cbia health connections

EMPLOYER PARTICIPATION AGREEMENT

Fixed Funding Solutions

check one: ❑ New Group ❑ Change Group Number _____

1 COMPANY INFORMATION

Company Name

Company Phone Number ( )
Company Fax Number ( )

Address (Street) | P.O. Box | City, State ZIP Code

Benefits Administrator | Benefits Administrator Email Address | Taxpayer Identification Number:

Employer Contribution Toward Group Benefits
Medical _____% Life _____% Dental _____% LTD _____% STD _____%

Effective date of Coverage (Subject to Approval by CBIA Health Connections)

SIC Code

Current Medical Carrier: _____ Date of policy termination: _____

Current Dental Carrier: _____ Date of policy termination: _____ (Attach proof of prior dental coverage)

2 ELIGIBILITY

Eligibility period:
Coverage begins first of the month following ❑ 30 ❑ 60 days

Eligibility for coverage:
❑ 30 or more hrs/wk ❑ 20 - 29 hrs/wk; Specify number of hours: _____

3 EMPLOYER VERIFICATION

Information for Current Calendar Year

- Number of full-time equivalent employees_____
- Number of employees eligible for coverage_____
- Number of COBRA individuals_____
- Number of approved waivers_____
- Number of retirees_____
- Number of employees not actively at work(excluding vacations)_____
- Is your company part of or affiliated with another company AND eligible to file a combined tax return under Chapter 208? ❑ Yes ❑ No
  If yes, name of affiliated company
  _____
  Number of employees at affiliated company_____

Information for Prior Calendar Year (for CMS/ Medicare secondary payer rule)

- Did your company have 20 or more total employees in all locations for 20 or more calendar weeks of the prior calendar year? ❑ Yes ❑ No
- Did your company have 100 or more total employees (including full time, part time, owners and partners, excluding retirees and COBRA enrollees) in all locations for 50% or more calendar weeks of the prior calendar year? ❑ Yes ❑ No

Information for Prior Calendar Year (for COBRA/State Continuation)

- Did your company have 20 or more employees on more than 50 percent of its typical business days in the previous calendar year? ❑ Yes ❑ No
  When determining your group size, count each full-time employee as one, and each part-time employee as a fraction of a full-time employee, with the fraction equal to the number of hours worked divided by the hours an employee must work to be considered full time.
- If you answered No, do you choose to offer continuation? ❑ Yes ❑ No
- Would you like CBIA to administer your group's continuation? ❑ Yes ❑ No
  If yes, separate form is required.

4 BENEFIT ELECTIONS. See marketing materials for benefit options available by group size.

A copy of the sold proposal for Life and Disability benefits must be signed and attached.

Medical - ConnectiCare Fixed Funding Solutions

Rates: ❑ Composite (4-tier) ❑ Employee-Specific

HealthEquity HRA/HSA Integrated Accounts
[indicate your choice(s)]

❑ Employee HSA Accounts ❑ Employee HRA Account
If HealthEquity HRA or HSA services are selected, you or your broker must complete the *HealthEquity HRA/HSA Setup form* online.

❑ Other vendor: please specify _____

❑ **Dental**
- ❑ Group
- ❑ Voluntary

❑ **Voluntary Vision** - select one
❑ 12/12/12 ❑ 12/12/24

❑ **Voluntary Accident & Illness Benefits**

❑ **Short-term Disability*** - select one
- ❑ Group
- ❑ Voluntary

❑ **Long-term Disability*** - select one
- ❑ Group
- ❑ Voluntary

Note: LTD is not available to employees who work fewer than 30 hours per week.

* If electing STD or LTD coverage an original completed Tax Service Agreement must be submitted. Separate Tax Service Agreements are required if electing both STD and LTD coverage.

❑ **Group Basic Life**

❑ **Supplemental Life (3 to 9 eligible employees)**

❑ **Voluntary Life (10+ eligible employees)**

❑ **Voluntary Dependent Life (10+ eligible employees)**

Additional No-cost Services

Separate forms are required to set up each of these services.

❑ CBIA COBRA Administration

❑ CBIA HRA Administration

❑ **Identity Theft Protection**
- ❑ Employer paid
  - ❑ Gold ❑ Platinum
  - ❑ Employee only ❑ Employee & family
- ❑ Employee paid

5 **RETIRED EMPLOYEES—**A retired employee is defined as a former employee who is age 65 or older and worked for your company as a full time employee for a minimum of 10 years and was retired by your company. Coverage is not available to retirees under age 65.

Are you selecting retiree coverage? ❑ Yes ❑ No

Check the retiree group you are selecting coverage for: ❑ Existing and future retired employees ❑ Existing only ❑ Future only

Check all the retiree coverages you are applying for: ❑ Dental ❑ Group Basic Life (AD&D discontinued at retirement) ❑ Voluntary Dental ❑ Voluntary Vision

Retirees are only eligible for coverage in Medicare plans offered in CBIA Health Connections.

6 PARTICIPATION AND CONTRIBUTION GUIDELINES AND OTHER IMPORTANT INFORMATION

The undersigned employer attests that it meets and will abide by all of the following participation requirements:

- The undersigned employer is a member of the Connecticut Business & Industry Association (CBIA) and will renew membership annually.
- The undersigned employer is a firm, corporation, partnership or association that has been actively engaged in business for at least three consecutive months.
- The undersigned employer acknowledges that an active eligible employee is an employee who works more than 30 hours per week. Some employers may also wish to provide coverage to employees who work 20-29 hours per week.
- A minimum of 50% of the full-time eligible employees enrolling in the CBIA Health Connections program work/reside in Connecticut.
- The undersigned employer employs a minimum of five (5) full-time active eligible employees.
- The undersigned employer must maintain a minimum of five (5) enrolled employees participating in all offered Group lines of coverage at all times. If there are fewer than five (5) active full-time employees enrolled in any Group line of coverage, that line of coverage will not be renewed.
- The undersigned employer must meet a minimum of 75% participation of eligible employees. Group dental requires 40% participation of eligible employees. Valid waivers can be excluded from the calculation for medical and dental coverage.
- The undersigned employer must meet a minimum of 100% participation for all coverages that are non-contributory, whereby the employer pays 100% of the premiums.

  For Fixed Funding Solutions medical:

  - The minimum employer contribution is 50% of the lowest cost single employee option offered by the employer.
  - Employer eligibility, final enrollment, rates, and fees are subject to underwriting, and approval by ConnectiCare Insurance Company, Inc. (CICI). Individual Medical Questionnaires may be required.
  - Plan designs contain exclusions and limitations and are designed for group health plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). Fixed Funding Solutions products are not available to non-ERISA groups.
  - State benefit mandates do not apply. Please read benefit descriptions carefully.
  - Dependent limiting age is up to age 26.
  - Retirees and their dependents are not eligible for benefits under the Fixed Funding Solutions suite of products.
  - Employers with 20 or more employees must offer Federal COBRA coverage. Federal COBRA applies to employers with 20 or more employees on more than 50% of its typical business days in the previous calendar year. Employers with 19 and fewer employees may choose whether to offer 18 months of Continuation to Mini-COBRA/Spousal Continuation beneficiaries under CCI's Fixed Funding Solutions product.

- The undersigned employer understands that there are separate participation requirements for voluntary coverages:

  Employers with nine (9) or fewer employees:
  - Voluntary Life, Short Term Disability and Long Term Disability have a minimum participation requirement of three (3) enrolled employees.
  - Voluntary Dental, Vision & Accident and Illness have a requirement of two (2) lines of coverage offered by CBIA Health Connections and three (3) employees enrolled in one line of coverage.
  - Supplemental Life does not have a minimum participation requirement; The employee must be also be enrolled in basic life coverage.

  Employers with 10 to 50 employees:
  - Voluntary Life, Short Term Disability and Long Term Disability have a minimum participation requirement of three (3) enrolled employees.
  - Voluntary Dental, Vision, and Accident and Illness have a requirement of one (1) line of coverage and three (3) employees enrolled for coverage.
  - Supplemental Life is not available.

  Employers with 51 or more employees:
  - Voluntary Life, Short Term Disability and Long Term Disability have a minimum participation requirement of ten (10) enrolled employees.
  - Voluntary Dental, Vision, and Accident and Illness have a requirement of one (1) line of coverage and three (3) employees enrolled for coverage.
  - Supplemental Life is not available.

- The undersigned employer has a place of business in Connecticut.
- The undersigned Employer agrees to provide annual certification of continued adherence to the Program participation requirements listed here.
- One hundred percent (100%) of the eligible employees enrolling in the Program are covered by Workers' Compensation insurance, except those eligible employees who are not legally required to be covered by Workers' Compensation insurance.
- The undersigned employer agrees to give a minimum 15-days advance written notification to CBIA Service Corporation if it wants to cancel any coverages. Otherwise, it will be liable for the premium or applicable charges until the termination of its participation in the Program.
- The undersigned employer agrees that reinstatement after cancellation for non-payment (including NSF payments) can only occur two (2) times during a rolling twelve (12) month period.

To disenroll individual(s) from an employer/union sponsored Medicare Advantage plan and convert them to Original Medicare, the employer or union must provide the following.

- The employer/union will provide CBIA a timely notice of contract termination or the ineligibility of an individual to participate in the employer or union group sponsored Medicare Advantage plan. Such notice must be prospective, not retroactive.
- The employer/union must provide a prospective notice to its members alerting them of the termination event and of other insurance options available to them through their employer/union.
- Medicare Advantage Notice: The Medicare Advantage organization (or the employer/union, acting on its behalf) must provide prospective notice to the beneficiary that his/her plan enrollment is ending at least 21 calendar days prior to the effective date of the disenrollment. The notice must include information about other individual plan options the beneficiary may choose and how to request enrollment.
- If the employer/union sponsored plan was a Medicare Advantage with Prescription Drug plan, the individual must be advised that the disenrollment action means the individual will not have Medicare drug coverage. Notice must include information about the potential for late-enrollment penalties that may apply in the future.

7 AGENT INFORMATION

I designate Agent of Record as: | Agency

Address (Street) | Address (City, State, ZIP Code)

The undersigned agent attests they are individually, and the applicable commissionable agent, are duly licensed and have the required training and appointments with the appropriate government agency, authority, and carrier(s) to solicit enrollment of qualified employees or former employees of an employer participating in CBIA Health Connections and also specifically into a Medicare Advantage with Prescription Drug "MAPD" Plan. The agent of record represents that he/she is authorized to execute this Agreement on behalf of the commissionable agent.

Commissions payable to:

Address (if different from above) | Telephone

Tax Identification number (if commissions are being paid to the agency) | Social Security Number (if commissions are being paid to the agent)

The undersigned agent of record and/or commissionable agent agrees that commissions shall only be paid to agents of records/commissionable agents that are properly licensed with government authorities and appointed with applicable carrier(s). In the event CBIA Service Corporation is assigned commissions due to lack of proper license/appointment all relevant parties acknowledge and agree the relationship is strictly limited to commission and no advice regarding any product was provided.

Agent of Record: Print Name | Agent of Record: Signature

8 AUTHORIZATIONS AND ATTESTATIONS

In consideration of the promises and mutual covenants herein contained and other good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually covenanted and agreed by and between the parties as follows:

The undersigned employer hereby covenants that it meets the Participation Requirements set forth in Section 6 of this Agreement. If accepted as a participating employer in the CBIA Health Connections program (Program), it agrees to be bound by all provisions and amendments of applicable participating carriers' Group Service Agreements, the CBIA Health Connections Administration Manual, the Business Associate Agreement incorporated herewith as Addendum, and for the Fixed Funding Solutions medical program, the ConnectiCare Stop Loss Policy and Administrative Services Agreement (ASA). It acknowledges that it is the plan administrator and sponsor for its employees' health benefit plan and that it is responsible for complying with applicable provisions of federal ERISA, COBRA, and HIPAA laws.

The undersigned employer agrees to pay monthly premiums or applicable charges to CBIA Service Corporation in advance, along with any applicable fees, for coverage provided or administered by carriers who participate in the Program (Participating Carriers). It understands that CBIA Service Corporation accepts payments for insured coverage as an agent of Participating Carriers. For self-funded coverage under the Fixed Funding Solutions medical program, it understands that CBIA Service Corporation acts as its billing and collection agent. As part of these services, it agrees that CBIA Service Corporation will bill and collect broker compensation between it and its broker at a default rate of $40 per employee per month unless later modified.

The undersigned employer acknowledges that CBIA Service Corporation is not an insurer or carrier and is not liable for payment of benefits.

The undersigned employer acknowledges that coverage will automatically renew unless a notice of termination is provided.

The undersigned employer acknowledges that by their signature and participation in Health Connections they are contracting with ConnectiCare, Inc, its affiliates, subsidiaries and successor corporations (CCI) to provide Medicare Advantage with Prescription Drug "MAPD" coverage to their Medicare Eligible employees or retirees as permitted by the Centers for Medicare and Medicaid Services (CMS) effective on the effective date of coverage set forth in this agreement. The undersigned employer is also agreeing to the terms and conditions contained in the ConnectiCare Medicare Advantage Group Agreement which can be found at cbia.com/medicare.

Should any information furnished by the Owner/Officer/Employee of the undersigned employer be a misrepresentation or fraudulent, CBIA Service Corporation may rescind enrollment for coverage(s) back to the date of this Agreement.

I hereby attest to the accuracy and truthfulness of the information provided, and I agree to comply with the above provisions.

Owner/Officer of the Company - print name | Witness (Agent) - print name

Owner/Officer signature | Date | Witness (Agent) signature | Date

Company Name

Street Address

City, State ZIP

Owner/Officer email address

CBIA Service Corporation accepts the undersigned employer as a Participating Employer in the Program. It agrees to enroll designated eligible employees and dependents for coverage(s), and to forward premium or applicable charges received for coverage(s) to designated Participating Carriers.

Authorized CBIA Service Corporation signature | Date

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4399 INSTRUCTIONS

A payor voluntarily electing to make public goods payments directly to the Office of Pool Administration must complete forms DOH-4399 (Payor Election Application) and DOH-4264 (Electronic Filing User ID Application).

Instructions for pages 1 and 2:

Effective Date: Enter effective date of election. Note: An election application received from any payor or organization shall begin on the first day of the month following the date it was received by the Office of Pool Administration unless a future date is specified.

Federal Employer Identification # (FEIN): Enter federal employer identification number (FEIN) of the payor. Please note that Section 2807-j(5)(a)(iii)(D) of the Public Health Law requires the New York State Department of Health to publish the FEIN of all electing payors on a secure website.

Payor Name: Enter name of payor. The payor name is that of the incorporated entity, local government, self-insured fund.

D/B/As: Enter any assumed name(s) ("d/b/a") under which the entity is doing business.

Address: Enter address of payor.

Contact Person: Enter name of contact person that will be responsible for providing the Department with the information regarding the payor's election, lines of business and claims processing.

Phone #: Enter phone number of the contact person.

E-Mail Address: Enter the e-mail address of the contact person.

If the election submission is for a payor that is utilizing a third-party administrator (TPA)/administrative services only (ASO) for claims processing, the following information must also be provided. If more than one TPA/ASO is utilized, attach a list of additional TPAs/ASOs.

TPA/ASO Name: Prefilled to ConnectiCare Insurance Company, Inc.

TPA/ASO FEIN: Prefilled to 06-1618303

The Signature of the chief financial officer or other duly authorized individual binds the payor to make direct pool payments for all its public goods funding obligations, file reports and remit funds in conformance with the Health Care Reform Act (HCRA) provisions and Department requirements, and represents an agreement as to the jurisdiction of the State for purposes of enforcing payments required under Public Health Law sections 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

Instructions for page 3:

This form must be completed by all payors making an election and represents a payor's attestation of the coverage it provides. A payor electing to pay the Department's Office of Pool Administration directly is making an election for all its coverages for which it assumes risk for the payment of medical claims. Payors utilizing multiple third-party administrators (TPA)/administrative services only (ASO) organizations must complete a Coverage Information form for each TPA/ASO.

- In each payor category which applies, the payor should mark an "X" in each column to indicate that the payor provides such coverage. Each box marked with an "X" represents the coverages that it assumes risk for. As stated before, a payor is required to elect for all coverages for which it assumes risk for the payment of medical claims. Shaded areas should not be checked.

- If an Article 43 NYS Insurance Law corporation or licensed commercial insurer has a separate incorporation for its Article 44 NYS Public Health Law business, that corporation must check the appropriate boxes on a single election form. Otherwise, the Article 44 NYS Public Health Law business is considered to be a product line of the Article 43 or commercial payor and the payor is required to make a single election for this and all other types of coverage provided by the corporation. A payor, who does not fall into any of the categories listed, should check "Other" in the payor identification section and explain their payor type in the space provided.

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

Effective Date: _____

FEDERAL EMPLOYER IDENTIFICATION # (FEIN): _____

PAYOR NAME: _____

D/B/As (IF APPLICABLE): _____

ADDRESS: _____

_____

CONTACT PERSON: _____

PHONE #: _____

E-MAIL ADDRESS: _____

If the above referenced entity is a payor that utilizes a third-party administrator (TPA)/administrative services only (ASO) for claims processing, please provide the following information:

TPA/ASO NAME: ConnectiCare Insurance Company Inc.

TPA/ASO FEIN: 06-1618303

By signature below, the above entity elects to make all public goods surcharge payments directly to the Office of Pool Administration for all its coverages for which it assumes risk for the payment of medical claims and agrees to:

1. remit to the Department's Office of Pool Administration required surcharge payments for all applicable services on a monthly basis on or before the 30th day following the calendar month for which monies have been paid to designated providers of service;

2. provide the Department's Office of Pool Administration monthly certified reports on or before the 30th day following the calendar month for which monies have been paid which separately report patient service expenditures for services provided by designated provider type(s) (i.e., hospital inpatient, hospital outpatient, diagnostic & treatment center, laboratory[1], or ambulatory surgery center) by product line;

3. provide the Department with certification of data and access to allowance expenditure data upon request for audit verification purposes; and

[1]For services provided on or after October 1, 2000, freestanding clinical laboratories with Article 5 Title V permits are exempt from HCRA surcharges.

4. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-j of the Public Health Law (see note below).

5. the Department's website posting of the above entity's FEIN in accordance with Public Health Law Section 2807-j(5)(a)(iii)(D).

By signature below, the above entity also agrees to make public goods covered lives payments directly to the Department's Office of Pool Administration in instances where it provides inpatient coverage as a corporation organized and operating in accordance with Article 43 of the Insurance Law, an organization operating in accordance with Article 44 of the Public Health Law, a self-insured fund, or an HMO or insurer licensed outside New York State and authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis. In such instances the above entity agrees to:

1. remit to the Department's Office of Pool Administration within 30 days after the end of each month one-twelfth of both the individual and family unit annual assessment amounts for each of the individuals and family units residing in the state which were included on the payor's membership rolls for all or a portion of the prior month and for which the payor covered general hospital inpatient care, including retroactive additions and deletions;

2. provide the Department with data certification and access to individual and family unit data, upon request, for audit verification purposes; and

3. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-t of the Public Health Law (see note below).

By signature below, the Chief Financial Officer or other duly authorized individual of the above entity certifies that the data submitted on all applicable attachments have been carefully prepared in accordance with instructions provided, and to the best of his/her knowledge, the information presented is accurate and correct.

Signature_____**Title**_____
Chief Financial Officer or Duly Authorized Individual

Date_____

Note: Payors making an election are only agreeing to the jurisdiction of NYS courts for purposes of enforcing payments required under 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

Payor Election Application

COVERAGE INFORMATION (See Attached For Further Explanation)

PAYOR NAME:_____ **FEDERAL ID#:**_____

TPA/ASO NAME: ConnectiCare Insurance Company Inc. **TPA/ASO FEDERAL ID#:** 06-1618303 (Prefilled)

MARK AN "X" IN EACH COLUMN TO INDICATE TYPE OF COVERAGE BY PAYOR TYPE

	TYPE OF PAYOR:	IDENTIFICATION OF TYPE OF COVERAGE:									
		INDEMNITY COVERAGE	HMO NON-MEDICAID OR NON-NYS MEDICAID COVERAGE	SELF-INSURED COVERAGE	NEW YORK STATE HMO/PHSP MEDICAID COVERAGE	NEW YORK STATE GOVT PROGRAM W/INPATIENT COMPONENT & NYS LOCAL GOVT CORRECTIONS	NEW YORK STATE WORKERS COMPENSATION LAW COVERAGE	NEW YORK STATE MOTOR VEHICLE REPARATIONS ACT COVERAGE	NEW YORK STATE VOLUNTEER AMBULANCE WORKER'S BENEFIT LAW COVERAGE	NEW YORK STATE VOLUNTEER FIREFIGHTERS' BENEFIT LAW COVERAGE	OTHER COVERAGE
1	Corporations Organized & Operating in accordance with Article 43 of the NYS Insurance Law										
2	Corporations that are Commercial Insurers licensed in New York State										
3	Corporations Organized & Operating in accordance with Article 44 of the NYS Public Health Law, not incorporated as Commercial Insurers or under Article 43 of the NYS Insurance Law										
4	Self-Insured Fund with No Third Party Administrator/Administrative Svcs Only Organization for Claims Processing										
5	Self-Insured Fund with a Third Party Administrator/Administrative Svcs Only Organization for Claims Processing			X							
6	New York State Governmental Agency/ New York State Local Government										
7	Other (please explain below): Includes: State/Local Governments outside New York for Medical Assistance Programs; insurers licensed outside New York State, authorized to write OTHER than Accident and Health										
8	HMOs and insurers licensed outside New York State, authorized to write Accident and Health										

Explanation of "Other" Payor Identification

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
COVERAGE INFORMATION

Payor Type 1: Corporation organized and operating in accordance with Article 43 of the New York State Insurance Law offering:

→ Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

→ Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid insureds

→ HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid managed care enrollees

Payor Type 2: Commercial Insurance Corporation licensed by New York State offering:

→ Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

→ Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid insureds

→ HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid insureds

→ New York State Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ New York State Motor Vehicles Reparations Act coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ New York State Volunteer Ambulance Workers Benefit Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ New York State Volunteer Firefighters Benefit Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

Payor Type 3: Corporation organized and operating in accordance with Article 44 of the New York State Public Health Law not incorporated as a NYS licensed commercial insurer or under Article 43 of the New York State Insurance Law offering:

→ HMO non-Medicaid managed care coverage, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid managed care enrollees

→ HMO Medicaid managed care coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid managed care enrollees

Payor Type 4/5: Self insured fund offering:

→ self insured employee health coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services and regional GME covered lives assessments for NYS resident plan participants

→ self insured employee health coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants

→ self insured New York State Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants

→ self insured **non-New York State** Workers Compensation Law coverage, thus requiring a surcharge obligation on affected services and a regional GME covered lives assessments (if coverage includes expense incurred inpatient hospital care) for NYS resident plan participants

→ self insured New York State Motor Vehicles Reparation Act coverage, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants

→ self insured **non-New York State** Motor Vehicles Reparations Act coverage, thus requiring a surcharge obligation on affected services and a regional GME covered lives assessments (if coverage includes expense incurred inpatient hospital care) for NYS resident plan participants

Payor Type 6: New York State Governmental Agency/ New York State Local Government:

→ New York State political subdivision for New York State county corrections, New York City corrections, and, New York State governmental agencies for New York State administered payments that reimburse hospitals for rendered inpatient services to eligible patients. (e.g. Office of Mental Health payments for services provided to individuals residing in New York State operated developmental centers), thus requiring a surcharge obligation on affected services but no regional GME covered lives assessment

Payor Type 7: Other

→ Insurers **licensed outside New York State, authorized to write OTHER than Accident and Health** thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ States **other than New York State** and localities **other than New York State political subdivisions** for medical assistance program expenses (i.e. Medicaid Programs in states OTHER than New York State), thus requiring a surcharge obligation on affected services but no regional GME covered lives assessment

→ NYS licensed fraternal benefit societies offering coverage with or without an expense incurred inpatient hospital component, requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

Payor Type 8: HMOs and insurers licensed outside New York State, authorized to write Accident and Health:

→ Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

→ Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring a surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds

→ HMOs **organized and operating outside New York State Insurance and Public Health Laws**, thus requiring a surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4264 INSTRUCTIONS

All electing payors/third party administrators (TPA)/administrative services only (ASO) organizations and designated providers are required to file Public Goods Pool reports electronically. This also applies to the 1% Statewide Assessment report filed by hospitals. A website has been established at www.hcrapools.org to facilitate this process.

New Request/Revision to Existing Account: Check the appropriate box. An entity requesting an initial account/password should check the *New Request* box; an entity that has an existing account and is advising the Department of a change to that account should check the *Revision to Existing Account* box.

Payor/TPA/ASO/Provider Name: Enter company name.

Federal Employer Identification Number (FEIN): Enter FEIN assigned to the entity named above.

Operating Certificate #: (For providers only): Enter Operating Certificate number assigned by the Department of Health to the entity named above. - Leave Blank

Report(s) being filed electronically (check ALL applicable types): Check all applicable types of reports that your entity will be filing electronically – Public Goods Pool (prefilled)

Signature: Must be signed by the Chief Executive/Financial Officer and/or Administrator of the entity named above.

Name/Title/Phone Number (Please Print): Enter name, title and phone number of the person signing above.

Address/City/State/Zip Code: Enter address of the person signing above.

E-mail Address: Enter e-mail address of the person signing above. This email address will be used to communicate Health Care Reform Act information, including delinquency reporting notifications and periodic legislative updates.

Date: Enter date this form is signed.

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

☐ **New Request** ☐ **Revision to Existing Account**

Payor/Third Party Administrator/Administrative Services Only Organization/Provider Name:

_____

Federal Employer Identification # (FEIN):_____

Operating Certificate # (FOR PROVIDERS ONLY): _____

Report(s) being filed electronically (check ALL that apply):
☐x Public Goods Pool
☐ 1% Statewide Assessment **(for hospitals only)**

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. If an email address is provided, this information will be sent electronically to the email address listed. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

Signature _____

Name (Please Print) _____

Title _____

Phone Number _____

Address _____

_____

City _____ **State** _____ **Zip Code** _____

E-mail Address _____

Date _____

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4403 INSTRUCTIONS

This form is to be completed by a payor whose status has changed from the original election as it relates to whether a TPA/ASO is utilized for claim processing.

Effective Date: Enter the effective date of the status change.

Payor Information: Enter the payor (group/entity) name, EIN, contact and phone #.

Type of Status Change: prefilled to changing TPA/ASO.

Section I: Previous TPA/ASO: Enter the name, EIN of the previous TPA/ASO on file with the Pool.

If the group/entity did not have a previous level funded plan, mark this section NA.

Section II: Prefilled to ConnectiCare Insurance Company., Inc.

Section III: Most common selections are option 1 or 3

Check option 1 if this is a change from a preexisting TPA on file.

Check option 2 if any claims incurred under the previous TPA have been adjudicated and the effective date.

Check option 3 if this is a new TPA/ASO election and there was no level funded plan previously in place.

Third Party Administrator (TPA) or Administrative Services Only (ASO) Status Change

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

This form must be completed if an electing payor is adding or changing their TPA/ASO.

Effective Date:_____

PAYOR INFORMATION:

Payor Name: _____ Payor FEIN: _____

Contact Person: _____ Phone #: _____

Type of Status Change (check appropriate box):

☐ **Additional TPA/ASO** (complete Section II only)

☒ **Changing TPA/ASO** (complete Sections I, II & III)

I. PREVIOUS TPA/ASO INFORMATION:

TPA/ASO Name: _____ TPA/ASO FEIN: _____

II. NEW or ADDITIONAL TPA/ASO INFORMATION:

TPA/ASO Name: ConnectiCare Insurance Company, Inc. TPA/ASO FEIN: 06-1618303

Address: 175 Scott Swamp Road
Farmington, CT 06032

TPA/ASO Contact Person: Stephanie Chaparro TPA/ASO Phone #: 860-214-2615

III. CHECK ONE OF THE FOLLOWING:

☐ Previous TPA/ASO will continue to process claims and file reports for all dates of service prior to the change for a period of one year following the end of the year in which the change in TPA occurred or until all such claims have been adjudicated, at which time a final monthly report with a copy of this form indicating same will be filed.

☐ All self-insured claims that previous TPA/ASO was responsible for have been adjudicated effective_____.

☐ New TPA/ASO is assuming responsibility for all pending claims and HCRA reporting requirements.

Signature of Payor: _____ **Date:** _____

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757

ADDENDUM

Business Associate Agreement

This Business Associate Agreement (the “Agreement”), is hereby made by and between CBIASC Service Corporation, a Connecticut corporation (“CBIASC”), and the “Covered Business”, an entity registered to do business in Connecticut, each individually a “Party” and together the “Parties”.

A. The purpose of this Agreement is to comply with the Health Insurance Portability and Accountability Act of 1996, as amended by sections 13400 through 13424 of the Health Information Technology for Economic Clinical Health Act ("HITECH") (the 1996 Act as amended by HITECH is referred to herein as "HIPAA"), the associated regulations, 45 CFR Part 160 and Part 164, Subparts A and E ("Privacy Regulations") and 45 CFR Parts 160, 162, and 164, Subpart C ("Security Regulations"), as may be amended, and other guidance that may be issued by the federal Department of Health and Human Services (all of the above laws, rules, regulations and guidance are collectively referred to herein as "HIPAA Rules").

B. Covered Business and CBIASC have entered into this Agreement because Covered Business may disclose Protected Health Information ("PHI") to CBIASC in connection with services provided to Covered Business, and CBIASC may create, maintain or disclose PHI on behalf of Covered Business (the "Services").

C. HIPAA requires Covered Business to obtain written assurances from CBIASC that CBIASC will appropriately safeguard the PHI.

Now, therefore, in consideration of the mutual promises set forth below and other good and valuable consideration, the sufficiency and receipt of which is hereby acknowledged, the Parties agree as follows:

1. Definitions.

1.1 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy and Security Regulations.

2. General Permitted Uses and Disclosures, and Obligations of CBIASC and Covered Business.

2.1 CBIASC may use or disclose PHI to perform functions, activities or services for, or on behalf of, Covered Business as specified in the Privacy Regulations, this Business Associate Agreement and any underlying Agreements between the parties or as otherwise

required by law. CBIASC will not use or disclose PHI in a manner (i) inconsistent with Covered Business's or its own obligations under the Privacy Regulations, or (ii) that would violate the Privacy Regulations if disclosed or used in such a manner by Covered Business.

2.2 CBIASC hereby acknowledges and agrees that it will comply with the requirements set forth in the HIPAA Rules commencing on the applicable effective date of each such provision and that such requirements are incorporated by reference into this Agreement.

2.3 CBIASC agrees to comply with all appropriate federal and state security and privacy laws which may be applicable to PHI provided to CBIASC by Covered Business to the extent such laws may be more protective of individual privacy than the HIPAA Rules.

2.4 CBIASC may use PHI for the proper management and administration of the CBIASC or to carry out the legal responsibilities of CBIASC, provided the disclosures are required by law, or CBIASC obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person and the person notifies CBIASC of any instances of which it is aware in which the confidentiality of the information has been breached.

2.5 CBIASC agrees to limit its uses and disclosures and requests for PHI to the minimum necessary required to perform its obligations in accordance with 45 CFR §164.502(b).

2.6 To the extent CBIASC is to carry out one or more of Covered Business's obligations under Subpart E of 45 CFR Part 164, CBIASC agrees to comply with the requirements of Subpart E that apply to Covered Business in the performance of such obligation(s).

2.7 Covered Business will not disclose PHI to CBIASC except to the extent permitted under the Privacy Rule and will limit disclosure to the minimum necessary for purposes of the services provided by CBIASC. Covered Business will not request CBIASC to take any action that would violate the HIPAA rules and related regulations if that action would violate those rules of done by Covered Business. Covered Business will promptly advise CBIASC of any additional limits or restrictions placed on PHI disclosed to CBIASC.

3. Safeguards for the Protection of PHI.

3.1 CBIASC will implement and maintain commercially appropriate security safeguards to ensure that PHI is not used or disclosed by CBIASC, its employees, agents or subcontractors in violation of this Agreement.

3.2 CBIASC agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic PHI that is created, received, maintained or transmitted by CBIASC under this Agreement. CBIASC will comply with the applicable requirements of the Security Regulations.

4. Reporting Unauthorized Uses and Disclosures.

CBIASC will report to Covered Business within five (5) days any use or disclosure of PHI not provided for by this Agreement of which it becomes aware, and CBIASC also agrees to report to Covered Business any Security Incident within five (5) days of its becoming aware of a Security Incident. A "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. Notwithstanding the foregoing, CBIASC and Covered Business acknowledge the ongoing existence and occurrence of attempted but unsuccessful Security Incidents that are trivial in nature, such as pings and port scans, and Covered Business acknowledges and agrees that no additional notification to Covered Business of such unsuccessful security incidents is required. However, to the extent CBIASC becomes aware of an unusually high number of such unsuccessful Security Incidents due to the repeated acts of a single party, or related parties, then CBIASC shall notify Covered Business of these attempts, and provide the names, if available, of said parties. Also, CBIASC will report to Covered Business within five (5) days any Breach of Unsecured PHI, as defined in § 164.402, in accordance with the requirements of 45 C.F.R. § 164.410.

5. Use by and Disclosure to Subcontractors, Agents, and Representatives.

CBIASC will require that any agents, vendors, or subcontractors of CBIASC to whom it provides PHI that is subject to this Agreement, agree to the same restrictions and conditions that apply to CBIASC with respect to such information [§ 164.504(e)(2)(ii)(D)], and CBIASC will enter into appropriate Business Associate Agreements with any subcontractors it may use in providing its services.

6. Individual Rights and Accounting of Disclosures.

6.1 As directed by the Covered Business, CBIASC shall make available PHI to the individual in accordance with 45 CFR §164.524 and incorporate any amendments to the PHI. If CBIASC maintains PHI in an electronic health record, CBIASC agrees to provide an electronic copy to the individual upon request.

6.2 CBIASC shall document all disclosures of PHI and any information related to such disclosures as would be required for Covered Business to respond to a request by an individual for an accounting of disclosures of PHI in accordance with the Privacy Regulations.

6.3 CBIASC agrees to provide to Covered Business, in a time and manner designated by Covered Business, information to permit Covered Business to respond to a request by an individual for an accounting of disclosures of PHI in accordance with the Privacy Regulations.

7. Audit, Inspection and Enforcement.

With reasonable notice, CBIASC agrees to make internal practices, books and records, including policies and procedures relating to the use and disclosure of PHI received from Covered Business, or created or received by CBIASC on behalf of Covered Business, available to the Covered Business and the Secretary of the Department of Health and Human Services ("Secretary") to monitor compliance with the HIPAA Rules. CBIASC shall promptly correct any violation of the HIPAA Rules or this Agreement found by Covered Business, according to Covered Business's guidelines, and shall certify to Covered Business, in writing that it made the correction. Covered Business's failure to detect any unsatisfactory practice does not constitute acceptance of the practice or a waiver of Covered Business's enforcement rights under this Agreement.

8. Obligations of Covered Business to Inform CBIASC of Privacy Practices and Restrictions.

8.1 Covered Business shall provide CBIASC with its Notice of Privacy Practices in accordance with the Privacy Regulations, as well as any changes to such Notice.

8.2 Covered Business shall notify CBIASC of any changes in, or revocation of, any Authorizations by individuals to use or disclose PHI, if such changes affect CBIASC's permitted or required uses and disclosures.

8.3 Covered Business shall notify CBIASC of any restriction to the use or disclosure of PHI that Covered Business has agreed to in accordance with the Privacy Regulations, if the restriction affects CBIASC's permitted or required uses and disclosures.

9. Term and Termination.

9.1 Term. This Agreement shall be effective as of the date of the Employer Participation Agreement, and shall terminate when all the PHI provided by Covered Business to CBIASC, or created or received by CBIASC on behalf of Covered Business, is destroyed or returned to Covered Business. If it is infeasible to return or destroy PHI, the protections herein are extended to such information, in accordance with the termination provisions in Section 9.3.

9.2 Termination for Cause. If either party is determined to have materially breached the HIPAA regulations or this Agreement, the non-breaching party may terminate the Agreement if the breaching party fails to cure the breach upon written notice from the non-breaching party.

9.3 Effect of Termination. Upon termination of this Agreement, if feasible, CBIASC will return or destroy all PHI received from Covered Business or created or received by CBIASC on behalf of Covered Business that CBIASC still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, CBIASC will extend the protections of this Agreement to the information retained and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible [§ 164.504(e)(2)(ii)(I)].

10. Miscellaneous.

10.1 Regulatory References. A reference in this Agreement to the Privacy or Security Regulations means the Privacy or Security Regulations in effect or as amended.

10.2 Amendment. This Agreement cannot be amended except by the mutual written agreement of CBIASC and Covered Business.

10.3 Waiver. A waiver of a breach of this Agreement shall not be deemed to be a waiver of a breach of any other provision of this Agreement, or of a future waiver of any subsequent breach of the same provision.

10.4 No Third Party Beneficiaries This Agreement is intended for the sole benefit of CBIASC and Covered Business and does not create

any third-party beneficiary rights, except as to the extent that the Privacy Rule validly requires the Secretary of the Department of Health and Human Services or any other person to be a third-party beneficiary to this Agreement.

10.5 Notices. Any notice to be given under this Agreement to a Party shall be made via Certified U.S. Mail, return receipt requested, commercial courier with receipt verification, or by hand delivery to, CBIASC at: CBIA Service Corporation, 350 Church Street, Hartford, CT 06103, or to Covered Business at the address provided in Section 1 of the Employer Participation Agreement, or to such other address as shall be specified by the applicable party in the future.

10.6 Entire Agreement. This Agreement constitutes the entire understanding among the parties with respect to its subject matter. If the terms of this Agreement are inconsistent with the terms of any present or future underlying service or sale agreement between the parties, the terms of this Agreement shall control.

10.7 Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Business to comply with the Privacy and Security Regulations.

10.8 Choice of Law. This Agreement shall be governed by the laws of the State of Connecticut, without regard to any statute or case law on choice of laws.

10.9 Venue. Each party hereby designates the Connecticut Superior Courts or the United States District Courts for the District of Connecticut, as the exclusive courts of proper jurisdiction and venue of and for any and all litigation relating to this Agreement; hereby irrevocably consents to such designation, jurisdiction and venue; and hereby waives any objection or defense relating to jurisdiction or venue with respect to any lawsuit or other legal proceeding commenced in or transferred to the Connecticut Superior Courts or the United States District Courts for the District of Connecticut.

10.10 Severability. In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event either Party believes in good faith that any provision of the Agreement fails to comply with the then-current requirements of the HIPAA rules or regulations, such party so shall notify the other party in writing. For a period of up to thirty (30) days, the parties shall address in good faith such concern and shall amend the terms of

this Agreement, if necessary to bring it into compliance. If after such thirty (30) day period, the Agreement fails to comply with the HIPAA rules or regulations with respect to the concern(s) raised pursuant to this Paragraph, then either party has the right to terminate this Agreement upon written notice to the other party.

10.11 Implementation of HIPAA. The parties acknowledge that HIPAA has undergone many changes. These changes may be further clarified in future regulations and guidance. Each party agrees to comply with the applicable provisions of HIPAA and any implementing regulations issued thereunder and to negotiate in good faith to modify this Agreement as reasonably necessary to comply with implementing regulations, as they become effective; provided, however, that if the parties are unable to reach agreement on such a modification, either party shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other party.

10.12 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which together shall comprise one and the same instrument. Delivery of a copy of the Employer Participation Agreement bearing an original signature by facsimile transmission, by electronic mail in “portable document format” (“.pdf”) form, or by any other electronic means intended to preserve the original graphic and pictorial appearance of a document, will have the same effect as physical delivery of the paper document bearing the original signature.