STATE OF CONNECTICUT
INSURANCE DEPARTMENT

PREFERRED PROVIDER NETWORK (PPN) SUPPLEMENTAL FORM

Connecticut General Statutes § 38a-479aa requires all Preferred Provider Networks (PPNs) offering services in the State of Connecticut to be licensed by the Connecticut Insurance Department ("Department"). If you have any questions about your responsibility to be licensed, please refer to Conn. Gen. Stat. §38a-479aa and any applicable amendments.

Instructions:

- Please complete this entire form, including the checklist and CEO certification. Both this supplemental form and the NIPR online application must be newly completed each year.
    - If you have not submitted the NIPR online application, you must submit through NIPR before completing this supplemental form.
        - If you are submitting a new application:
            - Go to www.nipr.com. Under Licensing Center, select "Apply for a New License."
        - If you are submitting a renewal application:
            - Go to www.nipr.com. Under Licensing Center, select "Renew an Existing License."
        - You will submit payment through NIPR.

- After applying online, email all required documentation to: cid.tpa@ct.gov, Attn: PPN.

Name of PPN: _____

PPN Tax Identification Number (TIN/FEIN): _____

PPN NPN#: _____

PPN Business Address:

PPN Mailing Address:

PPN Phone Number: _____

PPN Owner(s): _____

NIPR Transaction #: _____

***Contact Information at PPN*:**

Name: _____

Title: _____

Mailing Address:

Phone Number: _____

Fax Number: _____

E-Mail Address(es): _____

Does your PPN provide services for workers' compensation only? (Yes / No) _____

- **If yes, you are *not required* to complete the entirety of this form. Please return this page and the signed CEO Certification (page X) to the Insurance Department at cid.tpa@ct.gov, ATTN: PPN.**

Is your organization registered with the Department as a Pharmacy Benefit Manager ("PPN") pursuant to Conn. Gen. Stat. Secs. 38a-479aaa et seq.? (Yes / No) _____

- **If yes, you are *not required* to complete the entirety of this form. Please return this page and the signed CEO Certification (page X) to the Insurance Department at cid.tpa@ct.gov, ATTN: PPN.**

NIPR Transaction #: _____

Name & Description of Controlling Company or Organization:

Controlling Company Contact Name: _____

Controlling Company Business Address: (must be physical address / P.O. Box not allowed)

Controlling Company Mailing Address (if different / P.O. Box allowed):

Controlling Company Email(s): _____

Controlling Company Phone(s): _____

Controlling Company's Principal Owner(s): _____

Name of Related/ Predecessor Controlling Company of Organization:

Contact Name: _____

Related/ Predecessor Controlling Company of Organization Business Address: (must be physical address / P.O. Box not allowed)

Related/ Predecessor Controlling Company of Organization Mailing Address (if different / P.O. Box allowed):

Has any suspension, sanction or disciplinary action been taken against the entity in Connecticut or any other state over the past ten years? If, so, please provide us with a complete list of all actions taken on an annual basis, as well as a full explanation below. This includes actions taken against the entity not just related to PPN activity but also related to any other activity provided by the licensed entity, including but not limited to, TPA or UR activity.

NIPR Transaction #: _____

Has any suspension, sanction or disciplinary action been taken against the controlling company or organization in Connecticut or any other state over the past ten years? If, so, please provide us with a complete list of all actions taken on an annual basis, as well as a full explanation below. This includes actions taken against the entity not just related to PPN activity but also related to any other activity provided by the licensed entity, including but not limited to, TPA or UR activity.

Describe the PPN's service area:

How many total enrollees are served by the PPN Nationwide? _____

In CT? _____

List participating hospitals in Connecticut:

List all entities on whose behalf the PPN has contracts or agreements to provide health care services to Connecticut enrollees (e.g. Managed Care Organizations):

Name and address of the person to whom applications may be made for participation:

Indicate the type(s) of reimbursement arrangements that the PPN enters into with entities on whose behalf the PPN has contracts or agreements to provide health care services to Connecticut enrollees (e.g. Managed Care Organizations/ MCO):

Capitation? (Yes / No) _____

Fee for Service? (Yes / No) _____

Other?- Please explain (Yes / No) _____

Indicate types of services that the PPN provides for entities on whose behalf the PPN has contracts or agreements to provide health care services to Connecticut enrollees:

Medical services? (Yes / No) _____

Utilization Review? (Yes / No) _____

Claims administration? (Yes / No) _____

Dental Services? (Yes / No) _____

Other? List types of services. _____

NIPR Transaction #: _____

If the PPN includes providers of vision services, the PPN certifies compliance with section 20-138b of the Connecticut General Statutes. (Agree or N/A) _____

Indicate type(s) of reimbursement arrangements that the PPN enters into with participating providers:

Capitation (Yes / No) _____

Fee for Service (Yes / No) _____

Other?- Please explain (Yes / No) _____

NIPR Transaction #: _____

ADDITIONAL REQUIREMENTS:

- A certificate from the Secretary of State regarding the PPNs good standing to do business in Connecticut. **This must be <1 year old**.

  ☐ *Document in Warehouse* *Date Added:* _____

  ☐ *Document to Follow*

- A list of names, official positions, and occupations of members of the PPN & their controlling company's:
  - (1) Board of directors
  - (2) Executive officers responsible for the PPN/ controlling company's activities with respect to the health care services network

  ☐ *Document in Warehouse* *Date Added:* _____

  ☐ *Document to Follow*

- A copy of the PPN's and controlling company's financial statement completed in accordance with sections 38a-53 (annual statement) and 38a-54 (CPA Audited Report), as applicable for the end of its most recently concluded fiscal year, along with the name and address of any public accounting firm or internal accountant which prepared the financial statement.

  ☐ *Document in Warehouse* *Date Added:* _____

  ☐ *Document to Follow*

- In the case of a Connecticut or out-of-state PPN, a certificate that such PPN is in good standing in its state of organization. **This must be <1 year old.**

  ☐ *Document in Warehouse* *Date Added:* _____

  ☐ *Document to Follow*

- A general description of the PPN and participation in the PPN, including:
  - The primary care physicians, the specialty physicians, any other contracting providers and the number and percentage of each group's capacity to accept new patients;
  - A table listing all major categories of health care services provided by the PPN;
  - A list of subcontractors of the PPN, not including individual participating providers, that assume financial risk from the PPN and to what extent each subcontractor assumes financial risk;
  - A contingency plan describing how contracted health care services will be provided in the event of insolvency;

  ☐ *Document in Warehouse* *Date Added:* _____

  ☐ *Document to Follow*

- Documentation showing compliance with the below:
  - Each PPN shall maintain a minimum net worth of either (1) the greater of (A) $500,000, or (B) an amount equal to 8% of its annual expenditures as reported on its most recent financial statement completed and filed with the CID, or (2) another amount determined by the CID.
  - Each PPN shall maintain or arrange a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the CID for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations. Such outstanding amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for four months determined on the basis of the two months within the past year with the greatest amounts owed by the PPN to participating providers, (2) the actual outstanding amount owed by the PPN to participating providers, or (3) another amount determined by the CID. Such amount may be credited against the PPN's minimum net worth requirements set forth above. Please submit either new bond (or letter of credit, etc.) or continuation certificate for an

☐ *Document in Warehouse* *Date Added:* _____

☐ *Document to Follow*

NIPR Transaction #: _____

Financial Security Requirement:

Pursuant to the relevant part of Conn. Gen. Stat. Sec.38a-479aa as amended by Public Act 17-198, the financial security amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for four months determined on the basis of the two months within the past year with the greatest amounts owed by the preferred provider network to participating providers, (2) the actual outstanding amount owed by the preferred provider network to participating providers, or (3) another amount determined by the commissioner

Enter below the months, the year, and the amounts in which the network's total payments to provider/members were the highest within the past year. In addition, please provide the amount currently owed to provider/members. As stated above, the instrument used to meet the financial security requirement will be based on the greater of two times the highest two months, or the current outstanding amount due.

Highest Months of Payments to Providers in Past Year

Year: _____ **Month:** _____ **Amount:** _____

Year: _____ **Month:** _____ **Amount:** _____

SUM: $ 0.00

x2: $ 0.00

Actual outstanding amount due providers: _____

Accurate as of (date): _____

Each contract between this preferred provider network and its participating providers contains a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

(Yes / No) _____

NIPR Transaction #: _____

CEO CERTIFICATION OF ACCURACY

I, _____, _____ of
(Printed Name) (Title)

_____, hereby certify that
(Preferred Provider Network)

I have reviewed the information submitted in accordance with Connecticut General Statutes Section §38a-479aa, and that the information is true and accurate. I understand that any material modification of any matter or document furnished pursuant to this application must be filed with the Insurance Commissioner within thirty (30) days of such modification, including supporting documents to explain the modification.

_____ _____
(Signature of CEO) (Date)

SAMPLE-BOND FORM

STATE OF CONNECTICUT
PREFERRED PROVIDER NETWORK (PPN) BOND

KNOW ALL MEN BY THESE PRESENTS

That we, _____ of the
(Name of PPN)

County of _____ State of _____

as Principal, and _____, a surety

company having its principal place of business in _____

County of _____ State of _____ duly authorized to

do business in the State of Connecticut, as Surety, are held and firmly bound unto the

member/providers of the Preferred Provider Network (PPN) named, as Obligees, in the sum of

_____ dollars ($_____) for the payment of which sum the said Principal and Surety do jointly and severally bind themselves, their heirs, executors, administrators, successors, and assigns, and each and every one of them firmly by these presents.

THE CONDITION OF THIS OBLIGATION IS SUCH THAT, the Principal has made application to the Insurance Commissioner of the State of Connecticut for a license to engage in the business of a Preferred Provider Network (PPN) in accordance with the provisions of Section 38a-479aa of the Connecticut General Statutes and any applicable amendments and any regulation promulgated thereunder. This surety is intended for the sole purpose of meeting the obligation as described in Section 38a-479aa(i) "…for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations in accordance with subsection (b) of section 38a-479bb."

PROVIDED HOWEVER, that all obligations upon this bond shall cease upon the voluntary or involuntary termination of such license except as to such liability as shall have been accrued thereto.

IN WITNESS WHEREOF, the said Principal and Surety have signed and sealed this instrument this _____ day of _____ 20_____.

WITNESS

_____ By _____ L.S.

(As to Principal) _____ L.S.

_____ _____ L.S. Corporate Seal

(As to Surety) By _____ L.S.

_____ L.S.