New York State Department of Civil Service

and

Excellus Health Plan, Inc.

CONTRACT NO. C000737

This Contract is entered into by and between the New York State Department of Civil Service (hereinafter referred to as Department or DCS), having its principal office at the Empire State Plaza, Agency Building #1, Albany, New York 12239 and Excellus Health Plan, Inc. (herein after referred to as Contractor or HMO) for its HMO Blue product having its principal office at Excellus BlueCross BlueShield, dba HMO Blue 165 Court Street, Rochester, New York 14647, which is a health maintenance organization (HMO). The foregoing are 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 the Department (President) to establish a health benefit plan for the benefit of New York State employees, retirees, and their dependents, and for the benefit of Participating Employers (PE), 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 health benefit plan; and

Whereas, New York State (NYS), through the Department, oversees the New York State Health Insurance Program (NYSHIP) for New York State employees and retirees and their dependents; and

Whereas, NYSHIP is sponsored by the Council on Employee Health Insurance (Council); and

Whereas, the Joint Labor Management Committee (JLMC) is a committee consisting of representatives of the NYS collective bargaining units, the Department 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 plan benefits; and

Whereas, on June 29, 2020, the Department issued the document entitled “Health Maintenance Organizations Specifications for the New York State Health Insurance Program” to secure the services of qualified health maintenance organizations for participation in NYSHIP; and

Whereas, after thorough review by NYS and the JLMC of the Proposals received in response to the Specifications and the Contractor’s representation of its ability to deliver the project services for NYSHIP (Project Services); and

Whereas, the Department, in reliance upon the expertise of and representations made by the Contractor, desires to engage the Contractor to deliver the Project Services, pursuant to the terms and conditions set forth in this Contract;

Therefore, in consideration of the mutual covenants and provisions contained herein, the Parties agree as follows:

Section 1: Contract Duration, Amendments, Periodic Recruitment and Annual Recertification Requirements

1.0 This Contract 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 Contract is for the period starting January 1, 2021 through and including December 31, 2025, and subject to the termination provisions contained herein. For the purposes of this Contract, the "Effective Date" is defined as January 1st of the initial year of the Contract.

1.1 This Contract is subject to amendment(s) only upon the written agreement of the Parties, reduced to writing and approved by the AG and OSC.

1.2 The Contractor acknowledges that the State's execution of the Contract is contingent upon the State's determination that the Contractor is responsible, and that the State will be relying upon the Contractor's responses to the New York State Standard Vendor Responsibility Questionnaire when making its responsibility determination. The Contractor agrees that if it is found by the State that the Contractor's responses to the Questionnaire were intentionally false or intentionally incomplete, on such finding, the Department may terminate the Contract. In no case shall such termination of the Contract by the State be deemed a breach thereof, nor shall the State be liable for any damages for lost profits or otherwise, which may be sustained by the Contractor as a result of such termination.

1.3 The Department reserves the right, in consultation with the JLMC, to evaluate and award contracts to additional health maintenance organizations as described herein. Any contract awarded after January 1, 2021, will commence on the 1st day of January in the subsequent year the contract is awarded or at any time deemed to be in the best interests of the State, and end on December 31, 2025. Such contracts will be subject to the approval of the AG and the OSC. Health maintenance organizations interested in participating shall be required to submit a proposal which shall be evaluated under the original Specification's requirements. An addendum containing additional applicable statutory requirements in effect at the time of the periodic recruitment period may be added to the original Specification's requirements.

1.4 Annual Submission and Recertification

1.4.0 Contractor may continue participation in NYSHIP, at the discretion of the Department, in consultation with the JLMC. Acceptance by the Department and JLMC for participation is not a guarantee that the Department will approve the Contractor's continued participation in NYSHIP in 2022 or beyond. Upon acceptance for participation in NYSHIP, the Contractor must, on an annual basis submit documentation, referred to as the "Required Annual Submission," to the Department and JLMC. The Contractor's continued participation in NYSHIP for each year subsequent to the initial year of the Contract term is contingent upon the Department and the JLMC's review and approval of the Required Annual Submission. Failure of the Contractor to submit the Required Annual Submission documents to the Department by the established annual deadline (as identified in an annual call letter by the Department to the Contractor) may result in rejection of the Contractor's Submission, suspension of the Contractor's participation in NYSHIP for the default year, or other consequence, such as the Department's freezing of enrollment in that HMO. A suspended Contractor may apply for participation in subsequent years by adhering to the Required Annual Submission requirements. The deadline for this annual recertification is addressed through an annual call letter to the HMOs. The Department, in consultation with the JLMC, may also hold periodic annual

submission meetings with the Contractor to discuss Contractor performance or annual submission materials.

1.4.1 The Department will send out a listing of the JLMC members as part of the annual call letter to the HMOs. This listing will note changes in JLMC membership.

1.4.2 The Required Annual Submission documents will include, but are not limited to:

1.4.2.a A current DOH Certificate of Authority for an HMO to operate within an approved Service Area and the ability to provide comprehensive hospital, medical and prescription drug benefits for covered Enrollees. Enrollees means those Employees and Retirees eligible for NYSHIP coverage as set forth in the regulation of the President at 4 NYCRR part 73, and who has elected to receive HMO coverage under the terms and conditions of this Contract.

1.4.2.b Current HMO status based on the National Committee on Quality Assurance (NCQA) or Utilization Review Accreditation Committee (URAC).

1.4.2.c Subcontractors and Affiliates listing. Subcontractor or Affiliates is defined as those contractors with whom the Contractor subcontracts to provide Project Services and incorporates as part of the Contractor's Project Management Team. Affiliate is defined as 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.

1.4.2.d Service Area expansion requests.

1.4.2.e Submission to offer or discontinue a Medicare Advantage product.

1.4.2.f Most recent annual filing of Schedule M (Complaints).

1.4.2.g Coverage and benefit documents, including but not limited to:

1.4.2.g.i Enrollee Certificate of Coverage;

1.4.2.g.ii MAP Evidence of Coverage;

1.4.2.g.iii Choices - HMO e-page;

1.4.2.g.iv Schedule of Benefits;

1.4.2.g.v Side by Side comparison of changes in benefits from 20XX (current year) to 20XY (upcoming year);

1.4.2.g.vi Coverage Riders and Addendums;

1.4.2.g.vii Annual communication materials to Enrollees;

1.4.2.g.viii Summary of Benefits and Coverage; and

1.4.2.g.ix Other Required Submission Material

1.4.3 At the discretion of the Department and in consultation with the JLMC, the Required Annual Submission documents may be amended. The Department will notify the HMO in writing of such changes no later than thirty (30) days prior to the requested due date of the Required Annual Submission.

1.4.4 Additionally, during subsequent years of the Contract, the Department 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. The Department, in consultation with the JLMC, currently defines an "underserved county" as a county in which, in addition to the Empire Plan, only one (1) HMO is offered. The definition of an "underserved county" is subject to change for any given plan year by the Department in consultation with the JLMC.

Section 2: Document Incorporation and Order of Precedence

2.0 The Contract shall be composed solely of the following documents which, in the event of an inconsistency or conflicting terms, shall be given precedence in the order indicated:

2.0.0 Appendix A (Standard Clauses for All New York State Contracts), dated October 2019, attached hereto, is hereby expressly made a part of this Contract as fully as if set forth at length herein;

2.0.1 Any Amendments to the body of the Contract;

2.0.2 The body of the Contract (that portion preceding signatures);

2.0.3 Appendix B (Standard Clauses for Department Contracts), dated April 2020, attached hereto, is hereby expressly made a part of this Contract as fully as if set forth at length herein;

2.0.4 Appendix C (Information Security Requirements), dated April 2020, attached hereto, is hereby expressly made a part of this Contract as fully as if set forth at length herein;

2.0.5 Appendix C-1 (Glossary for Appendix B and Appendix C), dated April 2020, attached hereto, is hereby expressly made a part of this Contract as fully as if set forth at length herein;

2.0.6 Exhibit 1: 2021 HMO Specifications dated June 29, 2020, attached hereto, is hereby expressly made a part of this Contract as fully as if set forth at length herein;

2.0.7 Exhibit 2: Official Response to Offerors' Questions, dated July 14, 2020, attached hereto, is hereby expressly made a part of this Contract as fully as if set forth at length herein;

2.0.8 Exhibit 3: Clarifying questions and Contractor's written responses to clarifying questions regarding Contractor's Proposal, attached hereto, are hereby expressly made a part of this Contract as fully as if set forth at length herein; and

2.0.9 Exhibit 4: Contractor's Proposal dated July 27, 2020, attached hereto, is hereby expressly made a part of this Contract as fully as if set forth at length herein.

2.1 Only documents expressly enumerated above shall be deemed a part of the Contract, and references contained in those documents to additional Contractor documents not enumerated above shall be of no force and effect.

2.2 All prior agreements, representations, statements, negotiations and undertakings are superseded. All statements made by the Department shall be deemed to be representations and not warranties.

2.3 Nothing contained in this Contract, expressed or implied, is intended to confer upon any person, corporation, or other entity, other than the Parties hereto and their successors in interest and assigns, any rights or remedies under or by reason of the Contract.

2.4 The terms, provisions, representations, and warranties contained in the Contract shall survive performance hereunder.

Section 3: Legal Authority to Perform

3.0 The Contractor represents that it possesses the legal authority to perform the Project Services in accordance with the terms and conditions of the Contract.

3.1 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 Project Services in accordance with the Contract and the authority to do business in the State of New York or any other governmental jurisdiction in which the Project Services are to be delivered.

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

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

3.4 The Contractor must, throughout the term of the Contract, possess the legal capacity to enter into a Contract with the Department.

3.5 The Contractor, throughout the term of the Contract, must:

3.5.0 Be licensed as an insurer under Articles 42 or 43 of New York State Insurance Law or certified under Article 44 of New York State Public Health Law, in good standing, and in compliance with state solvency requirements; and

3.5.1 If applicable, be certified/licensed in accordance with the certification and oversight jurisdiction imposed by another state.

3.6 The Contractor throughout the term of the Contract, must be accredited by the National Committee on Quality Assurance (NCQA) and/or Utilization Review Accreditation Committee (URAC).

3.7 The Contractor must agree to accept all determinations of eligibility as made by the Department and must provide a rider that provides identical coverage criteria to the NYSHIP eligibility criteria presented in the 2020 NYSHIP Dependent Eligibility Rider, or any alternative form developed by the Department

3.8 The Contractor must agree to use any 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 Open SSH implementation of Secure FTP. Further, the Contractor must agree to comply with the Department's Information Security Requirements (Appendix C) including any additional protocols required by the Department to ensure the security of its data transmissions.

3.9 The Contractor must accept signed and valid NYSHIP Authorization for Release of Protected Health Information forms, or any alternative form developed by the Department, for the purpose of the release of Protected Health Information to Enrollees' designees.

Section 4: Project Services

4.0 No aspect of Contractor's performance of Project Services in accordance with the terms and conditions of the Contract 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 Contract as requiring Department approval. The Department shall act promptly and in good faith with respect to its approval or disapproval of the Plan.

4.1 The Contractor acknowledges and agrees that the Department shall hold the Contractor solely responsible for all contractual matters.

4.2 The Contractor shall provide all JLMC members with notification of changes in Subcontractors within 30 days of such changes becoming final.

Commercial Plan and MAP Requirements

4.3 The Contractor must provide coverage to both Commercial and Medicare primary Enrollees and dependents that comply with the requirements of the Contract throughout the term of the Contract. If the HMO has an approved MAP with Part D coverage in a Commercial Plan service area it must offer the MAP to Medicare primary enrollees. The Contractor cannot offer a Plan that provides coverage to Medicare eligible enrollees only.

4.4 Persons who have primary coverage with Medicare, who reside in the HMO's MAP NYSHIP approved Service Area are also eligible Enrollees under the NYSHIP.

4.5 The Contractor must meet or provide at least these items as described below.

4.5.0 The Commercial Plan offered by the Contractor must provide at least these minimum benefits:

4.5.0.a Must be fully Patient Protection and Affordable Care Act (PPACA) compliant.

4.5.0.b An HMO may specify copayments or coinsurance as part of their benefit package; however, copayments or coinsurance for inpatient hospital care and annual deductibles are not permitted.

4.5.0.c Starting with the 2022 plan year, and for each subsequent year of the Contract, an HMO may not utilize coinsurance as a cost sharing mechanism for air ambulance services in their proposed benefit package.

4.5.0.d Coverage must comply with all services required by Federal and State laws and/or regulations in addition to the following enhanced coverage:

4.5.0.e 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;

4.5.0.f 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;

4.5.0.g 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;

4.5.0.h 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 is permitted; and

4.5.0.i Coverage for diagnosis and treatment of Gender Dysphoria.

4.5.0.j Benefits for services not listed as minimum benefit requirements pursuant to this section 4, such as routine/preventive dental services and/or the provision of eyeglasses for routine vision correction may be included in the HMO’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.

4.5.0.k The Contractor may meet the minimum benefit requirements set forth in these requirements using a standard contract, or through a combination of a standard contract and riders. A Contractor may provide benefits in excess of the minimum benefits required by this Contract. The standard contract must be approved for offering by the appropriate regulatory authority. Riders shall be accepted by the Department in consultation with the JLMC only if such rider is necessary to bring the standard contract proposed by the HMO into conformity with the minimum benefit requirements. It is not the intent of the Department to purchase from HMOs riders that increase the 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 at an additional cost, or which provide benefits in excess of the minimum benefit requirements at an additional cost, may be rejected by the Department in consultation with the JLMC.

4.5.1 The MAP offered by the Contractor must meet or provide at least these items:

4.5.1.a The HMO's MAP must follow the regulations and requirements set forth in the Center for Medicare and Medicaid Services (CMS) Medicare Managed Care Manual (MMCM). The Department is obligated to follow the rules and regulations in the MMCM as applicable to the employer group.

4.5.1.b The benefit levels provided must meet or exceed the minimum benefits as set forth in this section and 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 an HMO from complying with this requirement must be clearly identified in the HMO's Proposal.

4.5.1.c If an HMO is submitting a MAP with Prescription Drug coverage, the Plan must be CMS approved for all counties in the proposed Service Area.

4.5.1.d Starting with the 2022 plan year, and for each subsequent year of the resulting Contract, an HMO's proposed MAP may not utilize coinsurance as a cost sharing mechanism for either Part B medications or air ambulance services.

4.5.1.e An HMO may submit only one product for Medicare primary Enrollees. It may submit either (a) the Commercial Plan which coordinates with Medicare and includes prescription drug coverage equal to, or better than, Medicare Part D or (b) a MAP with Prescription Drug Plan. An HMO must provide Part D coverage at an equal level to the Commercial Plan in the coverage gap.

4.5.1.f An HMO whose CMS Star quality rating falls below 3 stars and whose enrollment is frozen by CMS would be permitted to keep an Enrollee that otherwise would have aged-into the MAP in the Commercial Plan until CMS lifts the enrollment freeze.

4.5.1.g The Contractor must agree to cooperate with the Department to enroll individuals into the HMO's MAP as they become Medicare eligible in accordance with this 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:

4.5.1.g.i The Department shall provide advance notice to eligible Enrollees and/or their eligible Dependents that Department intends to enroll them in Medicare Advantage Prescription Drug Plan (MAPD) Plan;

4.5.1.g.ii 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 any consequences to their benefits opting out would bring. This notice shall be provided to Enrollees and/or their eligible dependents not less than 21 calendar days prior to the effective date of coverage in the MAPD Plan;

4.5.1.g.iii 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

4.5.1.g.iv 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."

4.5.1.h The Contractor must follow the procedures set forth in Chapter 2 of the MMCM, Optional Mechanism for MA Group-sponsored Plan Enrollment (as may be updated from time to time), which allows an employer to enroll its retirees using an 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 HMO's MAP as they become Medicare eligible in accordance with this process. Enrollments into the HMO's MAP may not occur unless received by the Contractor through the Department's enrollment files.

4.5.1.i The Contractor must obtain any additional Member information not included on the Department enrollment files 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.

4.5.1.j The Contractor shall furnish MAPD identification cards and Evidence of Coverage (EOC) documents, which describe in detail the prescription drug benefits covered by the plan, to each MAPD Member enrolled for MAPD Plan benefits.

4.5.1.k The Contractor shall agree to follow the procedures set forth in Chapter 2 of the MMCM, Optional Employer/Union MA Disenrollment Request Mechanism (as may be updated from time to time), 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 HMO's MAP. 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.

4.5.1.l A Contractor that offers a MAP through NYSHIP shall agree to notify the Department on a weekly basis in a format specified by the Department when CMS regulations impact the enrollment of a NYSHIP Enrollee or Dependent in the MAP. These events include but are not limited to the following:

4.5.1.l.iCMS generated disenrollment that remove a NYSHIP Enrollee or Dependent from the Medicare Advantage employer group plan;

4.5.1.l.ii Disenrollment prompted by MAPD Member correspondence where CMS regulations require the HMO 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;

4.5.1.l.iii 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 MAP, has an invalid or missing Medicare Beneficiary Identifier (MBI) or does not reside in service area; and

4.5.1.l.iv Other situations not described above.

4.5.1.m 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 who makes a timely application for enrollment.

4.5.1.n Termination of coverage for a MAPD Member who is determined by the Department to be ineligible for benefits shall be reported to the Contractor in the enrollment files transmitted on the scheduled basis. 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.

4.5.1.o A Contractor that offers a MAP through NYSHIP must within forty-five (45) business days from the date the Contractor receives the Low-Income Subsidy (LIS) payment from CMS, send the LIS beneficiary the low-income premium subsidy payment.

4.5.1.p 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.

Service Requirements

4.6 The Contractor agrees to provide coverage to both NYSHIP primary and Medicare primary Enrollees and Dependents. The Contractor may either submit a Commercial Plan offering that is available to both such groups or an offering that is a combination of a Commercial Plan and a MAP that includes the CMS-approved Part D coverage. If the Contractor has an approved MAP with Part D coverage in the same Service Area as the Commercial Plan offering, the Contractor must offer the MAP to Medicare Primary Enrollees. The Department and JLMC will consider participation requests from HMOs that include their entire Service Area or an HMO that limits its proposal to include only certain counties in the Service Area. The Department may, at its discretion and in conjunction with the JLMC, select an HMO's entire proposed Service Area or may select specific counties within the proposed Service Area for participation in NYSHIP.

4.7 The Contractor must ensure that comprehensive health care services are available to covered individuals. Title 10 of New York State Code, Rules, and Regulations (Part 98) defines Comprehensive Health Care Services as all those health services which an enrolled population might require in order to be maintained in good health, and shall include, but shall not be limited to:

4.7.0 Physician and other provider services (including consultant and referral services);

4.7.1 Inpatient and outpatient hospital services;

4.7.2 Diagnostic laboratory and therapeutic and diagnostic radiologic services; and

4.7.3 Emergency and preventive health services, including providing HIV counseling and recommending voluntary HIV testing to pregnant women.

4.8 The Contractor shall fulfill the following duties and responsibilities:

4.8.0 The Contractor must comply with New York State Laws and/or regulations; provide coverage to Members, either directly or through their Primary Care Physician (PCP), twenty-four (24) hours a day, 365 days a year; and instruct their Members on what to do to obtain services after regular business hours.

4.8.1 The Contractor must also abide by the following appointment standards:

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

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

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

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

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

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

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

Section 4.9 Communications Material Requirements

4.9.0 The Department and the JLMC place a high priority on ensuring that NYSHIP Members are able to make informed choices when selecting a health plan during the annual Option Transfer Period. The Option Transfer Period is defined as the time period during which Enrollees may change their existing health benefit option for the next Plan Year. The Department requires that the benefits offered by an HMO be fully described to the HMO's Members.

4.9.1 To assist NYSHIP Members in choosing a health insurance plan during the annual Option Transfer Period, the Department will develop a Health Insurance Choices guide. This guide will contain uniformly formatted pages for each plan offering (Commercial and Medicare Advantage, if offered) so that Members may easily compare the benefits offered. Please note that the Department reserves the right to add, remove or change any of the Choices page requirements for each plan year of the Contract.

4.9.2 The Contractor shall fulfill the following duties and responsibilities.

4.9.2.a All Member communication material must be pre-approved by the Department prior to distribution to Members. For purposes of the Contract, "Member communication material" is defined as any electronic or hardcopy communications directly or

indirectly distributed to NYSHIP Members. Distribution means delivery through any media electronic or otherwise directly or indirectly targeting NYSHIP Members. This includes both annual benefit plan communications and updated Member communication material distributed by the HMO throughout the year.

4.9.2.b Upon approval by the Department and in consultation with the JLMC, the Contractor must distribute the Cover Letter, Schedule of Benefits, and the applicable Side-by-Side Comparison of Benefit Changes to Members in hard copy, in one envelope and in one mailing. Final versions of these mailings must be sent to all JLMC members at least one (1) week prior to mailing to NYSHIP Members.

4.9.2.c All Member communication material must present a clear, factually correct, complete and easily understood description of the benefits available through the HMO. Any incorrect or incomplete Member communication material sent by the Contractor to NYSHIP Members related to Member communication materials must be corrected and re-sent at the Contractor's expense. Benefits offered and/or received through incorrect or incomplete Member communication material sent by the Contractor must be covered until the Member(s) receive the corrected Member communication material or, at the discretion of the Department, in consultation with the JLMC, for the balance of the Plan Year.

4.9.2.d Member communication materials may promote the HMO but must not make general or specific comparisons to any other NYSHIP option. The Contractor is not permitted to refer to the Empire Plan or plan specific comparisons to other HMOs. For example, a Contractor may not state that they "serve more NYSHIP Members than any other HMO that participates in NYSHIP."

4.9.2.e Member communication materials may not discriminate on the basis of a potential Member's health status, prior use of health service, or need for future health services.

4.9.2.f The Contractor may not distribute Member communication materials that mislead or confuse NYSHIP Members by promoting or misstating benefits for which the NYSHIP Member is not covered.

4.9.2.g The premium cost or rate information of all NYSHIP health plan options will be communicated to Enrollees by the Department's Employee Benefits Division and shall not be included in any communication materials distributed by the Contractor, with the exception of rate filing notifications required by the New York State Department of Financial Services (DFS). 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.

4.9.2.h Visual presentations of Members in the HMO Member communication material must represent a diverse New York State workforce.

4.9.2.i The Contractor must include the following statement in the Cover Letter for the Member communication materials mailing to HMO NYSHIP Members: "Your Eligibility Guidelines may be different from those guidelines listed in the Certificate of Coverage. 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."

4.9.2.j The Contractor must comply with PPACA to produce, revise, distribute and, upon request, translate a Summary of Benefits and Coverage (SBC) that accurately describes the NYSHIP group benefits and coverage to all HMO NYSHIP Members. The SBC must be provided to the Department in an Adobe Portable Document Format (PDF) electronic format document no later than 30 days before the beginning of each Plan Year for posting to the Department website. The Contractor must distribute a SBC to any eligible Employee or Retiree contacting the Contractor or the Department requesting a hard copy in accordance with PPACA 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.

4.9.2.k The 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 MAP (if offered) in the HMO's Submission.

4.9.2.l If the Contractor participates in NYSHIP in 2020, it is required to submit a Side by Side Comparison of Benefits that lists changes in the benefits offered to Enrollees from 2020 to 2021. Such changes include but are not limited to copayments; new benefits; number of days of a prescription supply; delivery of services; and provider networks. In the event there are no changes in the benefits offered, the Contractor is 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 website.

4.9.2.m In addition to the required Member communication material, the Contractor may develop and distribute other marketing materials to current NYSHIP Enrollees who live or work in the HMO's NYSHIP service area. All Member communication materials distributed to NYSHIP Members must present the NYSHIP HMO's benefits. The Department will not provide any information to Contractor regarding the identification of eligible NYSHIP Enrollees or their mailing addresses. Any Member communication materials distributed by the Contractor to NYSHIP Enrollees must be pre-approved by the Department, in consultation with the JLMC, prior to distribution.

4.9.2.n The Contractor shall not provide NYSHIP Members with gift(s) as an inducement to enroll in the HMO. Generally, a gift is something that has a fair market value of $15.00 or more (i.e. nominal value).

4.9.2.o The Contractor is not permitted to conduct NYSHIP related marketing activities including distribution of NYSHIP related material, at any worksite event without prior approval of the Department. The Contractor may only distribute Department approved materials that provide specific information regarding the NYSHIP HMO or relate to general health care issues at such events. Worksite events include, but are not limited to, health benefit fairs and information booths.

4.9.2.p Advertising or promotional material (e.g. billboards, brochures, flyers, postcards, business cards, posters, menus, sales sheets, etc.) shall not contain the NYSHIP logo or the term NYSHIP or any language that would infer the State promotes or supports the Contractor.

4.9.2.q If an HMO's benefit changes are expected to reduce premium costs, a notation may be included in the HMO communication materials that certain benefit changes are expected to result in decreased premiums or to help limit premium increases; however, the language may not state how much premiums will decrease or how much savings may be realized.

4.9.2.r All Member communication materials must be submitted to all JLMC Members for approval before the submission deadline specified in the annual call letter. JLMC may approve optional marketing materials submitted late, but also reserve the right to disapprove any material that does not meet the specified deadline. The Contractor shall adhere to the Department's decision on any and all optional marketing materials, regardless of format or timing of deployment. For purposes of this section "optional marketing materials" refer to any communication or promotional materials, electronic or otherwise, made visible and relevant to NYSHIP Members or used to promote enrollment by the Contractor that are outside of the required Member communications materials.

4.9.2.s The Contractor is required to advise all JLMC members of the potential withdrawal of any hospital or hospital group and of any significant provider group from the HMO'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.

4.9.2.t As part of its proposal, the Contractor was required to list its current five 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. On an ongoing basis during the term of the Contract, the Contractor must advise the Department and JLMC in writing of any change to NYSHIP's position in the standings.

4.9.2.u Notification of proposed changes in the configuration of Service Area counties, including a shift in Service Area counties within rating regions or the establishment of a new rating region(s), must be provided by the Contractor to the Department at the same time the request is submitted to the regulatory agency and noted as pending. The Department must be notified 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 members with copies of all notification materials for Members impacted by the region switch prior to distribution to the Members.

Section 4.10 Reporting

4.10.0 The Contractor must provide the Department with regular, periodic reports that are designed to document that Member, network, and account management service levels are being maintained and that claims are being paid in accordance with the Contract. The Contractor may on occasion be requested to provide ad-hoc reporting and analysis within 24 hours.

4.10.1 In order to fulfill its obligations to enrolled Plan Members and ensure Contract compliance, the Contractor must provide accurate claims data information on a claim processing cycle basis as well as summary reports concerning the Plan and its administration.

4.10.2 All electronic files must be in a format acceptable to the Department. The Department will review and approve the proposed format, but this format may be adjusted during the term of the Contract. Upon receipt by the Department, all electronic files are first validated for compliance with the agreed-upon file structure. Files that fail to adhere to this structure are rejected in their entirety and must be re-submitted.

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

4.10.4 The Contractor shall fulfill the following duties and responsibilities:

4.10.4.a 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 HMO must make these records available to the Department and JLMC in searchable format upon request. All Member identifying information must be redacted.

4.10.4.b The Department requires the Contractor to 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 HMO must make these records available to the Department or JLMC upon request.

4.10.4.c The Department requires the Contractor to 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 HMO must make these records available to the Department or JLMC upon request.

4.10.4.d Whenever the Contractor conducts a Member satisfaction survey that includes NYSHIP Enrollees, the Contractor must provide a copy of the survey and survey results electronically in searchable format within 30 days upon request from any JLMC member

4.10.4.e The Contractor must notify the Department on a weekly basis of any Members no longer eligible to be enrolled in the MAP for reasons identified by the Contractor or CMS; including but not limited to, missing MBI, no Medicare Parts A and/or B, or enrollment in another MAP or Medicare Part D plan. The Department must also be notified if an Enrollee moved out of the HMO Service Area or is deceased. The Contractor must notify the Department using the format provided in the Medicare Enrollment Report Format and Frequency, or any other alternative form identified by the Department

4.10.4.f The Contractor must file its Medical Loss Ratio (MLR) with the federal government by July 1st of each calendar year. The Contractor must provide its filed MLR to the Department no later than September 1st of each 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 September 30th of that calendar year as required under the PPACA. In addition, notification must be provided to both Enrollees and the employer group in instances where the MLR threshold has not been met.

4.10.4.g The Contractor must submit a Low-Income Subsidy (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:

4.10.4.g.i Payment Date

4.10.4.g.ii Carrier ID

4.10.4.g.iii Benefit Plan

4.10.4.g.iv Benefit Program

4.10.4.g.v Last Name, First Name

4.10.4.g.vi Date of Birth

4.10.4.g.vii MBI

4.10.4.g.viii Member ID

4.10.4.g.ix Social Security Number

4.10.4.g.x Number of Payments

4.10.4.g.xi Payment Start Date

4.10.4.g.xii Payment End Date

4.10.4.g.xiii ADJ (Adjustment) Reason Code

4.10.4.g.xiv ADJ (Adjustment) Reason Code Description

4.10.4.g.xv LIS Premium Subsidy Amount.

4.10.4.h Consistent with State and Federal regulations, Healthcare Effectiveness Data and Information Set (HEDIS) Reports need to be completed on a timely basis.

Section 4.11 Administrative Requirements

4.11.0 The Contractor's Account Management Team shall have a proactive, experienced account leader and team in place who have the authority and expertise to coordinate the appropriate resources.

4.11.1 The Contractor must:

4.11.1.a Ensure that there is a process in place to gain immediate access to appropriate corporate resources and senior management necessary to meet all HMO Project Service requirements and to address any issues that may arise during the performance of the Contract;

4.11.1.b Be 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 Contract to the satisfaction of the Department; and

4.11.1.c Immediately notify the Department in writing of actual or anticipated events impacting the HMO Project Service requirements and/or delivery of services to Members 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 HMO, legislation, class action settlements, and operational issues.

Section 4.12 Website Access

4.12.0 The Contractor must provide the Department and JLMC members responsible for administrative oversight of NYSHIP HMOs during the term of the Contract access to website applications that are available only to Members. The Contractor must also provide the address of its 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.

Section 4.13 Medicare Coordination and Secondary Payment

4.13.0 The Contractor shall coordinate and comply with the requirements of the Centers for Medicare and Medicaid Services (CMS); this includes complying with Medicare Crossover and all Medicare Secondary Payor (MSP) Mandatory Reporting and data matching established and required by CMS. Medicare Crossover is the process by which Medicare, as a primary insurance carrier for some Plan Members, automatically forwards Medicare Part B claims to the Contractor for processing. The Department also receives demand summary notices from Medicare for claims that Medicare believes were paid in error.

4.13.1 The Contractor shall also be required to provide the appropriate benefit level to Members diagnosed with end-stage renal disease (ESRD) and adjudicate claims as per Medicare Secondary Payor Rules and regulations.

4.13.2 The Contractor shall follow the procedures set forth below in handling Medicare Secondary Payer claims for any NYSHIP Enrollees and Dependents:

4.13.2.a The Contractor shall immediately remit to the Department a copy of any MSP notice received that pertains to a NYSHIP Member. The Contractor shall provide status updates on each MSP case through and including final payment resolution.

4.13.2.b Upon receipt of a demand letter directly from 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;

4.13.2.c 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 reimburse 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 insurer/third party administrator amounts paid on behalf of the Contractor for MSP claims by the NYSHIP insurer/third party administrator;

4.13.2.d The Contractor shall 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

4.13.2.e 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 the agency for the offset and shall reduce the next premium payment to the HMO by the amount of such offset.

Section 4.14 Disabled Dependent Determinations

4.14.0 The Contractor shall make clinical Disabled Dependent Determinations for Dependent children with a disability who are enrolled in the HMO. Disabled Dependents of NYSHIP Enrollees are entitled to be covered under the Enrollee's family coverage beyond the normal age-out limits if those Dependents are incapable of self-sustaining employment. As part of the Disabled Dependent Determination, a Statement of Disability Dependent 19 Years of Age or Older Form PS-451(or other alternative form identified by the Department) is completed by the Enrollee, the Dependent's physician and the Enrollee's Employer, and then evaluated by the HMO to determine if the Dependent is disabled. All determinations are subject to review by the HMO on a periodic basis. The following guidelines must be used for all Disabled Dependent Determinations.

If improvement of the Dependent's condition is:

4.14.0.a "Expected," the case will be normally reviewed within six to eight months, unless the HMO determines a need for a more frequent review.

4.14.0.b "Possible," the case will be normally reviewed no sooner than three years, unless the HMO determines a need for a more frequent review.

4.14.0.c "Not expected," the case will normally be reviewed no sooner than seven years, unless the HMO determines a need for a more frequent review.

4.14.1 Once the HMO makes the disability determination, the PS-451 must be sent to the Department to confirm eligibility. If the disabled Dependent is eligible, the HMO will receive confirmation of eligibility through the weekly enrollment transaction file.

4.14.2 The HMO must accept determinations of total disability under the above standards that were made by other NYSHIP plans provided there has not been a break in coverage between plans.

Section 5: Modification of Project Services

5.1 In the event that laws or regulations enacted by the Federal government and/or the State have an impact upon the conduct of this Contract in such a manner that the Department determines that any design elements or requirements of the Contract 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.

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

5.3 To the extent that any of the events as set forth in this Section 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 Contract as of the Effective Date and which the Contractor is required to perform or deliver under the Contract, 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 Contract, 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 Project Services that are no longer required. The Department will agree to modify guarantees as determined by the Department to be necessary to reflect Project Service 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.

Section 6: NYSHIP Eligibility and Effective Dates of Coverage

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

6.1 The Contractor shall accept all individuals determined by the Department to be eligible for services under the Contract that results from these requirements and may not enroll any individuals who have not been determined to be eligible by the Department. The Department will send the Contractor information about eligible Enrollees and Dependents on an enrollment file on a scheduled basis as determined by the Department.

6.2 To facilitate accurate enrollment records, the Contractor must work with NYS, including the New York State Office of Information Technology Services (ITS), to develop an automated process for Medicare enrollment reconciliations, at no additional cost to the State.

6.3 Individuals who may enroll in an HMO through NYSHIP include Employees and Retirees of the State of New York and PEs who live or work in the HMO's NYSHIP approved Service Area, as well as their Dependents. Persons who have primary coverage with Medicare, who reside in the HMO's MAP NYSHIP approved Service Area are also eligible Enrollees under the NYSHIP. Dependent eligibility is subject to the collective bargaining process and may change as a result of labor/management negotiations or changes to State and/or Federal law.

6.4 The HMO must agree to accept all determinations of eligibility as made by the Department and must provide an insurance rider that includes all NYSHIP Dependent eligibility provisions.

6.5 NYSHIP's dependent eligibility provisions include, but are not limited to:

6.5.0 An Enrollee's Spouse, including a legally separated spouse. If an Enrollee is divorced or the marriage has been annulled, the former spouse is not eligible as of the divorce or annulment effective date, even if a court orders the Enrollee to maintain coverage.

6.5.1 An Enrollee's Domestic Partner. The Enrollee may cover a same or opposite sex domestic partner as a dependent under NYSHIP. A domestic partnership, for eligibility under NYSHIP, is one in which the Enrollee and a partner are 18 years of age or older, unmarried and not related in a way that would bar marriage; living together; involved in an exclusive mutually committed relationship; and financially interdependent. To enroll a Domestic Partner, the Enrollee must have been in the partnership for six months and be able to provide proof of 6 months of cohabitation and 6 months of financial interdependence. There is a one year waiting period from the termination date of the Enrollee's previous partner's coverage before the Enrollee may again enroll a domestic partner.

6.5.2 An Enrollee's Children under 26 years of age. This includes the Enrollee's natural children, legally adopted children, children in a waiting period prior to finalization of adoption, stepchildren and children of the Enrollee's domestic partner who are covered without regard to financial dependence, residency with the Enrollee, student status or employment. Other children who reside permanently in the Enrollee's household, who are chiefly dependent on the Enrollee and for whom the Enrollee has assumed legal responsibility, in place of the parent, are also eligible. The Enrollee must verify eligibility by submitting a completed PS-457 Statement of Dependence, or other alternative form identified by the Department, form in addition to providing documentation to the Enrollee's employer upon enrollment and every two years thereafter. For "other children," legal responsibility by the Enrollee must have commenced before the child reached age 19.

6.5.3 An Enrollee's Child with Military Service. For purposes of eligibility for health insurance coverage as a child, up to four years for service in a branch of the U.S. Military between the age of 19 and 25 may be deducted from the Dependent child's age provided that the dependent child returns to school on a full-time basis, is unmarried and is otherwise not eligible for employer group coverage. The Enrollee must be able to provide written documentation from the U.S. Military. Proof of full-time student status at an accredited secondary or preparatory school, college or other educational institution will be required by the HMO for verification.

6.5.4 An Enrollee's unmarried Dependent child 26 or over who is incapable of self-sustaining employment by reason of mental disability, as defined in the mental hygiene law, or physical disability, who became incapacitated prior to attainment of the age at which Dependent coverage would otherwise be terminated, are eligible.

6.5.5 An Enrollee's unmarried children, including adopted children and stepchildren through age 29 ("Young Adult"), who live, work, or reside in New York State or the Service Area of the HMO's network-based NYSHIP policy are eligible to enroll for coverage under the Young Adult Option if these Young Adults:

6.5.5.a Are not insured by or eligible for coverage through the Young Adult's own employer-sponsored health plan, whether insured or self-funded,

provided that the health plan includes both hospital and medical benefits, and

6.5.5.b Are not covered under Medicare.

In addition:

6.5.5.c the Young Adult need not live with the parent, be financially dependent upon the parent, or be a student;

6.5.5.d the Young Adult's eligibility for health insurance coverage through a former employer under federal COBRA or State continuation coverage does not disqualify the Young Adult from electing the young adult option under NYSHIP;

6.5.5.e the Young Adult's children are not eligible for coverage under the Young Adult Option, but may be eligible for health insurance coverage under other programs, such as the Child Health Plus program;

6.5.5.f the parent need not have family coverage for the young adult to enroll in the Young Adult Option; and

6.5.5.g the Young Adult need not have been previously covered under the parent's NYSHIP coverage.

6.5.6 Dependent(s) of a deceased Enrollee may be eligible to continue coverage as a dependent survivor. The Enrollee must have completed at least 10 years of benefits eligible service, and the dependent must have been covered as the Enrollee's dependent under NYSHIP at the time of the Enrollee's death. The 10-year service requirement is waived if the Enrollee's death was the result of a work-related injury. Additionally, a dependent spouse, or domestic partner, is ineligible for survivor benefits if they remarry or acquired a new domestic partner. Dependent children must also meet all relevant eligibility criteria as a child dependent.

6.5.7 An Enrollee who is eligible for Vestee coverage may also cover their eligible dependent(s). The dependent(s) must meet the relevant eligibility criteria. A Vestee is a former benefits eligible employee who has met the service requirement to continue coverage as a retiree, and the relevant pension system service requirement, but has not met the age requirement to collect a pension. The eligible Enrollees may continue Vestee coverage until they qualify for retirement, so long as they are not canceled for non-payment of premium.

6.6 The Contractor shall also fulfill the following duties and responsibilities.

6.6.0 The Contractor shall 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.

6.6.1 The Contractor must maintain accurate, complete, and up-to-date enrollment files, based on information provided by the Department. These enrollment files shall be used by the Contractor to process claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files.

6.6.2 The Department will send the Contractor an eligible Enrollees and Dependents enrollment file on a scheduled basis. Except as set forth below, A Contractor shall not independently add an Enrollee or Dependent who has not been determined by the Department to be eligible.

6.6.3 The only time an HMO may disenroll an individual without first receiving a determination by the Department is when CMS tells an HMO to disenroll the individual due to other coverage. In this situation, the HMO must notify the Department within five (5) Business Days of notification by CMS.

6.6.4 The Contractor must comply with the Information Security Requirements (Appendix C) and ensure the confidentiality, integrity and security of all enrollment information.

6.6.5 Use of the enrollment data transmission protocol and encryption method as 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.

Section 7: Certificates

7.0 Within 30 days of notification by the Department of an Enrollee's enrollment, the Contractor shall issue to each Enrollee a Certificate, or advise each Enrollee the means to obtain 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 Contract principally affecting the Enrollee/MAPD member.

7.1 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.

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

Section 8: Coordination of Benefits

8.0 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.

Section 9: Cessation of Benefits

9.0 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 Contract, shall cease upon the termination of this Contract.

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

9.2 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.

Section 10: Records: Information to be Maintained by the Contractor

10.0 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.

10.1 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 Contract. 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 Contract.

10.2 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.

Section 11: Determination of Rate Basis, Payment of Premiums and Grace Period

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

11.0.1 The Contractor shall submit premium rates to the Department in accordance with the Contract. In order to prepare for the annual health insurance Option Transfer Period, NYSHIP premium rate submissions are due by September 1st of each Calendar Year. The premium rates shall be accompanied by the HMO's most recent available year-to-date loss ratio for the community pool in which NYSHIP Members are included. The premiums submitted to the Department shall be guaranteed rates under DFS regulation 11 NYCRR 52.42(b). The premium rates guaranteed shall be the presently prevailing approved or filed premiums. The premium rates for those Members who reside out of state must be the same as NYS premium rates filed with the NYS DFS.

Many HMOs submit for a rate adjustment to DFS with an effective date of January 1st. Such rate adjustments are only applicable until another rate request is made and approved by DFS. For administrative purposes, an HMO may guarantee the payment of the implemented rate for one year. To ensure the timely review and implementation of annual NYSHIP HMO premium rate changes by the Department, the HMO's selected for participation in NYSHIP must submit rate adjustments to DFS by June 1st of each calendar year.

11.0.2 The Contractor must provide the following detailed information to support the quoted premium rates.

11.0.3 The Contractor must provide a complete copy of the DFS's "Prior Approval Rate Change" application along with the printout of the System for Electronic Rate and Form Filing (SERFF) disposition notice indicating DFS approval of the rates submitted must be submitted to the Department by September 1st of each Calendar

Year. The SERFF, administered by the National Association of Insurance Commissioners (NAIC), is a web-based system that facilitates the submission of electronic rate and form filing and facilitates electronic storage, management analysis, and communication regarding filings and their disposition.

11.0.4 If the Contractor has a rate request pending DFS's approval with an effective date no later than January 1st, the Offeror must submit a complete copy of the DFS "Prior Approval Rate Change" application and the SERFF application notice indicating submission of the application by September 1st of each Calendar Year. The receipt confirmation from the DFS must be sent to the Department upon receipt from DFS.

11.0.5 NYSHIP rates are comprised of: (1) the HMO's Community Rates associated with the JLMC approved benefits for the following Plan Year, as submitted to and approved by DFS; and (2) Medicare Rate Adjustments (if applicable):

11.0.5.a The HMO'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.

11.0.5.b Medicare Rate Adjustments 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.

11.0.6 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 common premium rates 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.

11.0.7 The Contractor shall invoice the Department each month for premium payment in accordance with the provisions set forth herein, for Project Services rendered, together with full supporting detail(s) to the State's satisfaction. Such invoice shall be submitted on a monthly basis to accountspayable@ogs.ny.gov . The subject line should include the Invoice Number and the term "Department of Civil Service. The invoice must include:

11.0.7.a Name of the NYS Agency being billed;

11.0.7.b Name of the vendor and NYS Statewide Financial System (SFS) Vendor Number; and

11.0.7.c Contract number.

11.0.8 The Contractor shall calculate the total amount of premium payment for each coverage period by multiplying the number of Enrollees enrolled in the Plan by the premium rate then in effect for the respective types of coverage.

11.0.9 The Department reserves the right to adjust the premium payments charged by the Contractor based on a reconciliation of the Enrollee counts reported from the Department's NYBEAS by the Enrollee counts utilized by the Contractor to calculate the premium payments. The reconciliation will be performed by the Department on an annual basis using the average enrollee count for the respective Plan Year. However, the Department may perform additional reconciliations throughout a given year if the average monthly Enrollee counts utilized by the Contractor differ significantly from the Department's Enrollee counts, as reflected in NYBEAS.

11.0.10 After the Department approves the Contractor's invoice, the Department shall process the Contractor's invoice to OSC for payment. OSC shall render payment for invoices under the Agreement in accordance with ordinary State procedures and practices. The Department will make best efforts to process all acceptable invoices within thirty (30) days of their receipt; however, failure to make payment within said timeframe shall not be considered a breach of contract. The Contractor acknowledges that timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article XI-A of the State Finance Law. Submission of an invoice and payment thereof shall not preclude the Department, as applicable, from reimbursement or demanding a price adjustment in any case where Project Services as delivered are found to deviate from the terms and conditions of the Agreement.

11.0.11The State of New York is not liable for any cost incurred by the Contractor in preparation for or prior to the approval of an executed contract by the AG and OSC.

Section 12: Data Sharing and Ownership

12.0 All claims, enrollment and other data (i.e., materials) provided to the Contractor by the Department is being provided to the Contractor solely for the purposes of allowing the Contractor to fulfill its duties and responsibilities under the Contract and said materials are the sole property of the State. Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or federal law, the Contractor shall not share, sell, release, or make the materials available to third parties in any manner without the prior consent of the Department. This provision shall survive the expiration or termination of the Contract.

Section 13: Audit Authority

13.0 In addition to the audit authority requirements specified in Appendices A and B to this Contract, the Contractor agrees to cooperate with the Department, any other authorized State or Federal Department, and any law enforcement authority, in the investigation, documentation and litigation of any alleged illegal act, misconduct or unethical behavior related to the Contract, or in connection with any audit.

13.1 In addition to the Audit Authority requirements specified in Appendices A and B to this Contract, 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 Contract and any applicable State and federal statutory and regulatory authorities;

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

13.2.0 Review of the Contractor's activities and records relating to the documentation of its performance under this Contract 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).

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

13.2.2 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 this Contract.

13.3 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;

13.4 The Contractor shall make available for audit all data in its computerized files that is relevant to and subject to the Contract. 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;

13.5 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:

13.5.0 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 Contract;

13.5.1 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

13.5.2 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 Contract 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 Contract. 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;

13.6 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;

13.7 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 Contract.

13.8 If the Contractor has an independent audit performed of the records relating to this Contract, 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.

13.9 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 Contract, Standard Clauses for All New York State Contracts, or Appendix B, Standard Clauses for All Department Contracts.

Section 14: Confidentiality

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

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

14.1 The Contractor shall promptly advise the Department of all requests made to the Contractor for information regarding the performance of services under this Contract, 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 Contract or as required by law.

Section 15: Compliance with New York State Workers' Compensation Law

15.0 Sections 57 and 220 of the New York State Workers' Compensation Law (WCL) provide that the Department shall not enter into any Contract unless proof of workers' compensation and disability benefits insurance coverage is produced. Prior to entering into a Contract with the Department, the Contractor and Subcontractor(s) or Affiliates, with more than $100,000 in expected expenses over the life of the Contract, if any, are required to verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that they are properly insured or are otherwise in compliance with the insurance provisions of the WCL.

To the extent that the Contractor proposes the use of Subcontractors or Affiliates, the Contractor must verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that the Subcontractors or Affiliates are properly insured or are otherwise in compliance with the insurance provisions of the WCL.

Section 16: Insurance Requirements

16.0 Prior to the start of work the Contractor shall procure, at its sole cost and expense, and shall maintain in force at all times during the term of any Contract resulting from these Specifications, policies of insurance as required by this section, written by companies that

have an A.M. Best Company rating of "A-," Class "VII" or better. In addition, companies writing insurance intended to comply with the requirements of this Contract should be licensed or authorized by the New York State Department of Financial Services to issue insurance in the State of New York. The Department may, in its sole discretion, accept policies of insurance written by a non-authorized carrier or carriers when certificates and/or other policy documents are accompanied by a completed Excess Lines Association of New York (ELANY) affidavit or other documents demonstrating the company's strong financial rating. If, during the term of a policy, the carrier's A.M. Best rating falls below "A-," Class "VII," the insurance must be replaced, on or before the renewal date of the policy, with insurance that meets the requirements above. These policies must be written in accordance with the requirements of the paragraphs below, as applicable.

A Contractor shall deliver to the Department evidence of the insurance required by these Specifications and any Contract resulting from these Specifications in a form satisfactory to the Department. Policies must be written in accordance with the requirements of the paragraphs below, as applicable. While acceptance of insurance documentation shall not be unreasonably withheld, conditioned or delayed, acceptance and/or approval by the Department does not, and shall not be construed to, relieve a Contractor of any obligations, responsibilities or liabilities under these Specifications or any Contract resulting from these Specifications.

The Contractor shall not take any action or omit to take any action that would suspend or invalidate any of the required coverages during the term of any Contract resulting from these Specifications.

16.1 All policies of insurance required by this Solicitation or any Contract resulting from these Specifications shall comply with the following requirements:

16.1.0 Coverage Types and Policy Limits. The types of coverage and policy limits required from the selected Contractor are specified in paragraph 12. Specific Coverages and Limits below.

16.1.1 Policy Forms. Except as may be otherwise specifically provided herein or agreed to in any Contract resulting from these Specifications, all policies of insurance shall be written on an occurrence basis.

16.1.2 Certificates of Insurance/Notices. The selected Contractor shall provide the Department with a Certificate or Certificates of Insurance, in a form satisfactory to the Department, as detailed below, and pursuant to the timelines set forth in Section 11 below. Certificates should reference the Solicitation or award number and shall name the New York State Department of Civil Service, Agency Building 1, Empire State Plaza, Albany, NY 12239, as the certificate holder.

16.1.3 Certificates of Insurance shall:

16.1.3.a Be in the form acceptable to the Department and in accordance with the New York State Insurance Law (e.g., an ACORD certificate);

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

16.1.3.c Be signed by an authorized representative of the insurance carrier of the referenced insurance carriers; and

16.1.3.d Contain the following language in the Description of Operations / Locations / Vehicles section of the Certificate or on a submitted endorsement: Additional insured protection afforded is on a primary and non-contributory basis. A waiver of subrogation is granted in favor of the additional insureds.

16.1.4 Only original documents (Certificates of Insurance and any endorsements and other attachments) or electronic versions of the same that can be directly traced back to the insurer, agent or broker via e-mail distribution or similar means will be accepted.

The Department generally requires a Contractor to submit only certificates of insurance and additional insured endorsements, although the Department reserves the right to request other proof of insurance. A Contractor should refrain from submitting entire insurance policies, unless specifically requested by the Department. If an entire insurance policy is submitted but not requested, the Department shall not be obligated to review and shall not be chargeable with knowledge of its contents. In addition, submission of an entire insurance policy not requested by The Department does not constitute proof of compliance with the insurance requirements and does not discharge a Contractor from submitting the requested insurance documentation.

16.2 Primary Coverage

All liability insurance policies shall provide that the required coverage shall be primary and non-contributory to other insurance available to the Department and their officers, agents, and employees. Any other insurance maintained by the Department and their officers, agents, and employees shall be excess of and shall not contribute with the Contractor's insurance. Insurance policies that remove or restrict blanket contractual liability located in the "insured contract" definition (as generally stated in Section V, Number 9, Item f in the Insurance Services Offices (ISO) Commercial General Liability (CGL) policy) so as to limit coverage against Claims that arise out of the work, or that remove or modify the "insured contract" exception to the employers liability exclusion, or that do not cover the Additional Insured for Claims involving injury to employees of the Named Insured or subcontractors, are not acceptable.

16.3 Breach for Lack of Proof of Coverage

The failure to comply with the insurance requirements at any time during the term of any Contract resulting from this Solicitation shall be considered a breach of the terms of any Contract resulting from this Solicitation and shall allow the Department and their officers, agents, and employees to avail themselves of all remedies available under any Contract resulting from this Solicitation, at law or in equity.

16.4 Self-Insured Retention/Deductibles

Certificates of Insurance must indicate the applicable deductibles/self-insured retentions for each listed policy. Deductibles or self-insured retentions above $100,000.00 are subject to approval from the Department. Such approval shall not be unreasonably withheld, conditioned or delayed. A Contractor shall be solely responsible for all claim expenses and loss payments within the deductibles or self-insured retentions. If the Contractor is providing the required insurance through self-insurance, evidence of the financial capacity to support the self-insurance program along with a description of that program, including, but not limited to, information regarding the use of a third-party administrator shall be provided upon request.

16.5 Subcontractors

Prior to the commencement of any work by a Subcontractor, the Contractor shall require such Subcontractor to procure policies of insurance as required by this section and maintain the same in force during the term of any work performed by that Subcontractor. An Additional Insured Endorsement (ISO coverage form CG 20 38 04 13), or the equivalent, evidencing such coverage shall be provided to the Contractor prior to the commencement of any work by a subcontractor and pursuant to the timelines set forth in Section 4.7(11), as applicable, and shall be provided to the Department upon request. For subcontractors that are self-insured, the subcontractor shall be obligated to defend and indemnify the above-named additional insureds with respect to Commercial General Liability and Business Automobile Liability, in the same manner that the subcontractor would have been required to pursuant to this section had the subcontractor obtained such insurance policies.

16.6 Waiver of Subrogation

For all liability policies (except Professional Liability and Data Breach/Cyber Liability), the Contractor shall cause to be included in its policies insuring against loss, damage or destruction by fire or other insured casualty a waiver of the insurer's right of subrogation against the Department and their officers, agents, and employees, or, if such waiver is unobtainable (i) an express Contract that such policy shall not be invalidated if the Contractor waives or has waived before the casualty, the right of recovery against the Department and their officers, agents, and employees or (ii) any other form of permission for the release of the Department any entity authorized by law or regulation to use any Contract resulting from this Solicitation and their officers, agents, and employees. A Waiver of Subrogation Endorsement shall be provided upon request. A blanket Waiver of Subrogation Endorsement evidencing such coverage is also acceptable.

16.7 Additional Insured

The Contractor shall cause to be included in each of the liability policies (except Professional Liability and Data Breach/Cyber Liability) required below coverage for on-going and completed operations naming as additional insureds (via ISO coverage forms CG 20 10 04 13 or 20 38 04 13 and CG 20 37 04 13 and form CA 20 48 10 13, or a form or forms that provide equivalent coverage): the Department and their officers, agents, and employees. An Additional Insured Endorsement evidencing such coverage shall be provided to the Department pursuant to the timelines set forth in Section 11 below. A blanket Additional Insured Endorsement evidencing such coverage is also acceptable. If Contractor is self-insured, the Contractor shall be obligated to defend and indemnify the above-named additional insureds with respect to Commercial General Liability and Business Automobile Liability, in the same manner that the Contractor would have been required to pursuant to this Attachment had the Contractor obtained such insurance policies.

16.8 Excess/Umbrella Liability Policies

Required insurance coverage limits may be provided through a combination of primary and excess/umbrella liability policies. If coverage limits are provided through excess/umbrella liability policies, then a Schedule of underlying insurance listing policy information for all underlying insurance policies (insurer, policy number, policy term, coverage and limits of insurance), including proof that the excess/umbrella insurance follows form must be provided upon request.

16.9 Notice of Cancellation or Non-Renewal

Policies shall be written so as to include the requirements for notice of cancellation or non-renewal in accordance with the New York State Insurance Law. Within five (5) business days of receipt of any notice of cancellation or non-renewal of insurance, the Contractor shall provide the Department with a copy of any such notice received from an insurer together with proof of replacement coverage that complies with the insurance requirements of this Solicitation and any Contract resulting from this Solicitation.

16.10 Policy Renewal/Expiration

Upon policy renewal/expiration, evidence of renewal or replacement of coverage that complies with the insurance requirements set forth in this Solicitation and any Contract resulting from this Solicitation shall be delivered to the Department. If, at any time during the term of any Contract resulting from this Solicitation, the coverage provisions and limits of the policies required herein do not meet the provisions and limits set forth in this Solicitation or any Solicitation and any Contract resulting from this Solicitation, or proof thereof is not provided to the Department, the Contractor shall immediately cease work. The Contractor shall not resume work until authorized to do so by the Department.

16.11 Deadlines for Providing Insurance Documents after Renewal or Upon Request

As set forth herein, certain insurance documents must be provided to the Department contact identified in the Contract Award Notice after renewal or upon request. This requirement means that the Contractor shall provide the applicable insurance document to the Department as soon as possible but in no event later than the following time periods:

16.11.0 For certificates of insurance: 5 business days from request or renewal, whichever is later;

16.11.1 For information on self-insurance or self-retention programs: 15 calendar days from request or renewal, whichever is later;

16.11.2 For other requested documentation evidencing coverage: 15 calendar days from request or renewal, whichever is later;

16.11.3 For additional insured and waiver of subrogation endorsements: 30 calendar days from request or renewal, whichever is later; and

16.11.4 For notice of cancellation or non-renewal and proof of replacement coverage that complies with the requirements of this section: 5 business days from request or renewal, whichever is later.

16.11.5 Notwithstanding the foregoing, if the Contractor shall have promptly requested the insurance documents from its broker or insurer and shall have thereafter diligently taken all steps necessary to obtain such documents from its insurer and submit them to the Department, the Department shall extend the time period for a reasonable period under the circumstances, but in no event shall the extension exceed 30 calendar days.

16.12 Specific Coverage and Limits

16.12.0 Commercial General Liability

Commercial General Liability Insurance, (CGL) shall be written on the current edition of ISO occurrence form CG 00 01, or a substitute form providing equivalent coverage and shall cover liability arising from premises operations, independent contractors, products-completed operations, broad form property damage, personal & advertising injury, cross liability coverage, and liability assumed in a contract (including the tort liability of another assumed in a contract). Policy shall include bodily injury, property damage, and broad form contractual liability coverage. The limits under such policy shall not be less than the following:

16.12.0.a Each Occurrence – $2,000,000

16.12.0.b General Aggregate – $2,000,000

16.12.0.c Products/Completed Operations – $2,000,000

16.12.0.d Personal Advertising Injury – $1,000,000

16.12.0.e Medical Expense – $5,000

Coverage shall include, but not be limited to, the following:

16.12.0.f Premises liability;

16.12.0.g Independent contractors/subcontractors;

16.12.0.h Blanket contractual liability, including tort liability of another assumed in a contract;

16.12.0.i Defense and/or indemnification obligations, including obligations assumed under any Contract resulting from this Solicitation;

16.12.0.j Cross liability for additional insureds; and

16.12.0.k Products/completed operations for a term of no less than 1 year, commencing upon acceptance of the work, as required by the Contract.

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

16.12.1 Business Automobile Liability Insurance

The Contractor shall maintain Business Automobile Liability Insurance in the amount of at least $2,000,000 each occurrence, covering liability arising out of any automobile used in connection with performance under any Contract resulting from these Specifications, including owned, leased, hired and non-owned automobiles bearing or, under the

circumstances under which they are being used, required by the Motor Vehicles Laws of the State of New York to bear, license plates.

16.12.2 Professional Errors and Omissions Insurance

The Contractor shall maintain Professional Errors and Omissions (Professional Liability) in the amount of at least $1,000,000 each occurrence, for claims arising out of but not limited to delay or failure in diagnosing a disease or condition(if applicable) and alleged wrongful acts, including breach of Contract, bad faith and negligence. Such insurance shall apply to professional errors, acts, or omissions arising out of the scope of services.

16.2.2.a Such insurance shall include coverage of all professionals and technical personnel whose actions could be considered “professional services” arising out of the scope of services as additional named insureds.

16.2.2.b If coverage is written on a claims-made policy, the Contractor warrants that any applicable retroactive date precedes the start of work; and that continuous coverage will be maintained, or an extended discovery period exercised, throughout the performance of the services and for a period of not less than three years from the time work under any Contract resulting from this Solicitation is completed. Written proof of this extended reporting period must be provided to the Department upon request.

16.2.2.c The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Services of any Contract resulting from this Solicitation.

16.12.3 Technology Errors & Omissions Insurance or Professional Liability Insurance

The Contractor shall maintain, during the term of any Contract, Technology Errors and Omissions Insurance or Professional Liability Insurance in the amount of at least $10,000,000 each occurrence, for claims for damages arising from computer related services including, but not limited to, the following: consulting, data processing, programming, system integration, hardware or software development, installation, distribution or maintenance, systems analysis or design, training, staffing or other support services, any electronic equipment, computer software developed, manufactured, distributed, licensed, marketed or sold. The policy shall include coverage for third party fidelity including cyber theft if coverage is not met in a Data Breach and Privacy/Cyber Liability policy or a Fidelity/Employee Dishonesty policy.

If the policy is written on a claims made basis, the Contractor must provide to the Department proof that the policy provides the option to purchase an Extended Reporting Period (“tail coverage”) providing coverage for no less than one (1) year after work is completed in the event that coverage is cancelled or not renewed. This requirement applies to both primary and excess liability policies, as applicable.

16.12.4 Data Breach/Cyber Liability Insurance

Contractor is required to maintain during the term of any Contract and as otherwise required herein, Data Breach and Privacy/Cyber Liability Insurance in the amount of at least $10,000,000 each occurrence, including coverage for failure to protect confidential information and failure of the security of the Contractor’s computer systems or the Department systems due to the actions of the Contractor which results in unauthorized access to the Department or their data.

Said insurance shall provide coverage for damages arising from, but not limited to the following:

16.12.4.a Breach of duty to protect the security and confidentiality of nonpublic proprietary corporate information;

16.12.4.b Personally identifiable nonpublic information (e.g., medical, financial, or personal in nature in electronic or non-electronic form);

16.12.4.c Privacy notification costs;

16.12.4.d Regulatory defense and penalties;

16.12.4.e Website media liability; and

16.12.4.f Cyber theft of customer's property, including but not limited to money and securities, unless coverage is provided under a Fidelity/Employee Dishonesty policy or bond (subject to verification by the State).

Section 17: Use and Disclosure of Protected Health Information

17.0 The Contractor acknowledges that the Contractor is a "Business Associate" as that term is defined in the HIPAA implementing regulations at 45 CFR 160.103. of the Department as a consequence of the Contractor's provision of Project Services on behalf of the Department within the context of the Contractor's performance under the resulting Contract and that the Contractor's provision of Project Services will involve the disclosure to the Contractor of individually identifiable health information from the Department or other service providers on behalf of the Department, as well as the Contractor's disclosure to the Department of individually identifiable health information as a consequence of the Project Services performed under the resulting Contract. As such, the Contractor, as a Business Associate, will be required to comply with the provisions of this Section.

17.0.0 For purposes of this Section, 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 the resulting Contract, PHI may be received by the Contractor from the Department or may be created or received by the Contractor on behalf of the Department in the Contractor's capacity as a Business Associate. All PHI received or created by the Contractor in the Contractor's capacity as a Business Associate and as a consequence of its performance under the resulting Contract is referred to herein collectively as "Department's PHI."

17.0.1 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 (i) the Contractor is a HIPAA "Business Associate" of the group health plans identified herein as "covered entities" as a consequence of the Contractor's provision of certain services to and/or on behalf of the Department as administrator of the "covered entities" within the context of the Contractor's performance under the resulting Contract, 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 the resulting Contract; and (ii) Contactor is a "covered entity" under HIPAA in connection with its provision of certain services under the resulting Contract. To the extent Contractor acts as a HIPAA "Business Associate" of the group health plans identified as "covered entities", the Contractor shall adhere to the requirements as set forth herein. All consents and/or authorizations, if any, required for Contractor to perform the services hereunder and for the use and disclosure of information, including the Department's PHI, as permitted under the resulting Contract have or will be obtained from Enrollees and or Members.

17.0.2 Permitted Uses and Disclosures of the Department's PHI: The Contractor may create, receive, maintain, access, transmit, use and/or disclose the Department's PHI solely in accordance with the terms of the resulting Contract. In addition, the Contractor may use and/or disclose 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 Contractor 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 information has been breached. Additionally, the Contractor may use and/or disclose the Department's PHI, as appropriate: (i) for treatment, payment and health care operations as described in 45 CFR Section 164.506(c)(2), (3) or (4); and (ii) to de-identify the information or create a limited data set in accordance with 45 CFR §164.514, which de-identified information or limited data set may, consistent with Section 8(3)(e), below, be used and disclosed by Contractor only as agreed to in writing by the Department and permitted by law.

17.0.3 Nondisclosure of the Department's PHI: The Contractor shall not create, receive, maintain, access, transmit, use or further disclose the Department's PHI otherwise than as permitted or required by the resulting Contract or as otherwise required by law. The Contractor shall limit its uses and disclosures of PHI when practicable 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.

17.0.4 Safeguards: The Contractor shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for in the resulting Contract. The Contractor shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards that satisfy the standards set forth in the HIPPA Security Rule at 45

C.F.R §§164.308, 164.310, and 164.312, along with corresponding policies and procedures, as required by 45 C.F.R. § 164.316, 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, accesses, or that it transmits on behalf of the Department pursuant to the resulting Contract to the same extent that such electronic PHI would have to be safeguarded if created, received, maintained, accessed or transmitted by a group health plan identified herein.

17.0.5 Breach Notification:

In addition to the Disclosure of Breach requirements specified in Appendix B, the following provisions shall apply:

17.0.5.a Reporting: The Contractor shall report to the Department any breach of unsecured PHI, including any use or disclosure of the Department's PHI otherwise than as provided for by the resulting Contract, of which the Contractor becomes aware. An acquisition, access, transmission, use or disclosure of the Department's PHI that is unsecured in a manner not permitted by HIPAA or the resulting Contract is presumed to be a breach unless the Contractor demonstrates that there is a low probability that Department's PHI has been compromised based on the Contractor's risk assessment of at least the following factors: (i) the nature and extent of Department's PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used Department's PHI or to whom the disclosure was made; (iii) whether Department's PHI was actually acquired or viewed; and (iv) the extent to which the risk to Department's PHI has been mitigated.

17.0.5.b Required Information: In addition to the information required in Appendix B, Disclosure of Breach, the Contractor shall provide the following information to the Department within in the time period identified in Appendix B, Disclosure of Breach, 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:

17.0.5.b.i the date of the breach incident;

17.0.5.b.ii the date of the discovery of the breach;

17.0.5.b.iii a brief description of what happened;

17.0.5.b.iv a description of the types of unsecured PHI that were involved;

17.0.5.b.v identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the breach;

17.0.5.b.vi 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

17.0.5.b.vii any other details necessary to complete an assessment of the risk of harm to the individual.

17.0.6 The Contractor will be responsible to provide 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 of the United States Department of Health and Human Services and the media, as required by 45 CFR Part 164.

17.0.7 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.

17.0.8 The Contractor shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Contractor not permitted by the resulting Contract.

17.0.9 Associate's Agents: The Contractor shall require all of its agents or Subcontractors 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, to agree, by way of written Contract or other written arrangement, 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 the resulting Contract.

17.0.10 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, 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. The Contractor must provide the Department with access to the Department's PHI in the form and format requested, if it is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by the Parties, provided, however, that if the Department's PHI that is the subject of the request for access is maintained in one or more designated record sets electronically and if requested by the Department, the Contractor must provide the Department with access to the requested PHI in a readable electronic form and format.

17.0.11 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 PHI into copies of such Department PHI maintained by the Contractor.

17.0.12 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.

17.0.13 Termination

17.0.13.a This Contract 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 Section. Data return and destruction upon Contract termination is governed by Information Security Requirements, Appendix C.

17.0.14 Indemnification: Notwithstanding the provisions in Appendix B, the Contractor agrees to indemnify, defend and hold harmless the State and the Department and its 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 Contract or from any acts or omissions related to this Contract by the Contractor or its employees, officers, subcontractors, agents or other Members of its workforce, without limitations. 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 shall survive the expiration or termination of this Contract. This section is not subject to the limitation of liability provisions of the Contract.

17.0.15 Miscellaneous:

17.0.15.a Survival: The respective rights and obligations of Business Associate and the "covered entities" identified herein under HIPAA and as set forth in this Section, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION, shall survive termination of the resulting Contract.

17.0.15.b 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, as of their respective compliance dates.

17.0.15.c Interpretation: Any ambiguity in the resulting Contract shall be resolved to permit covered entities to comply with HIPAA.

Section 18: Public Officers Law

18.0 The Contractor and Contractor's employees and agents must be aware of and comply with the requirements of the New York State Public Officers Law (POL), particularly POL sections 73 and 74, as well as all other provisions of NYS law, rules and regulations, and policy establishing ethical standards for current and former State employees. Failure to comply with these provisions may result in disqualification from the Procurement process, termination, suspension or cancelation of the Contract and criminal proceedings as may be required by law.

Section 19: Notices

19.0 The Contractor shall immediately notify the Department upon learning of any situation that can reasonably be expected to adversely affect the rendition of Project Services.

19.1 All notices permitted or required hereunder shall be in writing and shall be transmitted via certified or registered United States mail, return receipt requested; by personal delivery; by expedited delivery service; or by e-mail. Such notification must be sent to:

State of New York Department of Civil Service
Name: Mr. James DeWan
Title: Director, Employee Benefits Division
Address: EBD, Room 1106, Albany, NY 12239
Telephone Number: (518) 473-1977
Facsimile Number: (518) 473-3292
E-Mail Address: James.DeWan@cs.ny.gov

Excellus Health Plan, Inc. dba HMO Blue
Name: Ms. Mary Bowe
Title: Regional Vice President of Sales
Address: Excellus BlueCross BlueShield
165 Court Street, Rochester, New York 14647
Telephone Number: 1-585-454-1700
Facsimile Number:
E-Mail Address: Mary.Bowe@excellus.com

19.2 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.

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

Section 20: Entire Agreement

20.0 The Contract, including all appendices and attachments, constitutes the entire agreement between the Parties hereto and no statement, promise, condition, understanding, inducement, or representation, oral or written, expressed or implied, which is not contained herein shall be binding or valid and the Contract shall not be changed, modified or altered in any manner except by an instrument in writing executed by both Parties hereto, except as otherwise provided herein. The Contract is subject to amendment(s) only upon mutual consent of the Parties, reduced to writing and approved by the AG and OSC.

Section 21: Amendments to Appendix C

21.0 The opening two paragraphs of section 4.2 of Appendix C, Right to Assess, Audit and Certify, are deleted and replaced with a new opening two paragraphs as follows:

Upon request, Contractor shall complete a security controls assessment conducted by the Department or its designated agent ("Security Assessment"). To the extent that the security controls assessment identifies any risks or deficiencies for which remediation is required, such remediation requirements or compensating controls will be provided in writing to the Contractor. The Department and Contractor agree to negotiate in good faith a mutually agreeable timeframe within which the remediation requirements or compensation controls must be successfully implemented. Contractor's failure to complete any remediation requirements within the agreed upon timeframe shall be deemed to be a material breach of the Agreement.

Where the Contractor is a Business Associate, or hosts, maintains or has access to Department Protected Health Information, certification in the HITRUST Common Security Framework (CSF) is required. The Department, in its discretion, may accept a comparable industry accepted security assessment certification in lieu of a HITRUST Common Security Framework (CSF) certification. If an alternative security assessment certification is accepted, then such alternative certification shall replace the following references to HITRUST.

21.1 Section 8.5 of Appendix C, Systems and Application Controls, is deleted and replaced with a new section 8.5 as follows:

Confidential Information must not be used in any non-production environment such as testing or quality assurance unless de-identification of the Data has been performed. In the event that de-identification is not practical or feasible, compensating controls must be in place protecting the Data to the same level of protection as afforded to the production environment. Confidential Information must not be placed into a non-production cloud computing environment unless deidentified or compensating controls are in place protecting the Data to the same level of protection as afforded to the production environment.

21.2 Section 11.4 of Appendix C, Access Control, is deleted and replaced with a new section 8.5 as follows:

Access reviews will be performed at least quarterly for privileged user accounts and at least annually for non- privileged user accounts. The Department reserves the right to request the Contractor to perform an additional access review for non-privileged user accounts if there is evidence of inappropriate access.

IN WITNESS WHEREOF, the Parties hereto have hereunto signed this Contract on the day and year appearing opposite their respective signatures.

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.

Contractor Certification: By signing I certify my express authority to sign on behalf of myself, my company, or other entity and full knowledge and acceptance of this Contract and all appendices. By signing, I affirm my understanding of and agreement to comply with the Department's procedures relative to the Procurement Lobbying Law as required by State Finance Law §139-j and §139-k.

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

Date: 11/23/2020

By: [redacted]
Name: Jacqueline P. Jones
Title Deputy Commissioner For Administration

NAME : Excellus BCBS

Date: November 4, 2020

By [redacted]
Name: Mary Bowe
Title VP Sales

STATE OF New York)
) ss:
COUNTY OF Monroe)

On the 4th day of November, 2020, before me personally came [redacted], 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 VP Sales of Excellus Health Plan, Inc. the corporation or organization described in and which executed the above instrument; and that (s)he signed his/her name thereto.

[redacted]
NOTARY PUBLIC
LISA M. SANTELLI
Notary Public in the State of New York
Monroe County
Commission Expires Dec. 26, 20 22

My commission expires:

Approved as to Form:

LETITIA JAMES
ATTORNEY GENERAL

By: _____

Date: _____

Approved:

THOMAS P. DINAPOLI
COMPTROLLER

By: _____

Date: _____

APPROVED
DEPT. OF AUDIT & CONTROL
Dec 31 2020
James M. Iwaneczko
FOR THE STATE COMPTROLLER