

INITIAL OPERATING PLAN & PREMIUM PROPOSAL

SCHEDULE A

Name of Medicaid Prepayment Plan: _____
MMCR Region: _____
Counties: _____

Rate Period Start: _____ Rate Period End: 3/31/____

Note: All Rate periods begin on April 1st or the month the plan expects to begin Medicaid operations and end on the subsequent March 31.
Extended rate periods may also be considered.

STOP-LOSS REINSURANCE:

New York State _____ Commercial _____ Self-Insured _____

If New York State does not provide reinsurance, specify if the reinsurer has been licensed by New York State and provide a brief description of the coverage.

Name of Commercial Reinsurer: _____

Amount and type of coverage: _____

BENEFIT PACKAGE OPTIONAL SERVICES:

Please indicate by responding yes or no which of the optional benefits listed below will be included in the core Medicaid benefit package in the county(s):

County	Dental	Family Planning	Emergent Trans.	Non-Emergent Trans.