Program Attestations

General Issuer Attestations

1.) Applicant attests that it will adhere to all requirements contained in 45 CFR 156, and all applicable federal and state law.

2.) Applicant attests that it will have a license by the end of the certification period, be in good standing, and be authorized to offer each specific type of insurance coverage offered in each State in which the issuer offers a QHP.

3.) Applicant attests that it will be bound by 2 CFR 376 and that no individual or entity that is a part of the Applicant's organization is excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. This attestation includes any member of the board of directors, key management or executive staff or major stockholder of the applicant and its affiliated companies, subsidiaries or subcontractors.

4.) Applicant attests that it will inform HHS, based on its best information, knowledge and belief, of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration against the applicant (under a current or former name), its principals, or any of its subcontractors. The applicant also attests that, based on its best information, knowledge and belief, none of its principals, nor any of its affiliates is presently debarred, suspended, proposed for debarment, or declared ineligible to participate in Federal programs by HHS or another Federal agency under 2 CFR 180.970 or any other applicable statute or regulation, and should such actions occur, it will inform HHS within 5 working days of learning of such action.

5.) Applicant attests that it will not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

6.) Applicant attests that it will market its QHPs in accordance with all applicable state laws and regulations and will not employ discriminatory marketing practices in accordance with 45 CFR 156.225.

7.) Applicant attests that it will adhere to all non-renewal and decertification requirements in accordance with 45 CFR 156.290.

8.) Applicant attests that it will adhere to requirements related to the segregation of funds for abortion services consistent with 45CFR 156.280 and all applicable guidance, as applicable.

9.) Applicant attests that it will adhere to provisions addressing payment of federally-qualified health centers in 45 CFR 156.235(e).

Compliance Plan

Applicant attests that it has a compliance plan that adheres to all applicable laws, regulations, and guidance, that the compliance plan is ready for implementation, and that the applicant agrees

to reasonably adhere to the compliance plan provided. Any changes to the compliance plan will be submitted to HHS for review.

Applicant will upload a copy of the applicant's compliance plan.

Organizational Chart

Applicant attests that it is providing its organizational chart and that it will inform HHS of any significant changes to the organizational chart provided within 30 days of that change after the submission of this application.

Applicant will upload a copy of the applicant's organizational chart.

Operational Attestations

1.) Applicant attests that it will notify HHS of any pending change in ownership of the QHP issuer or that issuer's parent entities and will obtain approval for transfer of responsibility for its QHPs prior to making any change in ownership.

2.) Applicant attests that it will comply with all QHP requirements, including technical requirements related to the use of FFE Plan Management system, on an ongoing basis and comply with Exchange systems, tools, processes, procedures, and requirements.

3.) Applicant attests that it has in place an effective internal claims, grievance, and appeals process that complies with 45 CFR 147.136 as applicable, and agrees to act in accordance with all requirements for an external review process with respect to QHP enrollees in an applicable State or Federal external review process in compliance with 45 CFR 147.136 as applicable.

Benefit Design Attestations

1.) Applicant attests that it will not employ benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs or pre-existing conditions in QHPs in accordance with 45 CFR 156.225.

2.) Applicant attests that it will comply with all benefit design standards, federal regulations and laws, and state mandated benefits for all services including: preventive services, emergency services, and formulary drug list.

3.) Applicant attests that it will abide by all cost-sharing limits:

a.) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) for emergency department services is the same regardless of provider network status, as applicable;

b.) it will make available enrollee cost sharing under an individual's plan or coverage for a specific item or service, consistent with 45 CFR 156.220.

4.) Applicant attests that it will follow all Actuarial Value requirements.

5.) Applicant attests that it will offer through the Exchange a minimum of one QHP at the silver coverage level and one QHP at the gold coverage level in accordance with 45 CFR 156.200(c), or a minimum of one plan at either a high or low coverage level for issuers of stand-alone dental plans.

6.) Applicant attests that it will offer a child-only QHP(s) at the same level of coverage(s) as any QHP or stand-alone dental plans offered through the Exchange in accordance with 45 CFR 156.200(c).

7.) Applicant attests that its catastrophic QHPs will only enroll individuals under the age of 30 or individuals deemed exempt from the individual mandate.

8.) Applicant attests that its QHPs provide coverage for each of the 10 statutory categories of EHB in accordance with the applicable EHB benchmark plan and federal law:

a.) its QHPs provide benefits and limitation on coverage that are substantially equal to those covered by the EHB-benchmark plan;

b.) it complies with the requirements of 45 CFR 146.136 with regard to mental health and substance use disorder services, including behavioral services;

c.) it provides coverage for preventive services described in 45 CFR 147.130;

d.) it complies with EHB requirements with respect to prescription drug coverage;

e.) any benefits substituted in designing QHP plan benefits are actuarially equivalent to those offered by the EHB benchmark plan;

f.) it complies with the prohibition on discrimination with regard to EHB;

g.) its QHPs' benefits reflect an appropriate balance among the EHB categories, so that benefits are not unduly weighted toward any category;

h.) its QHPs include all applicable state required benefits.

Stand-Alone Dental Attestations

1.) Applicant attests that all stand-alone dental plans that it offers it will comply with all benefit design standards and federal regulations and laws for stand-alone dental plans, as applicable, including that:

a.) the out-of-pocket maximum for its stand-alone dental plan is reasonable for the coverage of pediatric dental EHB;

b.) it offers the pediatric dental EHB;

c.) it does not include annual and lifetime dollar limits on the pediatric dental EHB.

2.) Applicant attests that any stand-alone dental plans it offers are limited scope dental plans.

3.) Applicant attests that any stand-alone dental plans it offers will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit.

Applicant attests that it either offers no stand-alone dental plans, or attests to all of the above.

Rate Attestations

Applicant attests that it will comply with all rate requirements as applicable, including that it will:

a.) charge the same rates for each qualified health plan, or stand-alone dental plan, of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent;

b.) set rates for an entire benefit year, or for the SHOP, plan year and submit the rate and benefit information to the Exchange as required in 45 CFR 156.210;

c.) submit to the Exchange a justification for a rate increase prior to the implementation of an increase;

d.) prominently post rate increase justifications on its Web site;

e.) adhere to all rating area variation requirements pursuant to 45 CFR 156.255 for QHPs;

f.) comply with federal rating requirements or the state's Affordable Care Act compliant rating requirements, as applicable.

Enrollment

1.) Applicant attests that it will meet the individual market requirement to:

a.) enroll a qualified individual during the initial and subsequent annual open enrollment periods and abide by the effective dates of coverage;

b.) make available, at a minimum, special enrollment periods (SEPs) established by the Exchange and abide by the effective dates of coverage determined by the Exchange.

2.) Applicant attests that it will enable enrollees to make enrollment changes during open and special enrollment periods for which they are eligible.

3.) Applicant attests that it will only terminate coverage as permitted by the Exchange and applicable State or federal law:

a.) the applicant will abide by the termination of coverage effective dates requirements;

b.) the applicant will maintain termination records in accordance with Exchange standards;

c.) the applicant will provide the enrollee with a notice of termination of coverage, consistent with the effective date required by applicable regulations, if terminating an enrollee's coverage for any reason. Notices must include an explanation of the reason for the termination. When applicable, the applicant will include in the notice an explanation of the enrollee's right to appeal;

d.) the applicant will establish a standard policy for the termination of coverage of enrollees due to non-payment of premium, provision of fraudulent application information or abuse of his or her benefit cards.

4.) Applicant attests that it will provide enrollees with required documentation including: an enrollment information package, effective dates of coverage, summary of benefits and coverage, evidence of coverage, provider directories, enrollment/disenrollment notices, coverage denials, ID cards, and any notices as required by State or federal law.

5.) Applicant attests that it will adhere to enrollment information collection and transmission requirements and will:

a.) accept enrollment information in an electronic format from the Exchange that is consistent with requirements;

b.) reconcile enrollment files with the Exchange no less than once a month;

c.) acknowledge receipt of enrollment information in accordance with Exchange standards and;

d.) timely, accurately and thoroughly process enrollment transactions and submit electronic 834 confirmation files to the Exchange to confirm the enrollees portion of the premium has been paid and coverage has been effectuated.

6.) Applicant attests that if applicant utilizes Application Programming Interface (API) provided by the Exchange, the applicant will:

a.) direct individuals to the Exchange in order to initiate the eligibility process;

b.) enroll an individual only after receiving confirmation from the Exchange that the eligibility process is complete and the individual has been determined eligible for enrollment in a QHP, in accordance with the standards.

7.) Applicant attests that the Issuer will follow the premium payment process requirements established by the Exchange in accordance with §156.265(d) and future guidance.

8.) Applicant attests that it will provide a grace period of at least three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid-in-full at least one month's premium. If an enrollee exhausts the grace period without submitting payment

in full of outstanding premium due, the applicant will terminate the enrollee's coverage effective at the end of first month of the payment grace period.

9.) Applicant attests that it will provide the enrollee with notice of payment delinquency if an enrollee is delinquent on premium payment.

10.) Applicant attests that it will develop, operate and maintain viable systems, processes, procedures, and communication protocols for:

a.) the timely, accurate and valid enrollment and termination of enrollees' coverage within the exchange;

b.) the prompt resolution of urgent issues affecting enrollees, such as changes in enrollment and discrepancies identified during reconciliation.

11.) Applicant attests that it will accept the total premium breakdown as determined by the Exchange and as specified in the electronic enrollment transmission. This includes:

a.) the total premium amount which is based on rate attestations submitted by the applicant;

b.) the APTC amount;

c.) any other payment amounts as depicted on the enrollment transmission.

12.) Applicant attests that it will accept the advance CSR amount as determined by the Exchange and as specified in the electronic enrollment transmission.

13.) Applicant attests that it will approve of the use of the following information for display on the FFE Web site for consumer education purposes: information on rates and premiums, information on benefits, the provider network URL(s) provided in this application, the URL(s) for the Summary of Benefits and Coverage provided in this application, the URL(s) for payment provided by this application, information on whether the issuer is a Medicaid managed care organization, and quality information, as applicable, derived from the accreditation survey, including accreditation status and CAHPS data.

Financial Management

1.) Applicant attests that it will acknowledge and agree to be bound by Federal statutes and requirements that govern Federal funds. Federal funds include, but are not limited to, advance payments of the premium tax credit, cost-sharing reductions, and Federal payments related to the risk adjustment, reinsurance, and risk corridor programs.

2.) Applicant attests that it will adhere to the risk corridor standards and requirements set by HHS as applicable for:

a.) risk corridor data standards and annual HHS notice of benefit and payment parameters for the calendar years 2014, 2015, and 2016 (45 CFR 153.510);

b.) remit charges to HHS under the circumstances described in 45 CFR 153.510(c).

3.) Applicant attests that it will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit and cost sharing reductions, including the provisions at 45 CFR 156.410, 156.425, 156.430, 156.440, 156.460, and 156.470.

4.) Applicant attests that it will submit to HHS the applicable plan variations that adhere to the standards set forth by HHS at 45 CFR 156.420.

5.) Applicant attests that it will pay all user fees in accordance with 45 CFR 156.200(b)(6).

6.) Applicant attests that it will reduce premiums on behalf of eligible individuals if the Exchange notifies the QHP Issuer that it will receive an APTC on behalf of that individual pursuant to §156.460.

7.) Applicant attests that it will adhere to the data standards and reporting for the CSR reconciliation process pursuant to 45 CFR 156.430(c) for QHPs.

8.) The following applies to applicants participating in the risk adjustment and reinsurance programs inside and/or outside of the Exchange. Applicant attests that it will:

a.) adhere to the risk adjustment standards and requirements set by HHS in the annual HHS notice of benefit and payment parameters (45 CFR Subparts G and H);

b.) remit charges to HHS under the circumstances described in 45 CFR 153.610;

c.) adhere to the reinsurance standards and requirements set by HHS in the annual HHS notice of benefit and payment parameters (45 CFR 153.400, 153.405, 153.410, 153.420);

d.) remit contributions to HHS under the circumstances described in 45 CFR 153.405;

e.) establish dedicated and secure server environments to host enrollee claims, encounter, and enrollment information for the purpose of performing risk adjustment and reinsurance operations for all plans offered;

f.) allow proper interface between the dedicated server environment and special, dedicated CMS resources that execute the risk adjustment and reinsurance operations;

g.) ensure the transfer of timely, routine, and uniform data from local systems to the dedicated server environment using CMS-defined standards, including file formats and processing schedules;

h.) comply with all information collection and reporting requirements approved through the Paperwork Reduction Act of 1995 and having a valid OMB control number for approved

collections. The Issuer will submit all required information in a CMS-established manner and common data format;

i.) cooperate with CMS, or its designee, through a process for establishing the server environment to implement these functions, including systems testing and operational readiness;

j.) use sufficient security procedures to ensure that all data available electronically are authorized and protect all data from improper access, and ensure that the operations environment is restricted to only authorized users;

k.) provide access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature to CMS or CMS' designee, if requested, for audit;

l.) retain all original source documentation and medical records pertaining to any such particular claims data for a period of at least 10 years;

m.) be responsible for all data submitted to CMS by itself, its employees, or its agents and based on best knowledge, information, and belief, submit data that are accurate, complete, and truthful;

n.) all information, in any form whatsoever, exchanged for risk adjustment shall be employed solely for the purposes of operating the premium stabilization programs and financial programs associated with state markets, including but not limited to, the calculation of user fees to fund such programs, oversight, and any validation and analysis that CMS determines necessary.

9.) The following attestation applies to applicants participating in the Exchanges and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim. 18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device, a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute. Applicant acknowledges the False Claims Act, 31 U.S.C., §§ 3729-3733.

10.) The following applies to applicants participating in the Exchanges and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Applicant attests to provide and promptly update when applicable changes occur in its Tax Identification Number (TIN) and associated legal entity name as registered with the Internal Revenue Service, financial institution account information, and any other information needed by CMS in order for the applicant to receive invoices, demand letters, and payments under the

APTC, CSR, user fees, reinsurance, risk adjustment, and risk corridors programs, as well as, any reconciliations of the aforementioned programs.

11.) The following applies to applicants participating in the Exchanges and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Applicant attests that it will develop, operate and maintain viable systems, processes, procedures and communication protocols to accept payment-related information submitted by CMS.

SHOP

1.) Applicant attests that it will adhere to the SHOP issuer requirements set by HHS in 45 CFR 156.285.

2.) Applicant attests that it will not vary premiums based on whether or not the employer offers employees a choice among QHPs.

3.) Applicant attests that it will issue SHOP QHP policies naming the qualified employer rather than the SHOP as the policyholder.

4.) Applicant attests that it waives the application of any minimum participation rates calculated at the issuer level that may be allowed under state law.

Applicant attests that it either offers no SHOP plans, or attests to all of the above.

Reporting Requirements

1.) Applicant attests that it will provide to the Exchange the following information in the manner identified by HHS, as applicable: claims payment policies and practices; periodic financial disclosures; data on enrollment; data on disenrollment; data on the number of claims that are denied; data on rating practices; information on cost-sharing and payments with respect to any out-of-network coverage; and information on enrollee rights under title I of the Affordable Care Act.

2.) Applicant attests that it will report required data on prescription drug distribution and costs consistent with 45 CFR 156.295 and all applicable guidance.

3.) Applicant attests that it will comply with the specific quality disclosure, reporting and implementation requirements of 45 CFR §156.200(b)(5) as will be detailed in future guidance.