Members and transmit the information required for the Contractor to submit a disenrollment request to CMS. For individual voluntary disenrollment requests, the Department shall agree to submit disenrollment information which accurately reflects the Department's record of the disenrollment made by each MAPD Member according to the processes the Department has in place.

6.10.3f A Contractor that offer a Medicare Advantage Plan through NYSHIP shall agree to notify the Department when CMS regulations impact the enrollment of a NYSHIP Enrollee or Dependent in the Medicare Advantage Plan. These events include but are not limited to the following:

6.10.3f(1) CMS-generated disenrollments that remove a NYSHIP Enrollee or Dependent from the Medicare Advantage employer group plan;

6.10.3f(2) Disenrollments prompted by MAPD Member correspondence where CMS regulations require the Contractor to act on the MAPD Member's request prior to the Department's notification through the Optional Employer/Union MA Disenrollment Request Mechanism or Group Disenrollment for Employer/Union Sponsored Plans;

6.10.3f(3) Enrollments received from the Department through the Group Enrollment for Employer/Union Sponsored Plans that cannot be processed with CMS. These situations include but are not limited to cases where the NYSHIP Enrollee or Dependent is not enrolled in Medicare Part A or Part B, already enrolled in another Medicare Advantage Plan, has an invalid or missing HICN or does not reside in Service Area; and

6.10.3f(4) Other situations not described above.

6.10.3g The Contractor shall agree that the commencement of coverage for Enrollees and their eligible Dependents will begin as of the requested

effective date, in accordance with CMS regulations, for any eligible NYSHIP individual who makes a timely application for enrollment.

6.10.3h The Department shall report to the Contractor termination of coverage for a MAPD Member who is determined by the Department to be ineligible for benefits in the enrollment files transmitted on the scheduled basis as pursuant to this Section 6.10.0 above. Upon the Department's notification to the Contractor, the coverage of such MAPD Member shall terminate after providing notice to such MAPD Member in accordance with the Department's policy and CMS regulations. The Department is responsible for providing NYSHIP required notice; the Contractor is responsible for providing CMS required notice. Retroactive disenrollment shall not be permitted except in specific situations approved by CMS.

6.10.3i The Contractor must, within fifteen (15) business days from the date the Contractor receives the Low Income Subsidy (LIS) payment from CMS, provide the Department with the detailed information set forth below. The Contractor must refund LIS beneficiaries the low-income premium subsidy payment within the required period of forty-five (45) days from the date the Contractor receives the monies from CMS. The information set forth below must be reported to the Department on a monthly basis and must contain information for each beneficiary, including the NYSHIP Enrollee's identification number. The LIS Premium data report fields must include:

6.10.3i(1) NYSHIP Enrollee's name
6.10.3i(2) NYSHIP Enrollee's social security number
6.10.3i(3) LIS eligible individual's name
6.10.3i(4) LIS eligible individual's social security number
6.10.3i(5) LIS eligible individual's date of birth
6.10.3i(6) LIS eligibility start date
6.10.3i(7) LIS eligibility end date
6.10.3i(8) Monthly subsidy amount received from CMS for the LIS individual
6.10.3i(9) Dual Eligibility indicator
6.10.3i(10) Date LIS payment received from CMS (MM/DD/YYYY)

The total amount reported in the monthly LIS Premium data report must equal the LIS Payments.

6.10.3j The Department acknowledges that a Medicare Part D Late Enrollment Penalty (LEP) may be assessed to a MAPD Member when the Member has a break in Creditable Coverage. To determine the existence of Creditable Coverage, the Contractor shall review the MAPD coverage history by viewing the MAPD NYSHIP enrollment record in the New York Benefits Eligibility & Accounting System (NYBEAS). For those MAPD Members whose NYBEAS record does not confirm continuous Creditable Coverage, the Contractor shall send a Creditable Coverage attestation form to the MAPD Members in accordance with CMS regulations. The Contractor shall bill the MAPD Member directly for any LEP assessed by CMS.

6.10.4 The Department acknowledges that, as a consequence of the Contractor's agreement with the Centers for Medicare and Medicaid Services (CMS) to operate Medicare Advantage plans, under which the Contractor may offer group Medicare Prescription Drug Plans (MAPD Plans) to employer sponsors, the Contractor is required to obtain a written agreement from each employer sponsor that provides that the employer-sponsor may determine how much of an Enrollee's Medicare Part D monthly beneficiary premium it will subsidize, subject to certain restrictions as set forth below, and that the Contractor is required to retain this written agreement and provide access CMS with access to it in accordance with 42 CFR §§423.504(d) and 423.505(d) and (e).

6.10.4a The Department may subsidize different amounts for different classes of Enrollees in the employer-sponsored MAPD Plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly). Different classes cannot be based on eligibility for the Low Income Subsidy.

6.10.4b The Department cannot vary the premium subsidy for individuals within a given class of Enrollees.

6.10.4c The Department cannot charge an Enrollee for prescription drug coverage provided under the MAPD Plan more than the sum of his/her monthly beneficiary premium attributable to basic prescription drug coverage plus 100% of the monthly beneficiary premium attributable to his/her non-Medicare Part D benefits (if any). The Department must pass through direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or, in those instances where the Enrollee pays premiums on behalf of an eligible spouse or Dependent, the amount paid by the enrollee on behalf of the spouse or Dependent).

6.10.4d For all Enrollees eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce any portion of the MAPD monthly beneficiary premium paid by the Enrollee (or, in those instances where the Enrollee pays premiums on behalf of a low-income eligible spouse or Dependent, the amount the Enrollee pays on behalf of the spouse or Dependent), with any remaining portion of the premium subsidy amount then applied toward any portion of the MAPD monthly beneficiary premium (including any MA premium) paid by the Department. However, if the sum of the Enrollee's MAPD monthly premium (or the spouse/Dependent's MAPD monthly premium, if applicable) and the Department's MAPD monthly premiums (the total monthly premium) are less than the monthly low-income premium subsidy amount, any portion of the low-income subsidy premium amount above the total MAPD monthly premium must be returned directly to CMS. Similarly, if there is no MAPD monthly premium charged the Enrollee or Department, the entire low-income premium subsidy amount must be returned directly to CMS and cannot be retained by the Contractor, the Department, or the Enrollee (or spouse/Dependent, if applicable).

6.10.4e The Contractor and Department may agree that the Department will be responsible for reducing up-front the MAPD premium contribution required for Enrollees eligible for the Low Income Subsidy. In those instances where the Department is not able to reduce up-front the MAPD premiums paid by the Enrollee (or, the Enrollee/participant, if applicable), the Contractor and the Department may agree that the Contractor shall

directly refund to the Enrollee (or Enrollee/participant, if applicable) the amount of the low-income premium subsidy up to the MAPD monthly premium contribution previously collected from the Enrollee (or spouse/Dependent, if applicable). The Contractor is required to complete the refund within forty-five (45) days of the date the Contractor receives from CMS the low-income premium subsidy amount payment for the low-income subsidy eligible Enrollee.

6.10.4f If the low income premium subsidy amount for which an Enrollee is eligible is less than the portion of the Part D monthly beneficiary premium paid by the Enrollee (or spouse/Dependent, if applicable), then the Department shall communicate to the Enrollee (or spouse/dependent) the financial consequences of the low-income subsidy eligible individual enrolling in the NYSHIP MAPD Plan as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

6.11.0 Disabled Dependent Determinations

6.11.1 The Contractor must establish a process to perform reviews of the Department's PS-451 form and all additional medical information submitted to support Dependent disability determinations. The review must be completed by a Clinical Manager in the United States (preferably in New York State) and a clinical determination must be completed within ten (10) Business Days of receipt of a completed form.

6.11.2 The Contractor must send a determination letter, approved in advance by the Department to the Enrollee and to the Department advising of the determination within three (3) Business Days of determination.

ARTICLE VII: MODIFICATION OF PROGRAM SERVICES

7.1.0 In the event that laws or regulations enacted by the Federal government and/or the State have an impact upon the conduct of this Agreement in such a manner that the Department determines that any design elements or requirements of the Agreement must be revised, the Department shall notify the Contractor of any such revisions and shall provide the Contractor with a reasonable time within which to implement such revisions.

7.2.0 In the event that the NYS and the unions representing State Employees enter into collective bargaining agreements, or the State otherwise requires changes in Plan design elements or requirements of the Agreement, the Department shall notify the Contractor of such changes and shall provide the Contractor with reasonable notice to implement such changes.

7.3.0 To the extent that any of the events as set forth in this Article shall take place and constitute a material and substantial change in the delivery of services that are contemplated in accordance with the terms of the Agreement as of the Effective Date and which the Contractor is required to perform or deliver under the Agreement, either Party may submit a written request to initiate review of the premiums(s) received by the Contractor for services provided and guarantees made by the Contractor under the terms of the Agreement, accompanied by appropriate documentation. The Department reserves the right to request, and the Contractor shall agree to provide additional information and documentation the Department deems necessary to verify that a modification of the premiums or guarantees is warranted. The Department will agree to modify the premiums(s) to the extent necessary to compensate the Contractor for documented additional costs determined by Department to be reasonable and necessary. The Contractor will agree to modify the premium(s) to the extent necessary to relieve the Department of the obligation to pay for Program services that are no longer required. The Department will agree to modify guarantees as determined by the Department to be necessary to reflect Program modifications. Should the Parties agree to modify the premium(s) and/or guarantees, such approval shall be subject to written amendment and approval by OSC and the AG. The Contractor shall implement changes as required by the Department with or without final resolution of any premium proposal.

ARTICLE VIII: ELIGIBILITY AND EFFECTIVE DATES OF COVERAGE

8.1.0 Each Employee and/or Dependent shall be eligible for benefits under this Agreement in accordance with the Department's prevailing eligibility criteria, in accordance with the Regulations of the President of the Civil Service Commission.

8.2.0 Coverage for Enrollees and enrolled Dependents pursuant to the Contractor's Plan shall take effect in accordance with the Department's prevailing eligibility criteria, in compliance with the Regulations of the President of the Civil Service Commission. These regulations shall be the sole determining factor with respect to effective dates of coverage. On behalf

of the President of the Civil Service Commission, the Department shall exercise sole authority to determine the interpretation and application of these regulations.

8.3.0 The Department shall transmit enrollment information provided by the Enrollee to the Contractor. The Contractor shall use the enrollment data transmission protocol and encryption method required by the Department for that purpose. The current data transmission protocol must be either FTP or Secure FTP, and the current encryption methodology must be PGP or as otherwise specified by the Department. If Secure FTP is used, it must be compatible with the OpenSSH implementation of Secure FTP. Further, the Applicant must agree to execute the Department's Third Party Connection Agreement and Third Party User Agreement and their amendments, as required, and any other agreement or protocol required by the Department to ensure the security of its data transmissions. Enrollments processed in accordance with the Department's procedures for executing such enrollment and the reports generated as a result of these procedures shall be the sole means of determining valid enrollment for Plan benefits.

ARTICLE IX: CERTIFICATES

9.1.0 Within 30 days of notification by the Department of an Enrollee's enrollment, the Contractor shall issue to each Enrollee a Certificate and to each MAPD Enrollee an EOC which shall state the benefits to which each is entitled. Such certificate shall summarize the provisions of this Agreement principally affecting the Enrollee/MAPD member.

9.2.0 The Certificate and EOC shall provide a clear, easily understood description of the benefits provided by the Contractor and shall include a comprehensive statement of any exclusions or limitations of the benefits.

9.3.0 Benefits shall be provided by the Contractor in performance of the Plan and in accordance with the terms and conditions of this Agreement, including but not limited to Exhibits B and C to this Agreement.

ARTICLE X: COORDINATION OF BENEFITS

10.1.0 A Coordination of Benefits provision shall be applied by the Contractor in accordance with applicable statutes and regulations of the New York State Department of Financial Services, as may be amended from time to time, or in accordance with the regulations appropriate to the applicable jurisdiction.

ARTICLE XI: CESSATION OF BENEFITS

11.1.0 Except as otherwise provided by law, all benefits to be provided by the Contractor in performance of the Plan, pursuant to the terms and conditions of this Agreement, shall cease upon the termination of this Agreement.

11.2.0 An Enrollee's benefits may cease prior to the termination of this Agreement in accordance with the Certificate's or EOC's provisions pertaining to cessation of benefits.

11.3.0 An Enrollee's coverage may be terminated by the Contractor for cause; however, in no case shall an Enrollee's benefits be terminated by the Contractor without 30 days prior written notification to the Department.

ARTICLE XII: RECORDS: INFORMATION TO BE MAINTAINED BY THE CONTRACTOR

12.1.0 The Contractor shall maintain records from which may be determined the names of all Enrollees and Enrollees' Dependents, if any, enrolled hereunder, and the type of benefits in force for each such Enrollee, together with the date when any benefits became effective and the effective date of any increase or decrease in the type of benefits. Such records shall be based on information provided to the Contractor by the Department. The Contractor shall promptly update its records to reflect the information transmitted from the Department's records.

12.2.0 The Department and the Enrollee shall furnish to the Contractor all information which the Contractor may reasonably require with regard to any matters pertaining to the enrollment of the Enrollee under this Agreement. The Department agrees to allow the Contractor reasonable access to documents, books and records of the Department which may have a bearing on the benefits provided by the Contractor or calculation of the Contractor's premium payments as set forth under this Agreement.

12.3.0 Should the Contractor request that any special reports be produced from the data in the Department's enrollment records, the Contractor may, at the sole discretion of the Department, be required to bear the production cost of such reports. Such requests shall be honored by the Department at its sole discretion.

ARTICLE XIII: REPORTS

13.1.0 The Contractor must submit financial, management, health services utilization, and Medicare Part D administration reports, including but not limited to those identified in

Article VI of this Agreement, as may be required by the Department for its use in the review and management of NYSHIP.

13.2.0 Upon request of the Department, the Contractor shall furnish to the Department a copy of any member satisfaction survey prepared by Contractor and, where the survey methods permit, shall separately identify the survey results of NYSHIP Enrollees. If the number of NYSHIP Enrollees in the Contractor's plan is nominal as measured by either the gross number of Enrollees or as a percentage of the Contractor's total Enrollees, or if the Department requires an additional satisfaction survey, the Department will meet with the Contractor to agree on the scope of the desired survey and respective responsibility for any associated costs.

13.3.0 Upon request of the Department, the Contractor shall furnish to the Department evidence of maintenance of satisfactory contingent reserve funds and/or existence of an adequate risk sharing arrangement or reinsurance contracts and/or copies of filed examination reports by the New York State Department of Health and Department of Financial Services or the appropriate regulatory and/or oversight agency in the Contractor's jurisdiction.

13.4.0 Health Services Utilization Reports will include, but not be limited to, the annual Schedule M, Complaint/Grievance/External Appeal Reports The Contractor shall, upon request of the Department, provide such other reports when required by one or more members of the Joint Labor Management Committee which participate in the Department's Health Insurance Program.

13.5.0 If the Department desires additional reports not otherwise specified in this Agreement, New York Public Health Law Article 44, or by New York Insurance Law Article 43, or if the Department desires to change the format of those reports, the Department and Contractor agree to discuss the development and costs related to such additional reports or amended formats.

13.6.0 The Department shall keep all Contractor-specific reports and information strictly confidential and shall not disclose the reports, any information obtained from the reports, or any information obtained through an audit of the Contractor to any other Contractor, insurer or to the public except as directed by a court of competent jurisdiction or as necessary to comply with applicable New York State or federal law or regulations. Except as required by law, regulatory requirements or in connection with normal business

operations, no such records may be otherwise used or released to any person by the Contractor, the Department, their respective agencies or representatives, either during the term of this Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the Department, be grounds for termination of this Agreement. Notwithstanding the above, the Department as it deems necessary may use aggregate data as reflective of information contained in the reports submitted by the Contractor.

ARTICLE XIV DETERMINATION OF RATE BASIS, PAYMENT OF PREMIUMS AND GRACE PERIOD

14.1.0 The Department shall establish the premium rates to be paid to the Contractor during the term of this Agreement in accordance with the following:

14.1.1 The Contractor shall submit a premium rate or rates to the Department no later than September 15 of each year, for the following calendar year. The premium rate or rates shall be accompanied by the Contractor's most recent available year-to-date loss ratio for the community pool in which Enrollees are included.

14.1.2 The premium rates for a Contractor whose Service Area lies wholly within the State shall be guaranteed rates under 11 NYCRR 52.42 (b). The premium rate guaranteed shall be the presently prevailing approved or filed premiums or the Contractor's best estimate of the expected approved or filed premium rates for the following year adjusted by any prospective or retrospective adjustments required for guaranteed premium rates under 11 NYCRR 52.42 (b). The Contractor, upon request shall provide an explanation for the premium rate that has been quoted. The Contractor shall also provide the Department with copies of all loss ratio reports required by Section 4308 (h) (1) of the Insurance Law at the same time such reports are submitted to the NYS Department of Financial Services.

14.1.3 In the event Contractor has multiple geographic rating regions within the State, the Contractor may submit premium rates for each geographical rating region. The Department reserves the right for its own purposes, to blend, or to request the Contractor to blend, the guaranteed rates into a single premium rate to be the basis for payment to the Contractor. Any blended rate must be weighted based on the number of Enrollees and Dependents enrolled with the Contractor in each region. If the Contractor performs the blending, the Contractor must submit

documentation as requested by the Department for its review of the resulting blended rate.

14.1.4 In the event the Contractor has multiple geographic rating regions within and outside New York State, the premium rate submitted for the geographic regions outside New York State shall be based upon the premium rate submitted for a geographic rating region within New York State.

14.1.5 If the Contractor has no premium rate(s) subject to filing with or approval by the NYS Department of Financial Services then the premium rate(s) determined as payable by the Department shall be based on the premium rate(s) filed with and approved, or pending approval, by the appropriate regulatory and/or oversight agency in the Contractor's jurisdiction.

14.2.0 In the event that the premium rate paid by the Department to the Contractor during the term of this Agreement, is revised by the NYS Department of Financial Services or other appropriate regulatory and/or oversight agency in the Contractor's jurisdiction, the Department shall adjust the Department's share of the premium paid to the Contractor to reflect such revision. Such adjustment shall be calculated by the Department to recapture excess Department premium paid by the Department to the Contractor if the premium rate paid exceeds the approved premium rate, or the Department shall distribute additional Department share premium due to the Contractor if the premium rate paid is less than the approved premium rate. The Department may make such adjustment through subsequent year premium rates paid to the Contractor, or at its option, adjust the premium rate paid to the Contractor prior to renewal of this Agreement.

14.3.0 The Department shall make premium payments to the Contractor on the first day of each coverage period, starting with the effective date of this Agreement; the coverage period shall be determined by the Department. The total amount of premium payment for each coverage period shall be calculated by the Department by multiplying the number of Enrollees enrolled in the Plan by the premium rate then in effect for the respective types of coverage.

14.4.0 The payment of any premium shall not maintain the benefits under this Agreement in force beyond the day immediately preceding the next due date, except as follows:

14.4.1 A grace period of forty-five (45) days shall be granted by the Contractor to the Department for the payment of premium accruing under this Agreement. During

the grace period, this Agreement shall remain in force, but the Department shall be liable to the Contractor for the payment of premium accruing for the period the Agreement continues in force.

14.4.2 If the Department fails to pay any premium payment within the grace period, this Agreement may be terminated on the last day of such grace period, except that if written notice is given by the Department to the Contractor prior to the expiration of the grace period that this Agreement is to be terminated before the expiration of the grace period, this Agreement shall be terminated as of the date of receipt of such written notice by the Contractor or the date specified by the Department for such termination, whichever is later. In such instance, subject to the Department's review and approval, the Department shall be liable to the Contractor for the payment of the pro-rata premium payment for the period commencing with the last due date and ending with the date of termination.

14.4.3 On an annual basis coinciding with the end of the State's fiscal year, the Statewide Financial System (SFS) will be shut down for approximately one to two week during which no payment transactions will be processed. The shutdown typically occurs between the last week of March and first week of April. The SFS may also be shut down for short periods during other times of the year for maintenance or upgrades or other reasons that are outside the control of the Department. Payments delayed as a result of the SFS shut down will be processed on the first business day after the SFS returns to operation.

ARTICLE XV: COMMUNICATIONS AND MARKETING PROGRAM

15.1.0 During an Option Transfer Period established by the Department, the Department shall provide potential Enrollees with option transfer procedural information, including but not limited to the amount of the Enrollee contribution to the premium cost of the Contractor. Upon written notice of the Department's approval of the Contractor's participation for the subsequent Plan Year, the Contractor shall prepare marketing materials and other general educational material for distribution to Employees and Retirees which shall be factual and easily understood. Written benefit descriptions must include all applicable copayments, and significant limitations and exclusions. The material must state that there may be additional exclusions and/or limitations which are not listed but are available on request. A description of any changes in the level of benefits and/or method of delivery of such benefits since the last offering must be included. Information regarding the availability of

an Enrollee Certificate of Insurance, EOC and Summary of Benefits and Coverage must also be included.

15.2.0 The Contractor must comply with the federal Patient Protection and Affordable Care Act (ACA), to produce, revise, distribute, and translate upon request a Summary of Benefits and Coverage (SBC) accurately describing the NYSHIP group benefits and coverage. The SBC must be provided to the Department in an electronic format as a PDF document no later than 30 days before the beginning of each Plan Year. The Contractor must distribute a SBC to any eligible Employee or Retiree contacting the Contractor or the Department to request a copy in accordance with ACA requirements for timely distribution. Annually at plan renewal and upon material modification of the SBC, the Contractor must provide timely notice to all current Enrollees via a postcard, plan materials, or other ACA-compliant means of notification, of how to view or obtain a copy of the SBC from the Contractor.

15.3.0 Upon request of the Department, the Contractor shall provide a representative to answer questions at a Health Fair and/or make a presentation to potential Enrollees, make available copies of Certificates of Insurance and/or EOCs, applicable riders and the SBC that pertains to this Agreement.

15.4.0 The Contractor shall not distribute generic marketing material to potential Enrollees if, in the Department's judgment, these materials contain eligibility, benefit descriptions, or other provisions which are substantially inconsistent with those provisions applicable to NYSHIP Enrollees covered by the Contractor.

15.5.0 The Department shall have the right to review and approve drafts of all printed materials proposed for distribution to Enrollees. The Contractor's electronic or print media marketing campaigns shall be accurate, professional and appropriate, and shall be subject to the Department's review, if specifically addressed to Enrollees. The Department shall provide the Contractor with guidelines for acceptable marketing materials.

15.6.0 The Department shall notify the Contractor of the due date for submitting proposed marketing materials for use during the Option Transfer Period. The Department shall complete a review of the proposed marketing materials prior to the beginning of the Option Transfer Period. The Contractor shall have the right to prepare, submit and clarify factual information about its benefits contained in such publications prior to distribution.

Upon approval of the Contractor's marketing material, the Department will authorize the Contractor to distribute it.

15.7.0 In resolving Enrollee grievances, the materials given to potential Enrollees must be considered. The Contractor shall be liable for any errors, omissions or misrepresentations contained in the materials which the Contractor has prepared under this Agreement and upon which any Enrollee has relied to his/her detriment.

ARTICLE XVI: AUDIT AUTHORITY

16.1.0 In addition to the Audit Authority requirements specified in Appendices A and B to this Agreement, the Contractor acknowledges that the Department has the authority to conduct financial and performance audits of the Contractor's delivery of HMO services in accordance with the Agreement and any applicable State and federal statutory and regulatory authorities;

16.2.0 Such audit activity may include, but not necessarily be limited to, the following activities:

16.2.1 Review of the Contractor's activities and records relating to the documentation of its performance under this Agreement in areas such as determination of Enrollee or Dependent eligibility and application of various Department program administrative features (e.g., dependent survivor benefits, reasonable adjudication of disabled dependent status).

16.2.2 Comparison of the information in the Contractor's enrollment file to that on the enrollment reports issued to the Contractor by the Department.

16.2.3 Assessment of the Contractor's information, utilization and demographic systems to the extent necessary to verify accuracy of data on the reports provided to the Department in accordance with Article XIII - Reports, of this Agreement.

16.3.0 The Contractor shall maintain and make available documentary evidence necessary to perform such reviews. Documentation maintained and made available by the Contractor may include, but is not limited to, source documents, books of account, subsidiary records and supporting work papers, claim documentation, pertinent contracts, subcontracts, Provider agreements, and correspondence;

16.4.0 The Contractor shall make available for audit all data in its computerized files that is relevant to and subject to the Agreement. Such data may, at Department discretion, be

submitted to the Department in machine-readable format, or the data may be extracted by the Department, or by the Contractor under the direction of the Department;

16.5.0 The Contractor shall support audits conducted by the Department, Office of the State Comptroller or any designee of these agencies, as follows, including but not limited to:

16.5.1 Providing ample audit resources including access to the Contractor's online system to the Department and OSC at their respective offices through the date of the final financial settlement of the Agreement;

16.5.2 The capability and contractual right of the State to effectively audit the Contractor's Provider Network, including the use of statistical sampling audit techniques and the extrapolation of errors; and

16.5.3 Providing full cooperation with all Department and/or OSC audits consistent with the requirements of Appendices A and B and as set forth in this Agreement including provision of access to protected health information and all other confidential information when required for audit purposes as determined by the Department and/or OSC as appropriate. The Contractor must respond to all State (including OSC) audit requests for information and/or clarification within fifteen (15) Business Days. The Contractor must perform timely reviews and respond in a time period specified by the Department to preliminary findings submitted by the Department or the OSC's audit unit in accordance with the requirements of Article XVI "Audit Authority" in this Agreement. Such audits may include, but are not limited to both electronically submitted and paper claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The Contractor shall facilitate audits of Network Providers, including on-site audits, as requested by the Department and/or OSC;

16.6.0 The Contractor shall, at the Department's request, and in a time period specified by the Department, search its files, retrieve information and records, and provide to the auditors such documentary evidence as they require. The Contractor shall make sufficient resources available for the efficient performance of audit procedures;

16.7.0 The Contractor shall comment on the contents of any audit report prepared by the Department and transmit such comments in writing to the Department within 30 days of receiving any audit report. The response will specifically address each audit

recommendation. If the Contractor agrees with the recommendation, the response will include a work plan and timetable to implement the recommendation. If the Contractor disagrees with an audit recommendation, the response will give all details and reasons for such disagreement. Resolution of any disagreement as to the resolution of an audit recommendation shall be subject to the dispute resolution procedures set forth in Appendix B of this Agreement.

16.8.0 If the Contractor has an independent audit performed of the records relating to this Agreement, a certified copy of the audit report shall be provided to the Department within 10 days after receipt of such audit report by the Contractor.

16.9.0 The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the Office of the State Comptroller as set forth in either Appendix A of this Agreement, Standard Clauses for All New York State Contracts, or Appendix B, Standard Clauses for All Department Contracts.

ARTICLE XVII: CONFIDENTIALITY

In addition to the Confidentiality requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

17.1.0 All claims and enrollment records relating to the Agreement are confidential and shall be used by the Contractor solely for the purpose of carrying out its obligations under the Agreement and for providing the Department with material and information as may be specified elsewhere in this Agreement;

17.2.0 Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or federal law(s) or regulation(s), or with the written consent of the Enrollee and Dependent, no records may be otherwise used or released to any party other than the Department by the Contractor, its officers, employees, agents, consultants, Key Subcontractors or Affiliates either during the term of the Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the Department, be grounds for termination of the Agreement;

17.3.0 The Contractor, its officers, employees, agents, consultants and/or any Key Subcontractors or Affiliates agree to comply, during the performance of the Agreement, with all applicable federal and State privacy, security and confidentiality statutes, including but not limited to the Personal Privacy Protection Law (New York Public Officer's Law

Article 6-A, as amended), and its implementing regulations, policies and requirements, for all material and information obtained by the Insurer through its performance under the Agreement, with particular emphasis on such information relating to enrollees and dependents;

17.4.0 The Contractor shall be responsible for assuring that any Agreement between the Contractor and any of its officers, employees, agents, consultants and/or Key Subcontractors or Affiliates contains a provision that strictly conforms to the various confidentiality provisions of this Agreement;

17.5.0 The Contractor shall promptly advise the Department of all requests made to the Contractor for information regarding the performance of services under this Agreement, including, but not limited to, requests for any material and information provided by the Department, except as required by Key Subcontractors or Affiliates solely for the purpose of fulfilling the Insurer's obligations under this Agreement or as required by law.

ARTICLE XVIII: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

18.1.0 For purposes of this Agreement, the term "Protected Health Information" ("PHI") means any information, including demographic information collected from an individual, that relates to the past, present, or future physical or mental health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual, that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Within the context of this Agreement, PHI may be received by the Contractor from the Department or may be created or received by the Contractor on behalf of the Department. All PHI received or created by the Contractor as a consequence of its performance under this Agreement is referred to herein collectively as "Department's PHI."

18.2.0 The Contractor acknowledges that the Department administers on behalf of New York State several group health plans as that term is defined in HIPAA's implementing regulations at 45 CFR Parts 160 and 164, and that each of those group health plans consequently is a "covered entity" under HIPAA. These group health plans include NYSHIP, which encompasses the Empire Plan as well as participating health maintenance organizations; the Dental Plan, and the Vision Plan. In this capacity, the Department is responsible for the administration of these "covered entities" under

HIPAA. The Contractor further acknowledges that the Department has designated NYSHIP and the Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Contractor further acknowledges that the Contractor is a HIPAA "business associate" of the Department as a consequence of the Contractor's provision of services to and/or on behalf of the Department within the context of the Contractor's performance under this Agreement, and that the Contractor's provision of such services may involve the disclosure to the Contractor of individually identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Contractor's disclosure to the Department of individually identifiable health information as a consequence of the services performed under this Agreement.

18.3.0 Permitted Uses and Disclosures of the Department's PHI: The Contractor may use and/or disclose the Department's PHI solely in accordance with the terms of this Agreement. In addition, the Contractor may use the Department's PHI to provide data aggregation services relating to the health care operations of the Department. Further, the Contractor may use and disclose the Department's PHI for the proper management and administration of the Contract if such use is necessary for the Contractor's proper management and administration or to carry out the Contractor's legal responsibilities, or if such disclosure is required by law or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it shall be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware in which the confidentiality of the PHI has been breached.

18.4.0 Nondisclosure of the Department's PHI: The Contractor shall not use or further disclose the Department's PHI other than as permitted or required by this Agreement or as otherwise required by law. The Contractor shall limit its uses and disclosures of PHI when practical to the information comprising a Limited Data Set and in all other cases to the minimum necessary to accomplish the intended purpose of the PHI's access, use, or disclosure.

18.5.0 Safeguards: The Contractor shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for by this Agreement. The Contractor shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, to reasonably and appropriately protect the confidentiality, integrity and

availability of any electronic PHI that it creates, receives, maintains, or that it transmits on behalf of the Department pursuant to this Agreement.

18.6.0 Breach Notification:

18.6.1 ***Reporting:*** The Contractor shall report to the Department any breach of unsecured PHI, even if the breach is not reportable under HIPAA, including any use or disclosure of the Department's PHI otherwise than as provided for by this Agreement, of which the Contractor becomes aware. Further, the Contractor shall report to the Department any security incident of which it becomes aware. "Security incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in an information system. The Contractor shall notify the Department within five (5) Business Days of the date the Contractor becomes aware of the event.

18.6.2 ***Required Information:*** The Contractor shall provide the following information to the Department within ten (10) Business Days of discovery except when, despite all reasonable efforts by the Contractor to obtain the information required, circumstances beyond the control of the Contractor necessitate additional time. Under such circumstances, the Contractor shall provide to the Department the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) Days from the date of discovery:

18.6.2a the date of the breach incident;

18.6.2b the date of the discovery of the breach;

18.6.2c a brief description of what happened;

18.6.2d a description of the types of unsecured PHI that were involved;

18.6.2e identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the breach;

18.6.2f A brief description of what the Contractor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

18.6.2g any other details necessary to complete an assessment of the risk of harm to the individual.

18.6.3 The Department will be responsible for providing notification to individuals whose unsecured PHI has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach, as well as the Secretary and the media, as required by 45 CFR Part 164.

18.6.4 The Contractor shall maintain procedures to sufficiently investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the Department upon request.

18.6.5 For purposes of this Agreement, "Unsuccessful Security Incidents" include activity such as pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of electronic PHI.

18.6.6 The Contractor shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Contractor not permitted by this Agreement.

18.7.0 Associate's Agents: The Contractor shall require all of its agents or Key Subcontractors or Affiliates to whom it provides the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, agree to the same restrictions and conditions on the access, use, and disclosure of PHI that apply to the Contractor with respect to the Department's PHI under this Agreement.

18.8.0 Availability of Information to the Department: The Contractor shall make available to the Department such information and documentation as the Department may require regarding any disclosures of PHI by the Contractor to fulfill the Department's obligations to provide access to, to provide a copy of, and to account for disclosures of the Department's PHI in accordance with HIPAA and its implementing regulations. The Contractor shall provide such information and documentation within a reasonable amount of time of its receipt of the request from the Department.

18.9.0 Amendment of the Department's PHI*:* The Contractor shall make the Department's PHI available to the Department as the Department may require to fulfill the Department's obligations to amend individuals' PHI pursuant to HIPAA and its implementing regulations. The Contractor shall, as directed by the Department, incorporate any amendments to the Department's PHI into copies of the Department's PHI as maintained by the Contractor.

18.10.0 Internal Practices: The Contractor shall make its internal practices, policies and procedures, books, records, and agreements relating to the use and disclosure of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, available to Department and/or the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the Department and/or the Secretary for purposes of determining the Department's compliance with HIPAA and its implementing regulations.

18.11.0 Termination:

18.11.1 This Agreement may be terminated by the Department at the Department's discretion if the Department determines that the Contractor, as a business associate, has violated a material term of this Article or of the Agreement with respect to the Contractor's obligations under this Article.

18.11.2 ***Disposition of the Department's PHI:*** At the time this Agreement is terminated, the Contractor shall, if feasible, return or destroy all of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, that the Contractor still maintains in any form and retain no copies of such information. Alternatively, if such return or destruction is not feasible, the Contractor shall extend indefinitely the protections of this Agreement to the information and shall limit further uses and disclosures to those purposes that make the return or destruction of the Department's PHI infeasible.

18.12.0 Indemnification: The Contractor agrees to indemnify, defend and hold harmless the State, the Department and Department's respective employees, officers, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this Article or from any acts or omissions related to this Article by the Contractor or its

employees, officers, Key Subcontractors or Affiliates, agents or other members of its workforce. Accordingly, the Contractor shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Contractor's acts or omissions hereunder. The Contractor's obligation to indemnify any Indemnified Party under this Article shall survive the expiration or termination of this Agreement.

18.13.0 Miscellaneous:

18.13.1 ***Amendments*****:** This Article may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. The Parties agree to take such action as is necessary to amend this Article from time to time as is necessary to achieve and maintain compliance with the requirements of 45 CFR Parts 160-164.

18.13.2 ***Survival*****:** The respective rights and obligations of the Business Associate (Contractor), and Covered Entity under HIPAA as set forth in this Article shall survive termination of this Agreement.

18.13.3 ***Regulatory References*****:** Any reference herein to a federal regulatory section within the Code of Federal Regulations shall be a reference to such section as it may be subsequently updated, amended or modified.

18.13.4 ***Interpretation*****:** Any ambiguity in this Article shall be resolved to permit covered entities to comply with HIPAA.

ARTICLE XIX: NOTICES

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

19.1.1 via certified or registered United States mail, return receipt requested;

19.1.2 by facsimile transmission;

19.1.3 by personal delivery;

19.1.4 by expedited delivery service; or

19.1.5 by e-mail.

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

State of New York [Agency Name]

Name: (TBD)
Title: Director, Employee Benefits Division
Address:
Telephone Number: (TBD)
Facsimile Number: (TBD)
E-Mail Address: (TBD)

[Contractor Name]

Name: (TBD)
Title: (TBD)
Address: (TBD)
Telephone Number: (TBD)
Facsimile Number: (TBD)
E-Mail Address: (TBD)

19.3.0 Any such notice 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.

19.4.0 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 Agreement 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 representatives for the purposes of receiving notices under this Agreement. 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.

ARTICLE XX: TERMINATION

20.1.0 In addition to the Termination of Agreement requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

20.1.1 The State retains the right to cancel the Agreement without cause and in its sole discretion, provided that the Department shall give written notice to the Contractor not less than thirty (30) Days prior to the date upon which termination shall become effective, such notice to be made via registered or certified mail, return receipt requested or hand delivered. The date of such notice shall be deemed to be the date of postmark in the case of mail or the date of hand delivery. This provision should not be understood as waiving the State's right to terminate the Agreement for cause or to stop work immediately for unsatisfactory work, but is supplementary to that provision. In the event of cancellation without cause by the State, the State agrees to negotiate a payment based on the Fixed Hourly Rates as set forth in the Contractor's Financial Proposal for hours actually worked by Contractor personnel on a given project activity, not to exceed the fixed fee of the project activity;

20.1.2 If the Contractor ceases conducting business in the normal course, becomes insolvent, makes a general assignment for the benefit of creditors, suffers or permits the appointment of a receiver for its business or assets, or avails itself of or becomes subject to any proceeding under the Federal Bankruptcy Act or any statute of any state relating to insolvency or the protection of rights of creditors, the State, in its sole discretion, may terminate the Agreement or may exercise such other remedies as shall be available under the Agreement, at law and/or equity;

20.1.3 No delay or omission to exercise any right, power or remedy accruing to the State or Department upon breach or default by the Contractor under the Agreement shall impair any such right, power or remedy, or shall be construed as a waiver of any such breach or default, or any similar breach or default thereafter occurring, nor shall any waiver of a single breach or default be deemed a waiver of any subsequent breach or default. All waivers must be in writing;

20.1.4 If, due to default that remains uncured for the period provided herein, a third party shall commence to perform Contractor's obligations under the Agreement, the State shall thereafter be released from all obligations to Contractor hereunder, including any obligation to make payment to Contractor, provided however that the State shall continue to be obliged to pay for any and all Project Services provided prior to any such date. If the State employs a third party to perform Contractor's obligations under the Agreement, Contractor shall be liable for the payment of any cost differential that the State incurs as a result of having to employ such third party to cure or resolve the issue;

20.1.5 In the event of the Contractor's default, in addition to availing itself of specific remedies set forth in the Agreement, the State may pursue all legal and equitable remedies for breach. In addition to pursuing any other legal or equitable remedies, the State shall have the right to take one or more of the following actions:

20.1.5a terminate the Agreement in whole or in part;

20.1.5b suspend, in whole or in part, payments due Contractor under the Agreement; and

20.1.5c pursue equitable remedies to compel Contractor to perform.

20.1.6 The Contractor shall be liable for any and all excess costs for remedies pursued by the State, and for costs incurred by the State in procuring alternate Services;

20.1.6a ***For Violation of Procurement Lobbying Law***. The Department reserves the right to terminate the Agreement in the event it is determined by the Department in its sole discretion that the certification filed by the Contractor in accordance with §139-j and/or §139-k of the New York State Finance Law was intentionally false or intentionally incomplete. Upon such finding, the Department may, at its sole option, exercise its termination right by providing 10 days written notification to the Contractor, or providing notice in accordance with other written notification terms in the Agreement;

20.1.6b ***For Violation of Section 5-a of the Tax Law***. The Department reserves the right to terminate the Agreement in the event that Contractor fails to file a certification pursuant to section 5-a of the Tax Law or the Tax Department or OFT discovers that the certification(s) filed by the Contractor pursuant to section 5-a of the Tax Law is/are false. Upon such finding(s), the Department may exercise its termination right by providing written notification to the Contractor;

20.1.6.c ***Termination Notice***. Notices required by this section shall be provided consistent with Article 9 of Appendix B; and

20.1.6.d ***Mitigation of Costs***. The Contractor shall not undertake any additional or new contractual obligations on or after the date of return receipt notice without the prior written approval of the State. On or after the date of return receipt notice and during the termination notice period, the Contractor shall take all

commercially reasonable and prudent actions to close out unnecessary outstanding, existing obligations as economically as possible for the State.

ARTICLE XXI: IRAN DIVESTMENT ACT

21.1.0 As a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York, a new provision has been added to the State Finance Law (SFL), § 165-a, effective April 12, 2012. Under the Act, the Commissioner of the Office of General Services (OGS) was charged with the responsibility to develop a list (Prohibited Entities List) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). Pursuant to SFL § 165-a(3)(b), the initial list was posted to the OGS website on August 10, 2012.

21.2.0 By entering into this Contract, Contractor (or any assignee) certifies that it is not on the "Entities Determined To Be Non-Responsive Bidders/Offerors Pursuant to The New York State Iran Divestment Act of 2012" list (Prohibited Entities List) posted on the OGS website at http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf and further certifies that it will not utilize on the Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that after should it seek to renew or extend the Contract, it must provide the same certification at the time the Contract is renewed or extended. Contractor also agrees that any proposed Assignee of the Contract will be required to certify that it is not on the Prohibited Entities List before the Department may approve a request for Assignment of the Contract.

21.3.0 During the term of the Contract, should the Department receive information that a person (as defined in State Finance Law 165-a) is in violation of the above-referenced certification, the Department 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 which is in violation of the Act within ninety (90) days after the determination of such violation, then the Department shall take such action as may be appropriate and provided for by law, rule or contract, including, but not limited to, seeking compliance, recovering damages, or declaring the Contractor in default.

The Department reserves the right to reject any request for renewal, extension, or assignment for an entity that appears on the Prohibited Entities List prior to the renewal, extension or assignment of the Contract, and pursue a responsibility review with Contractor should it appear on the Prohibited Entities List hereafter.

ARTICLE XXII: VENDOR RESPONSIBILITY

22.1.0 The Contractor is required to provide the Department with an updated Vendor Responsibility Questionnaire when requested to do so by the Department throughout the term of the Agreement. Regardless, the Contractor is required to report to the Department any material changes in the information reported in its initial Vendor Responsibility Questionnaire.

22.2.0 The Contractor shall at all times during the Agreement term remain responsible. The Contractor agrees, if requested by the Commissioner 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.

22.3.0 Suspension of Work (for Non-Responsibility): The Commissioner or his or her designee, in his or her sole discretion, reserves the right to suspend any or all activities under this Agreement, at any time, when he or she discovers information that call into question the responsibility of the Contractor. In the event of such suspension, the Contractor must comply with the terms of the suspension order. Agreement activity may resume at such time as the Commissioner or his or her designee issues a written notice authorizing a resumption of performance under the Agreement.

22.4.0 Termination (for Non-Responsibility): Upon written notice to the Contractor, a reasonable opportunity to be heard with the appropriate Department officials or staff, the Contract may be terminated by the Commissioner or his or her designee at the Contractor's expense where the Contractor is determined by the Commissioner of the Department or his or her designee to be non-responsible. In such an event, the Commissioner or his or her designee may complete the requirements of the Agreement in any manner he or she may deem advisable and pursue legal or equitable remedies for breach.

Contractor: _____

Contract Number: _____

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."

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

Date: _____ By: _____

Name: _____

Title _____

(Contractor)

Date: _____ By _____

Name: _____

Title _____

STATE OF)
) ss:
COUNTY OF)

On the _____ day of _____, _____ , before me personally came _____, to me known, and known to me to be the person who executed the above instrument, who, being duly sworn by me, did for her/himself depose and say that (s)he is the _____ of _____ the corporation or organization described in and which executed the above instrument; and that (s)he signed his/her name thereto.

_____
NOTARY PUBLIC

My commission expires:_____

Approved as to Form:

ERIC SCHNEIDERMAN
ATTORNEY GENERAL

By: _____

Date: _____

Approved:

THOMAS P.DINAPOLI
COMPTROLLER

By: _____

Date: _____