COVERED CALIFORNIA
QUALIFIED HEALTH PLAN ISSUER CONTRACT FOR 2017 – 2019
FOR THE INDIVIDUAL MARKET

between

Covered California, the California Health Benefit Exchange
(the "Exchange")

and

("Contractor")

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QUALIFIED HEALTH PLAN ISSUER CONTRACT
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_____ ("Contractor")

THIS QUALIFIED HEALTH PLAN ISSUER CONTRACT ("Agreement") is entered into by and between the California Health Benefit Exchange, an independent entity established within the government of the State of California doing business as Covered California (the "Exchange"), and _____ , a health insurance issuer as defined in Title 10 California Code of Regulations ("CCR") § 6410 ("Contractor"). (Except as otherwise expressly defined, capitalized terms shall have the meaning set forth at Article 13 Definitions).

RECITALS

A. The Exchange is authorized under the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, "Affordable Care Act"), and the California Patient Protection and Affordable Care Act, (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010) ("California Affordable Care Act") to selectively contract with Health Insurance Issuers in order to make available to Enrollees of the Exchange health care coverage choices that seek to provide the optimal combination of choice, value, access, quality and service to Qualified Individuals;

B. The Application process conducted by the Exchange is based on the assessment of certain requirements, criteria and standards that: (i) the Exchange determines are reasonable and necessary for bidding Health Insurance Issuers to market, offer, and sell Qualified Health Plans through the Exchange, (ii) are set forth in the Application and (iii) are required under applicable laws, rules and regulations or otherwise necessary to meet the needs of Enrollees in the Exchange, including, those set forth at 10 CCR § 6400 et seq. and 45 C.F.R. Part § 155 et seq.;

C. In connection with the evaluation of the responses to the Application received from Health Insurance Issuers, the Exchange is required under 10 CCR § 6428 et seq.: (i) to evaluate the proposed QHP Issuer's compliance with requirements imposed under the Application, and (ii) to give greater consideration to potential QHP Issuers that further the mission of the Exchange by promoting, among other items, the following: (1) affordability for the consumer – both in terms of premium and at point of care, (2) "value" competition based upon quality, service, and price, (3) competition based upon meaningful QHP Issuer choice and ability to demonstrate product differentiation within the required guidelines for standard benefit plans, (4) competition throughout the State, (5) alignment with Providers and delivery systems that serve the low-income population, (6) delivery system improvement, effective prevention programs and payment reform, and (7) long-term collaboration and cooperation between the Exchange and Health Insurance Issuers;

D. Contractor is a Health Insurance Issuer authorized to provide Covered Services to Enrollees under applicable laws, rules and regulations pursuant to: (i) a certificate of authority issued by the California Department of Insurance ("CDI") under § 699 et seq. of the California Insurance Code, or (ii) a licensed issued by the Department of Managed Health Care ("DMHC") pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (§ 1340 et seq. of the California Health and Safety Code). (Except as otherwise stated, references to "Codes" set forth herein shall refer to the laws of the State of California.);

E. Based on the Exchange's evaluation of the proposal submitted by Contractor in response to the Application ("Proposal") and its consideration of other factors required to be considered under applicable laws, rules and regulations and/as otherwise necessary to meet the needs of Enrollees, the Exchange intends to designate Contractor as a QHP Issuer (as defined at 10 CCR § 6410) pursuant to the Exchange's determination that Contractor's proposed QHPs meet the requirements necessary to provide health insurance coverage as a QHP to Qualified Individuals who purchase health insurance coverage through the Exchange;

F. Contractor desires to participate in the Exchange as a QHP Issuer; and

G. Contractor and the Exchange desire to enter into this Agreement to set forth the terms and conditions of Contractor's role as a QHP Issuer and operation of the QHPs through the Exchange.

ARTICLE 1 – GENERAL PROVISIONS

1.1 Purpose

This Agreement sets forth the expectations of the Exchange and Contractor with respect to: (a) the delivery of services and benefits to Enrollees; (b) the respective roles of the Exchange and the Contractor related to enrollment, eligibility and customer service for Enrollees; (c) coordination and cooperation between the Exchange and Contractor to promote quality, high value care for Enrollees and other health care consumers; (d) the Exchange's expectation of enhanced alignment between Contractor and its participating providers to deliver high quality, high value health care services; and (e) administrative, financial and reporting relationships and agreements between the Exchange and Contractor.

The Exchange enters into this Agreement with Contractor to further its mission to increase the number of insured Californians, improve health care quality and access to care, promote health, lower costs and reduce health disparities. The Exchange seeks to accomplish this mission by creating an innovative and competitive marketplace that empowers consumers to choose the health plan and providers that offer the best value. The Exchange's "triple aim" framework seeks to improve the patient care experience, including quality and satisfaction, improve the health of the population, and reduce the per capita costs of Covered Services. Through the execution of this Agreement, the Exchange and Contractor jointly commit to be actively engaged in promoting change and working collaboratively to define and implement additional initiatives to continuously improve quality and value.

1.2 Applicable Laws and Regulations

a) This Agreement is in accord with and pursuant to the California Affordable Care Act, Section 100500 et seq., Title 22 of the California Government Code (Chapter 655, Statues of 2010 and Chapter 659, Statutes of 2010) and the implementing regulations, Title 10, Chapter 12 of the California Code of Regulations, § 6400 et seq., as enacted or as modified during the course of this Agreement. This Agreement is also in accord with and pursuant to the Federal Patient Protection and Affordable Care Act and its implementing Federal regulations, as enacted or modified during the course of this Agreement, including but not limited to standards for qualified health plan certification set forth at 45 C.F.R. Part 156 et seq. (Subpart C: Qualified Health Plan Minimum Certification Standards).

b) Contractor is subject to the obligations imposed on Contractor under applicable laws, rules and regulations of the Federal Affordable Care Act, the California Affordable Care Act, and any other applicable Federal, State or local laws, rules and regulations. Nothing in this Agreement limits such obligations imposed on Contractor, including any failure to reference a specific state or Federal regulatory requirement applicable to the Exchange or Contractor. In those instances where the Exchange imposes a requirement in accordance with the California

Affordable Care Act or as otherwise authorized by California law, that exceeds a requirement of the Federal Affordable Care Act or other Federal law, the State law and Exchange requirement shall control unless otherwise required by law, rules and regulations.

c) Compliance Programs. Contractor shall, and shall require Participating Providers and all subcontractors to, comply with all applicable Federal, State, and local laws, regulations, executive orders, ordinances and guidance, including without limitation, the Affordable Care Act and the California Affordable Care Act; the Americans with Disabilities Act, the Anti-Kickback Statute, the Public Contracts Anti-Kickback Act, the Stark Law, and the Knox-Keene Health Care Service Plan Act of 1975 and California Insurance Code, as applicable.

1.3 Relationship of the Parties

a) Independent contractors. The parties acknowledge that in performance of the duties under this Agreement the Exchange and the Contractor are acting and performing as independent contractors. Nothing in this Agreement shall be construed or deemed to create a relationship of employer or employee or partner or joint venture or principal and agent between the Exchange and Contractor. In accordance with State and Federal law, the Exchange is not operating on behalf of Contractor or any subcontractor of Contractor. Neither Contractor nor its Participating Providers, authorized subcontractors, or any agents, officers or employees of Contractor shall be deemed as agents, officers, employers, partners or associates of the Exchange.

b) Subcontractors. Contractor shall require any subcontractor or assignee to comply with applicable requirements in this Agreement. Nothing in this Agreement shall limit Contractor's ability to hold subcontractor liable for performance under a contract between Contractor and its subcontractor(s). Contractor's obligations pursuant to this Agreement and applicable laws, rules or regulations shall not be waived or released if Contractor subcontracts or otherwise delegates services of this contract. Contractor shall exercise due diligence in the selection of subcontractors and monitor services provided by subcontractors for compliance with the terms of this Agreement and applicable laws, rules or regulatory requirements or orders.

1.4 General Duties of the Exchange

The Exchange is approved by the United States Department of Health and Human Services ("DHHS") pursuant to 45 C.F.R. §155.105 and performs its duties in accordance with State and Federal laws and this Agreement. The duties of the Exchange include:

a) Certification of QHP Issuers (45 C.F.R. Part 155, Subpart K);

b) Consultation with stakeholders (45 C.F.R. § 155.130);

c) Consumer assistance tools and programs, including but not limited to operation of a toll-free call center (45 U.S.C. §18031 (d) and 45 C.F.R. § 155.205);

d) Eligibility and enrollment determinations, as well as exemption determinations in the Individual Exchange (45 C.F.R. Part 155, Subparts D, E, H, I);

e) Financial support for continued operation of the Exchange (45 C.F.R. § 155.160);

f) Navigator program standards, in accordance with Federal rules, designed to raise awareness of the Exchange by providing consumer access to education and other resources regarding eligibility, enrollment, and program specifications (45 C.F.R. § 155.210);

g) Non-interference with Federal law and nondiscrimination standards (45 C.F.R. § 155.120);

h) Notices to Enrollees (45 C.F.R. § 155.230);

i) Oversight, financial and quality activities (45 C.F.R. § 155.200);

j) Participation of brokers to enroll Qualified Individuals in QHPs (45 C.F.R. § 155.220);

k) Ensuring that individuals can pay premiums owed directly to qualified health plan issuers and ensuring compliance with related Federal requirements (45 C.F.R. § 155.240);

l) Privacy and security of personally identifiable information (45 C.F.R. § 155.260);

m) Use of standards and protocols for electronic transactions (45 C.F.R. § 155.270);

n) Operation and management of CalHEERS. The Exchange also has a duty, as part of its management of CalHEERS, to determine how CalHEERS presents information about cost, quality and provider availability for consumers to inform their selection of issuer and benefit design in the Exchange. The Exchange shall solicit comment from Contractor on the design but retains final authority to make design and presentation decisions in its sole discretion; and

o) The Exchange agrees to provide a dedicated team member responsible for working with Contractor to resolve any and all issues that arise from implementation of the Exchange.

1.4.1 Confidentiality of Contractor Documents

The Exchange shall treat as confidential and exempt from public disclosure all documents and information provided by Contractor to the Exchange, or to the vendor for the Exchange, providing the documents or information are deemed to be, or qualify for treatment as, confidential information under the Public Records Act, Government Code § 6250, et seq., or other applicable Federal and State laws, rules and regulations. Documents and information that the Exchange will treat as confidential include, but are not limited to, provider rates and the Contractor's business or marketing plans.

1.5 General Duties of the Contractor

Contractor and the Exchange acknowledge and agree that Contractor's QHPs are important to furthering the goal of the Exchange with respect to delivering better care and higher value. Contractor agrees that Contractor's QHPs identified at Attachment 1 ("Contractor's QHP List") shall be offered through the Exchange to provide access to Covered Services to Enrollees in accordance with the terms and conditions required by this Agreement and as required for designation of each health insurance plan as a QHP.

Contractor shall maintain the organization and administrative capacity to support and ensure implementation and operation of this Agreement. This requirement includes the following:

a) Contractor maintains the legal capacity to contract with the Exchange and complies with the requirements for participation in the Exchange pursuant to this Agreement and applicable Federal and State laws, rules and regulations;

b) A dedicated liaison is available as the primary contact person to coordinate and cooperate with the Exchange in the implementation of this Agreement and the contact person and/or other personnel are available to the Exchange as needed to fulfill Contractor's duties under this Agreement. Contractor's dedicated liaison is subject to a carrier evaluation designed to measure the Exchange staff satisfaction with Contractor's account management services. The Exchange will complete Attachment 5, Carrier Evaluation, on a semi-annual basis to evaluate these services;

c) Qualified Health Plans identified in Attachment 1 are offered in accordance with the terms and conditions of this Agreement and compliance with the Affordable Care Act and the California Affordable Care Act and implementing regulations, and with applicable Federal and State laws, rules and regulations, as may be amended from time to time as required under applicable laws, rules and regulations or as otherwise authorized under this Agreement;

d) Notify the Exchange of any material concerns identified by Contractor or by a regulatory agency that may impact Contractor's performance under this Agreement; and

e) Participate in quarterly in-person meetings between the Exchange and Contractor at the Exchange's headquarters to report and review program performance results, including all Services and components of the program, i.e., clinical, financial, contractual reporting requirements, customer service, appeals and any other program recommendations.

1.6 Transition between the Exchange and Other Coverage

In order to further the Exchange's mission regarding continued access to health insurance coverage, Contractor shall establish policies and practices to maximize smooth transitions and continuous coverage for Enrollees to and from the Medi-Cal program and other governmental

health care programs and coverage provided by employers, including coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the California Continuation Benefits Replacement Act, or Health and Safety Code § 1366.20 et seq. ("Cal-COBRA").

1.7 Coordination with Other Programs

Contractor and the Exchange recognize that the performance of Services under this Agreement depends upon the joint effort of the Exchange, Contractor, Participating Providers and other authorized subcontractors of Contractor. Contractor shall coordinate and cooperate with Participating Providers and such subcontractors to the extent necessary, and as applicable, to promote compliance by Participating Providers and such subcontractors with the terms set forth in this Agreement. Contractor shall also coordinate and comply with requirements of other State agencies that affect its Enrollees, including, the Department of Health Care Services ("DHCS") (and the Medi-Cal program) regarding the development and implementation of CalHEERS with respect to eligibility and enrollment considerations or as may be required under inter-governmental agency agreements or other laws, rules, regulations or program instructions.

The Contractor shall cooperate with the Exchange and DHCS to implement coverage or subsidy programs to complement existing programs that are administered by DHCS. Such programs may provide State or Federal funding for all or a portion of Enrollee premiums or subsidies to reduce or eliminate cost-sharing charges. These programs may require special authorization and coverage of certain health benefits for individuals enrolled under these special programs, which may not otherwise be covered by a QHP.

1.8 Changes in Requirements

The parties agree that the Exchange may make prospective changes to benefits and services during a contract year to incorporate changes in State or Federal laws, requirements imposed by regulators or as mutually agreed by the Exchange and Contractor. The projected cost of any such benefit or service change will be included in the cost of health care projections and changes to the Monthly Rates will be implemented after Contractor has demonstrated the cost impact of the benefit or service change in accordance with the requirements set forth in Article 5.

1.9 Evaluation of Contractor Performance

The Exchange shall evaluate Contractor's performance with respect to fulfillment of its obligations under this Agreement on an ongoing basis, including, but not limited to, during the 90-day period prior to each anniversary of the Agreement Effective Date set forth in Section 7.1 so long as the Agreement remains in effect. In the event evaluations conducted by the Exchange reveal a significant problem or pattern of non-compliance with terms of this Agreement as reasonably determined and documented by the Exchange, the Exchange shall have the right,

without limitation, to conduct reasonable additional reviews of Contractor's compliance and operational performance. Such evaluations shall also be considered in connection with decisions relating to re-certification and de-certification in accordance with the terms set forth at Article 7.

1.10 Required Notice of Contractor Changes

Except as set forth below, notices pursuant to this section shall be provided by Contractor promptly within ten (10) days following Contractor's knowledge of such occurrence; provided, however, (i) such notice shall be provided immediately if such occurrence may reasonably be deemed to adversely affect the quality of care or safety of Enrollees and (ii) in no event shall notice be provided by Contractor beyond the thirty (30) day period following the date of occurrence. All written notices from Contractor pursuant to this section shall contain sufficient information to permit the Exchange to evaluate the events under the same criteria that were used by the Exchange in its award of this Agreement to Contractor. Contractor agrees to provide the Exchange with such additional information as the Exchange may request. If Contractor requests confidential treatment for any information it provides, the Exchange shall treat the information as confidential, consistent with Section 1.4.1.

Contractor shall notify the Exchange in writing upon the occurrence of any of the following events:

a) Contractor is in breach of any of its obligations under this Agreement;

b) Change in the majority ownership, control, or business structure of Contractor;

c) Change in Contractor's business, partnership or corporate organization that may reasonably be expected to have a material impact on Contractor's performance of this Agreement or on the Exchange's rights under this Agreement;

d) Breach by Contractor of any term set forth in this Agreement or Contractor otherwise ceases to meet the requirements for a QHP Issuer, including those set forth at and 45 C.F.R. § 156.200 et seq. (Subpart C Article 3—Qualified Health Plan Minimum Certification Standards);

e) Immediate notice in the event that Contractor files any federal bankruptcy action or state receivership action, any federal bankruptcy or state receivership action is commenced against Contractor, Contractor is adjudicated bankrupt, or a receiver is appointed and qualifies; and

f) Changes in Contractor's Provider Network by notice consistent with Section 3.3.

   i. Contractor shall notify the Exchange with respect to any material changes to its Essential Community Provider (ECP) contracting arrangements consistent with Section 3.3; and

ii. Significant changes in operations of Contractor that may reasonably be expected to significantly impair Contractor's operation of QHPs or delivery of Covered Services to Enrollees.

1.11 Nondiscrimination

a) Services and Benefits. During the performance of this Agreement, Contractor shall not, and shall require Participating Providers and other subcontractors, as well as their agents and employees to not, in accordance with the Affordable Care Act Section 1557 (42 U.S.C. 18116), cause an individual to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or subject to any other applicable State and Federal laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through the Exchange.

b) Employment and Workplace. Contractor shall not, and shall require Participating Providers and other subcontractors, as well as their agents and employees to not, unlawfully discriminate, harass or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (40 or over), marital status, genetic information, sexual orientation, gender identity or use of family and medical care leave. Contractor shall, and shall require Participating Providers and other subcontractors, as well as their agents and employees, to evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Contractor shall, and shall require Participating Providers and subcontractors, as well as their agents and employees, to comply with the provisions of the Fair Employment and Housing Act (Government Code, § 12900, et seq.) and the applicable regulations promulgated thereunder (2 CCR 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, § 12990, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2 CCR § 8103, et seq., are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall, and shall require Participating Providers and other subcontractors to give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Contractor shall include the nondiscrimination and compliance provisions of this clause in all subcontracts to perform work under this Agreement.

1.12 Conflict of Interest; Integrity

Contractor shall, and shall require Participating Providers to be free from any conflicts of interest with respect to Services provided under this Agreement. Contractor represents that Contractor and its personnel do not currently have, and will not have throughout the term of the Agreement, any direct interest that may present a conflict in any manner with the performance of Services required under this Agreement. Contractor also represents that it is not aware of any conflicts of interest of any Participating Provider or any basis for potential violations of Contractor or Participating Provider with respect to laws, rules and regulations that govern referrals required for the provision of certain Covered Services, including Federal and State anti-kickback and anti-self-referral laws, rules and regulations. Contractor shall immediately (1) identify any conflict of interest that is identified during the term of the Agreement and (2) take any necessary action to assure that any activities are not properly influenced by a conflict of interest.

Contractor shall comply with any and all other policies adopted by the Exchange regarding conflicts of interest and ethical standards, copies of which shall be made available by the Exchange for review and comment by the Contractor prior to implementation.

1.13 Other Financial Information

In addition to financial information to be provided to the Exchange under other provisions of this Agreement or pursuant to applicable laws, rules and regulations, at the request of the Exchange, Contractor shall provide the Exchange with financial information that is (i) provided by Contractor to Health Insurance Regulators or other regulatory bodies, or (ii) reasonable and customary information prepared by Contractor, including supporting information relating to Contractor's QHP Enrollees. Possible requests may include (but not be limited to) annual audited financial statements and annual profit and loss statements.

1.14 Other Laws

Contractor shall comply with applicable laws, rules and regulations, including the following:

a) Americans with Disabilities Act. Contractor shall comply with the Americans with Disabilities Act (ADA) of 1990, (42 U.S.C. Section 12101, et seq.), which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA, unless specifically exempted.

b) Drug-Free Workplace. Contractor shall comply with the requirements of the Drug-Free Workplace Act of 1990 (Government Code Section 8350, et seq.).

c) Child Support Compliance Act. Contractor shall fully comply with all applicable State and Federal laws relating to child and family support enforcement, including, but not limited to,

disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code.

d) Domestic Partners. Contractor shall fully comply with Public Contract Code Section 10295.3 with regard to benefits for domestic partners.

e) Environmental. Contractor shall comply with environmental laws, rules and regulations applicable to its operations, including, those relating to certifies compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30, commencing with Section 42460 of the Public Resources Code, relating to hazardous and solid waste.

f) Other Laws. Contractor shall comply with any and all other State and Federal laws, rules and regulations applicable to this Agreement, to the operation of the Exchange, and Contractor's provision of Services under this Agreement.

1.15 Contractor's Representations and Warranties

Contractor represents and warrants that neither the execution of this Agreement by Contractor, nor the acts contemplated hereby, nor compliance by Contractor with any provisions hereof will:

a) Violate any provision of the charter documents of Contractor;

b) Violate any laws, rules, regulations or any judgment, decree, order, regulation or rule of any court or governmental authority applicable to Contractor; or

c) Violate, or be in conflict with, or constitute a default under, or permit the termination of, or require the consent of any person under, any agreement to which Contractor may be bound, the occurrence of which in the aggregate would have a material adverse effect on the properties, business, prospects, earnings, assets, liabilities, or condition (financial or otherwise) of Contractor.

Due Organization. Contractor represents and warrants that it is duly organized, validly existing, and in good standing under the laws of the state of its incorporation or organization.

Power and Authority. Contractor represents and warrants that: (i) it has the power and authority to enter into this Agreement and to carry out its obligations hereunder; (ii) the execution of this Agreement has been duly authorized and executed by Contractor and no other internal proceeding on the part of Contractor is necessary to authorize this Agreement; and (iii) to the best of its knowledge, Contractor has completed, obtained, and performed all registrations, filings, approvals, authorizations, consents, or examinations required by any Health Insurance Regulators and other government or governmental authority for its acts contemplated by this Agreement.

1.16 Fraud, Waste and Abuse; Ethical Conduct

Contractor shall maintain and enforce policies, procedures, processes, systems and internal controls (i) to reduce fraud, waste and abuse, and (ii) to enhance compliance with other applicable laws, rules and regulations in connection with the performance of Contractor's obligations under this Agreement. Contractor shall maintain an effective compliance program that meets the requirements of applicable laws, rules and regulations. Contractor shall provide evidence of such compliance program as reasonably requested by the Exchange. Contractor shall timely communicate to the Exchange any material concerns identified by Contractor or by a regulatory agency related to regulatory compliance that may impact performance under this Agreement.

Contractor shall provide the Exchange with a description of its fraud, waste and abuse detection and prevention programs and report total moneys recovered by Contractor in the most recent 12-month period in relation to Services provided to Enrollees. This description shall be provided upon the request of the Exchange and will be updated during each year that this Agreement is in effect and shall include an overview of fraud and abuse detection and prevention program activities conducted by Contractor, Participating Providers, other subcontractors and/or their authorized Agents, including a summary of key findings and the development, implementation and enforcement of any corrective action plans for changing, upgrading, or improving these programs.

Contractor shall maintain and enforce a code of ethical conduct and make it available to the public through posting on Contractor's website.

1.17 Current Enrollee Notification

Contractor shall notify Contractor's individual Enrollees of the availability of Exchange coverage and potential eligibility for subsidies in the Exchange as required in State and Federal law. Contractor shall identify potential subsidy-eligible individuals, educate them about Exchange coverage, and assist them in enrolling in Qualified Health Plans in the Exchange.

ARTICLE 2 – ELIGIBILITY AND ENROLLMENT

2.1 Eligibility and Enrollment Responsibilities

2.1.1 Exchange Responsibilities

a) The Exchange shall be solely responsible for the determination of eligibility and enrollment of individuals in the Exchange in accordance with applicable Federal and State laws, rules and regulations.

b) The Exchange shall determine eligibility and enroll eligible individuals in the Exchange pursuant to its management and participation in CalHEERS, a project jointly sponsored by the Exchange and DHCS with the assistance of the Office of Systems Integration. The Exchange and CalHEERS shall develop, implement and maintain processes to make the eligibility and enrollment decisions regarding the Exchange and other California health care programs and submit that information to Contractor in a timely manner in accordance with Federal and State laws, rules and regulations and the terms set forth in this Agreement.

c) The Exchange shall notify Contractor regarding each eligible applicant who has completed an application for enrollment and selected Contractor as the QHP Issuer. The Exchange shall transmit information required for Contractor to enroll the applicant within five (5) business days of receipt of verification of eligibility and selection of Contractor's QHP.

d) The Exchange shall send enrollment information to Contractor on a daily basis and Contractor shall reconcile specified enrollment information received from the Exchange with Contractor's enrollment data on a monthly basis.

e) In addition, the Exchange shall issue certifications of individual exemption in a timely manner consistent with the Affordable Care Act standards.

2.1.2 Contractor Responsibilities

a) Contractor shall comply with all Federal and State eligibility and enrollment laws and regulations, including, but not limited to, the Affordable Care Act § 1411 et seq. (42 U.S.C. § 18081 et seq.), 45 C.F.R. §155.400 et seq., Government Code § 100503, and 10 CCR § 6400 et seq.

b) Contractor shall comply with all Exchange eligibility and enrollment determinations, including those made through CalHEERS and that result from an applicant's appeal of an Exchange determination. Contractor shall implement appeals decisions and provide the Exchange with evidence the appeal resolution has been implemented within ten (10) business days of receiving all necessary data elements from the Exchange required to implement the appeals decision. Contractor shall immediately notify the Exchange if it receives an appeal

decision that does not have all necessary data elements required for the Contractor to implement the appeal decision. In the event that an Enrollee requires immediate care, the QHP Issuer will work closely with the Exchange to implement the appeals decision as soon as reasonably possible. Contractor shall accept all Enrollees assigned by the Exchange except as otherwise authorized by policies and procedures of the Exchange or upon the approval of the Exchange.

c) Contractor shall review and compare the Exchange enrollment reconciliation file, distributed monthly, against the Contractor's membership enrollment and financial databases. Contractor shall prepare a comparison extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the reconciliation process guide.

d) Contractor shall provide a supplemental file for those members who are missing from the Exchange enrollment reconciliation file in accordance with the defined list of fields and technical requirements established by the Exchange. Contractor shall verify that missing members from the Exchange enrollment reconciliation file include only members whose enrollment originated through Covered California during Open Enrollment, Renewal or Special Enrollment Period (SEP) for the Plan Year the Enrollee is eligible for. Contractor shall provide this file within two weeks of the receipt of the monthly reconciliation file.

e) Contractor shall rely upon the accuracy of current eligibility and enrollment information furnished by the Exchange during the term of this Agreement; provided, however, that Contractor shall: (i) reconcile premium payment information with enrollment and eligibility information received from the Exchange on a monthly basis, and (ii) Contractor shall only accept changes to eligibility information submitted by Enrollees when the Exchange notifies or confirms such change to Contractor.

2.1.3 Collection Practices

Contractor shall maintain fair and reasonable collection practices that comply with applicable laws, rules and regulations. Contractor shall monitor the collection activities and provide the Exchange with reasonable documentation to facilitate the Exchange's monitoring, tracking or reporting with respect to Contractor's collection efforts including, policies, and procedures and copy of any form of delinquency or termination warning or notice sent to an Enrollee or Employer. Contractor shall not initiate collection activities if they have knowledge of a pending appeal, including notice from the consumer, Covered California, or Contractor's regulator.

2.2 Individual Exchange

2.2.1 Enrollment and Enrollment Periods

Contractor acknowledges and agrees that the Exchange is required to: (i) allow Qualified Individuals to enroll in a QHP or change QHPs during annual Open Enrollment Periods, and (ii) allow certain Qualified Individuals to enroll in or change QHPs during Special Enrollment Periods as a result of specified triggering events per applicable Federal and State laws, rules and regulations. Contractor agrees to accept new individual Enrollees in the Exchange who enroll during these periods.

2.2.2 Individual Exchange Coverage Effective Dates

Contractor shall ensure a coverage effective date for the Enrollee as of (1) the first (1st) day of the next subsequent month for a QHP selection notice received by the Exchange between the first (1st) day and fifteenth (15th) day of the month, or (2) the first (1st) day of the second (2nd) following month for QHP selections received by the Exchange from the sixteenth (16th) day through the last day of a month, or (3) such other applicable dates specified in 10 CCR § 6502 for the Open Enrollment Period and 10 CCR § 6504 for the Special Enrollment Period and as otherwise established by Contractor in accordance with applicable laws, rules and regulations.

The Exchange shall require payment of premium in accordance with 10 CCR § 6500. Premium payment due date shall not be earlier than the fourth (4th) remaining business day of the month prior to the month coverage begins.

Contractor shall provide the Exchange with information necessary to confirm Contractor's receipt of premium payment from Enrollee that is required to commence coverage. The Exchange shall establish the specific terms and conditions relating to commencement of coverage, including the administration of advance payments of the premium tax credit and cost sharing reductions and cancellation or postponement of the effective date of coverage in the event of nonpayment or partial payment of an initial premium, in accordance with applicable laws, rules and regulations.

The first premium binder payment shall be either paid directly to the Contractor or processed through a third-party administrator and deposited into an account owned by the third-party administrator and settled by the third-party administrator to the Contractor's own bank account.

2.2.3 Premiums for Coverage in the Individual Exchange

Contractor shall not be entitled to collect from Enrollees or receive funds above the premium amounts except with respect to cost-sharing amounts or to the extent that such payment (i) is expressly authorized under the QHPs, such as out-of-network services that comply with the notice requirements set forth at Section 3.4.3, or (ii) relates to a charge for non-sufficient funds or

transaction fees initiated by Enrollee at rates that are reasonable and customary for such transactions. Contractor shall not pursue collections of any said fees from the Exchange. Contractor shall not pursue collection of any delinquent premiums from the Exchange for an Enrollee enrolled in the Individual Exchange who is responsible for directly paying his or her premium to Contractor.

Premium charged to individuals includes the assessment of the participation fee (see Sections 5.1.3 Participation Fee).

2.2.4 Terminations of Coverage

Contractor shall terminate coverage in a Contractor's QHP in accordance with the requirements established by the Exchange pursuant to 10 CCR § 6506 and other applicable State and Federal laws, rules and regulations.

Contractor shall terminate coverage for an individual Enrollee's non-payment of premium as follows: (i) effective as of the last day of the first month of a three (3) month grace period in the event of nonpayment of premiums by individuals receiving advance payments of the premium tax credit; or (ii) effective the last day of coverage established by grace periods under applicable State law, including requirements relating to Health and Safety Code § 1365 and Insurance Code § 10273.6 for individuals not receiving advance payments of the premium tax credit.

Contractor shall notify the Agent or Agency of Record a late payment notification at the same time the Enrollee receives notification.

The Exchange and Contractor must send a termination transaction to the other party within five (5) business days of any individual Enrollee termination.

2.2.5 Notice to Provider Regarding Enrollee's Grace Period Status

a) In the event of nonpayment of premium by an individual Exchange Enrollee receiving advance payments of the premium tax credit, Contractor shall provide notice to its network providers within 15 days of the start of the second month of the three month grace period. This notice shall inform the network provider of the Enrollee's suspension of coverage during the second and third months of the Enrollee's grace period, and shall include any other information required by State and Federal law. This notice obligation only applies to network providers who have submitted claims to the QHP Issuer within the previous two months, any provider who is an assigned Primary Care Provider for that Enrollee, and providers who have an outstanding prior authorization to provide services to the APTC Enrollee.

b) Notwithstanding (a) above, this notice obligation does not relieve the QHP Issuer from compliance with existing state laws governing claims payment.

2.2.6 Agents in the Individual Exchange

a) Compensation. The provisions of this Section apply to Agents who sell Contractor's QHPs though the Individual Exchange.

b) Compensation Methodology. Contractor must pay a commission to Agents to ensure Contractor is fairly and affirmatively offering all of its products at each metal level during both Open and Special Enrollment Periods. Contractor shall be solely responsible for compensating Agents who sell Contractor's QHP through the individual market of the Exchange. Contractor shall use a standardized Agent compensation program with levels and terms that shall result in the same aggregate compensation amount to Agents whether products are sold within or outside of the Exchange. Contractor shall provide the Exchange with a description of its standard Agent compensation program, standard Agent contract, and policies on an annual basis.

c) Incentive Compensation Program. In order to enhance consistency in sales efforts for products offered inside and outside of the Exchange, Contractor shall add the Agent's sale of Contractor's QHPs through the Exchange to the Agent's sale of Contractor's individual policies outside the Exchange to determine Agent's aggregate sales that are used by Contractor to determine incentive or other compensation payable by Contractor to Agent, to the extent such aggregation is necessary to determine Agent compensation under Contractor's applicable Agent agreement or compensation program. Contractor shall not change the Agent commission structure or rates during the Plan Year. Contractor must pay the same commission during the Open and Special Enrollment Periods for each Plan Year. Contractor shall not vary Agent commission levels by metal tier. Contractor shall approve and pay Agent commissions on all new Agent-of-record and change of Agent-of-record delegations as outlined in contract sections 2.2.6 (f) and 2.2.6 (g). Contractor shall provide information as may reasonably be required by the Exchange from time to time to monitor Contractor's compliance with the requirements set forth in this Section. Contractor's standard Agent compensation and incentive compensation programs entered into or in effect prior to January 1, 2014 shall not be subject to the requirements of this Section.

d) Agent Appointments. Contractor shall maintain a reasonable appointment process for appointing Agents who contract with Contractor to sell Contractor's QHPs to individuals through the Exchange. Such appointment process shall include: (i) providing or arranging for education programs to assure that Agents are trained to sell Contractor's QHPs through the Exchange, (ii) providing or arranging for programs that enable Agents to become certified by the Exchange; provided, however, that certification by the Exchange shall not be a required condition for an Agent to sell Contractor's QHPs outside of the Exchange and (iii) confirmation of Agent's compliance with State laws, rules and regulations applicable to Agents, including those relating to confidentiality and conflicts of interest, and such other qualifications as determined in Contractor's reasonable discretion.

e) Agent Conduct. Contractor shall implement policies and procedures to ensure that only Agents who have been duly certified by the Exchange and maintain that certification may receive compensation for enrolling individuals in the Exchange.

f) Agent of Record. At initial enrollment, individuals may notify the Exchange of an Agent delegation. The Exchange shall send notice of the delegation to the Contractor via a new enrollment file or a weekly reconciliation file. The format of the reconciliation file shall be defined by the Exchange. The Exchange will solicit comments from the QHP Issuers prior to finalizing the format of the reconciliation file. Upon receipt of the notification, contractor shall approve the delegation (unless an Agent is not licensed or not appointed) and has five (5) days to update their system. The Exchange recognizes that Contractor may contract with insurance agencies who employ or contract with Agents. The Exchange further understands that Contractor may delegate the agency, or primary Agent at the agency, instead of the specific Agent who enrolled a consumer. As such, an Agent delegation may consist of an Agent, agency, or primary Agent with an agency. The Contractor shall send an Agent of Records Exception Report by 5PM on the last business day of the month which includes any changes the Exchange requested, but were not made.

g) Change to Agent of Record. Individuals may notify the Exchange of an Agent delegation change. The Exchange shall send notice of the delegation change to the Contractor via a weekly reconciliation file (or an 834 maintenance file). Upon receipt of the notification, Contractor shall approve the delegation (unless an Agent is not licensed or not appointed), and has five (5) days to update their system to reflect this change upon receipt of all required information from the Exchange. Contractor shall notify the existing agent of the delegation change within ten (10) business days. The Contractor shall send an Agent of Record Exception Report by 5PM on the last business day of the month which includes any changes the Exchange requested, but were not made. The Exchange further understands that Contractor may delegate the agency, or primary Agent at the agency, instead of the specific Agent. As such, an Agent delegation may consist of an Agent, agency, or primary Agent with an agency.

h) Carrier Scorecard. The Exchange will administer an annual Agent survey that rates the services Contractor provides to Agents, including those services required in this section 2.2.6. The Exchange will solicit comments from the QHP Issuers to develop the Agent Survey prior to finalization. The Exchange will utilize the results of this survey to identify areas of improvement and work with QHP Issuers to improve performance.

2.3 Enrollment and Marketing Coordination and Cooperation

The Exchange recognizes that the successful delivery of services to Enrollees depends on successful coordination with Contractor in all aspects including collaborative enrollment and marketing.

The Exchange will take such action as it deems necessary and feasible to develop and implement programs and activities to support Contractor in its marketing and enrollment efforts, in accordance with applicable laws, rules and regulations. Such activities may include making available the following programs and resources for use by Contractor:

a) A subsidy calculator available by electronic means to facilitate a comparison of QHPs that is consistent with tools the Exchange will use for its own eligibility screenings, to ensure that preliminary eligibility screenings use the same tool;

b) Education, marketing and outreach programs that will seek to increase enrollment through the Exchange and inform consumers, including Contractor's current Enrollees, that there is a range of QHPs available in the Exchange in addition to Contractor's QHPs;

c) A standard interface through which Contractor may electronically accept the initial binding payment (via credit card, debit card, ACH or other mutually acceptable means) to effectuate coverage in the Individual Exchange;

d) Complete documentation and reasonable testing timelines for interfaces with the Exchange's eligibility and enrollment system;

e) Eligibility and enrollment training for Contractor's staff and for licensed Agents and brokers;

f) Joint marketing programs to support renewal, retention and enrollment in the Exchange of existing members of Contractor's health insurance plans who are eligible for the Federal subsidies;

g) Joint marketing activities of the Exchange, Contractor and other Health Insurance Issuers designed to drive awareness and enrollment in the Exchange;

h) The Exchange will treat as confidential, all Contractor marketing plans and materials consistent with Section 1.4.1;

i) The Exchange's annual marketing plans, including Open Enrollment Period (OEP), Special Enrollment Period (SEP) retention and renewal efforts; and

j) Customer service support that will include substantially extended customer service hours during Open Enrollment Periods.

To support the collaborative marketing and enrollment effort, Contractor shall:

a) Following the Exchange making the technology available and within a reasonable time after the receipt of notice from the Exchange about the technology, and determination of its compatibility with Contractor's system, the Contractor shall prominently display the subsidy calculator on its website;

b) Educate its Agents on Contractor's QHPs offered in the Exchange, work with the Exchange to efficiently educate its Agents and brokers about the Exchange's individual marketplace and inform Agents that a prospective Enrollee's health status is irrelevant to advice provided with respect to health plan selection other than informing individuals about their estimated out-of-pocket costs;

c) Provide education and awareness regarding eligibility for Federal tax credits, plan offerings and benefits available through the Exchange in connection with any applicable outreach to Contractor's existing members, as mutually agreed;

d) Cooperate with the Exchange to develop and implement an Enrollee retention plan;

e) Submit to the Exchange a marketing plan at least thirty (30) days prior to Open Enrollment that details the anticipated budget, objectives, strategy, creative messaging and ad placement by medium promoting acquisition activities. Marketing plans for Retention and Renewal efforts should be submitted to the Exchange within thirty (30) days after Open Enrollment begins;

f) Submit to the Exchange annual actualized spend amounts for: (1) OEP within thirty (30) days after OEP closes, and (2) SEP for the calendar year, thirty (30) days after the calendar year ends, and (3) for retention and renewal, thirty (30) days after OEP begins. The Exchange shall treat as confidential consistent with Section 1.4.1; and

g) Have successfully tested interfaces with the Exchange's eligibility and enrollment system, or be prepared to complete successful interface tests by dates established by the Exchange.

2.4 Enrollee Materials and Branding Documents

a) Exchange Logo. Contractor shall include the Exchange logo on premium invoices, ID cards and Enrollee termination notices. The Contractor shall include the Exchange logo and other information in notices and other materials based upon the mutual agreement of the Exchange and Contractor as to which materials should include the Exchange logo. Contractor shall comply with the Exchange co-branding requirements related to the format and use of the Exchange logo as outlined in the Covered California Brand Style Guide. The Exchange shall make the updated Brand Style Guide available to Contractor online and notify Contractor when updates are made.

b) Cobranded Marketing Materials. Contractor must submit all cobranded marketing materials for review and approval to Covered California prior to release. Contractor shall allow at least ten (10) business days from the date of the request for Covered California to review any materials submitted.

c) Enrollee Materials. Upon request, Contractor shall provide the Exchange with at least one (1) copy, unless otherwise specified, of any information Contractor intends to send or make

available to all the Exchange Enrollees, including, but not limited to, Evidence of Coverage (EOC) and disclosure forms, Enrollee newsletters, new Enrollee materials, health education materials, and special announcements. The materials provided to the Exchange under this Section will not require prior-approval by the Exchange before the Contractor distributes such materials; provided, however, that Contractor shall duly evaluate any changes proposed by the Exchange with respect to such materials. Contractor shall maintain an electronic file that is open to the Exchange, or email all Enrollee materials to the Exchange. Such files shall be accessible by the Exchange as required by applicable laws, rules and regulations and as otherwise mutually agreed upon by the parties.

d) Distribution of Enrollment Materials. Contractor agrees to distribute to prospective Enrollees the Open Enrollment publications developed and printed by the Exchange for Enrollees prior to the Open Enrollment Period at a time mutually agreed to by the Contractor and the Exchange. Contractor shall be responsible for the mailing cost associated with these publications.

e) Marketing Materials. In order to promote the effective marketing and enrollment of individuals inside and outside the Exchange, Contractor shall provide the Exchange with marketing material and all related collateral used by Contractor for the Exchange and non-Exchange plans on an annual basis and at such other intervals as may be reasonably requested by the Exchange. The Exchange shall treat such marketing materials as confidential information consistent with Section 1.4.1.

f) Identification Cards. Contractor shall issue identification cards to Enrollees in a form that shall be agreed to by the Exchange. Identification cards should include the product name matching the naming convention on the Exchange website and provider directory. Contractor shall submit card design to the Exchange annually at least thirty (30) days prior to Open Enrollment.

g) Mailing Addresses; Other Information. The Exchange and Contractor shall coordinate with respect to the continuous update of changes in an Enrollee's address or other relevant information.

h) Evidence of Coverage Booklet on Contractor's Website. During each year of this Agreement which carries over into a subsequent Plan Year, Contractor shall make the Evidence of Coverage booklet, including any documents referenced in the EOC, for the next benefit year available on Contractor's website no later than the first day of the Open Enrollment Period provided that Contractor has received any revisions in the material that is to be included in the Evidence of Coverage from the Exchange and the applicable Regulator in sufficient time to allow for posting on the first day of Open Enrollment. The Evidence of Coverage booklet for the then-current benefit year shall remain on Contractor's website through December 31 of the then-current benefit year.

i) Marketing Plans. Contractor and the Exchange recognize that Enrollees and other health care consumers benefit from efforts relating to outreach activities designed to increase heath awareness and encourage enrollment. The parties shall share marketing plans on an annual basis and with respect to periodic updates of material changes. The marketing plans of the Exchange and Contractor shall include proposed and actual marketing approaches, messaging and channels and provide samples of any planned marketing materials and related collateral as well as planned, and when completed, expenses for the marketing budget. The Contractor shall include this information for both the Exchange and the outside individual market. The Exchange shall treat all marketing information provided under this Section as confidential information consistent with Section 1.4.1. The obligation of the Exchange to maintain confidentiality of this information shall survive termination or expiration of this Agreement.

ARTICLE 3 – QHP ISSUER PROGRAM REQUIREMENTS

3.1 Basic Requirements

3.1.1 Licensed in Good Standing

Contractor shall be licensed and in good standing to offer health insurance coverage through its QHPs offered under this Agreement. For purposes of this Agreement, each QHP Issuer must be in "good standing," which is determined by the Exchange pursuant to 45 C.F.R § 156.200(b)(4) and shall require: (i) Contractor to hold a certificate of authority from CDI or a health care service plan ("HCSP") license from DMHC, as applicable, and (ii) the absence of any material statutory or regulatory violations, including penalties, during the year prior to the date of the Agreement and throughout the term of Agreement, with respect to the regulatory categories identified at Table 3.1.1 below ("Good Standing"). The Exchange, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

Table 3.1.1 Definition of Good Standing	Agency
Verification that issuer holds a state health care service plan license or insurance certificate of authority.	
• Approved for lines of business sought in the Exchange (e.g. commercial, small group, individual)	DMHC and CDI
• Approved to operate in what geographic service areas	DMHC and CDI
• Most recent financial exam and medical survey report reviewed	DMHC
•Most recent market conduct exam reviewed	CDI
Affirmation of no material[1] statutory or regulatory violations, including penalties levied, during the year prior to the date of the Agreement or throughout the term of Agreement in relation to any of the following, where applicable:	
• Financial solvency and reserves reviewed	DMHC and CDI
• Administrative and organizational capacity acceptable	DMHC
• Benefit Design	
• State mandates (to cover and to offer)	DMHC and CDI
• Essential health benefits (State required)	DMHC and CDI
• Basic health care services	DMHC and CDI
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI
• Actuarial value confirmation (using 2017-2019 Federal Actuarial Value Calculator as applicable.)	DMHC and CDI
• Network adequacy and accessibility standards are met	DMHC and CDI
• Provider contracts	DMHC and CDI
• Language Access	DMHC and CDI
• Uniform disclosure (summary of benefits and coverage)	DMHC and CDI
• Claims payment policies and practices	DMHC and CDI
• Provider complaints	DMHC and CDI
• Utilization review policies and practices	DMHC and CDI
• Quality assurance/management policies and practices	DMHC and CDI
• Enrollee/Member grievances/complaints and appeals policies and practices	DMHC and CDI
• Independent medical review	DMHC and CDI
• Marketing and advertising	DMHC and CDI
• Guaranteed issue individual and small group	DMHC and CDI
• Rating Factors	DMHC and CDI
• Medical Loss Ratio	DMHC and CDI
• Premium rate review	DMHC and CDI
• Geographic rating regions	
• Rate development and justification is consistent with ACA requirements	DMHC and CDI

[1]Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

3.1.2 Certification

Contractor shall comply with requirements for QHPs set forth in this Agreement and under the California Affordable Care Act, the Affordable Care Act and other State and Federal laws, rules and regulations. Contractor shall maintain timely compliance with standards required for certification that are issued, adopted or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange qualifies as a QHP.

3.1.3 Accreditation

a) Contractor agrees to maintain a current accreditation throughout the term of the Agreement from one of the following accrediting bodies: (i) Utilization Review Accreditation Commission (URAC); (ii) National Committee on Quality Assurance (NCQA); (iii) Accreditation Association for Ambulatory Health Care (AAAHC). Contractor shall authorize the accrediting agency to provide information and data to the Exchange relating to Contractor's accreditation, including the most recent accreditation survey and other data and information maintained by accrediting agency as required under 45 C.F.R. § 156.275.

b) Contractor shall be currently accredited and maintain its NCQA, URAC or AAAHC health plan accreditation throughout the term of the Agreement. Contractor shall notify the Exchange of the date of any accreditation review scheduled during the term of this Agreement and the results of such review. Upon completion of any health plan accreditation review conducted during the term of this Agreement, Contractor shall provide the Exchange with a copy of the Assessment Report within forty-five (45) days of report receipt.

c) If Contractor receives a rating of less than "accredited" in any category, loses an accreditation, or fails to maintain a current and up to date accreditation, Contractor shall notify the Exchange within ten (10) business days of such rating(s) change. Contractor will implement strategies to raise the Contractor's rating to a level of at least "accredited" or to reinstate accreditation. Contractor will submit a written corrective action plan (CAP) to the Exchange within forty-five (45) days of receiving its initial notification of the change in category ratings.

d) Following the initial submission of the corrective action plans ("CAPs"), Contractor shall provide a written report to the Exchange on at least a quarterly basis regarding the status and progress of the submitted corrective action plan(s). Contractor shall request a follow-up review by the accreditation entity at the end of twelve (12) months and submit a copy of the follow-up Assessment Report to the Exchange within thirty (30) days of receipt, if applicable.

e) In the event Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, the Exchange reserves the right to terminate any agreement by and between Contractor and the Exchange or suspend enrollment in Contractor's QHPs, to ensure the

Exchange is in compliance with the federal requirement that all participating issuers maintain a current approved accreditation pursuant to 45 C.F.R. § 156.275(a).

f) Upon request by the Exchange, Contractor will identify all health plan certification or accreditation programs undertaken, including any failed accreditation or certifications, and will also provide the full written report of such certification or accreditation undertakings to the Exchange.

3.1.4 Plan Naming Conventions

Contractor must adhere to Covered California's Plan Naming Conventions on all Regulator plan filings, marketing material, Enrollee material, and SERFF submissions.

3.1.5 Operational Requirements and Liquidated Damages

The timely and accurate submission of Contractor's QHP filings and documents to the Exchange for upload into CalHEERS is critical to the successful launch of each Renewal and Open Enrollment Period. When submissions are late, or inaccurate, the Exchange suffers financial harm with each resubmission and such actions put the Renewal and Open Enrollment process at risk. The parties agree that the liquidated damages below are proportional to the damages the Exchange incurs from each respective error made by Contractor. Therefore, Contractor agrees to meet the following operational requirements:

SERFF Template Completion
Contractor must submit complete and accurate SERFF Templates to the Exchange beginning with submissions for the 2017 Plan Year, and each year thereafter. The Exchange will participate in two rounds of validation with the Contractor. Contractor agrees to pay liquidated damages in the amount of $5,000 for each additional round of validation beyond the first two rounds. Changes to any or all of Contractor's SERFF Templates counts as one round of validation. If instructions provided by the Exchange include inaccurate information which necessitates an additional round of validation, or an additional round of validation is necessary due to required changes by Covered California or Contractor's regulator, those rounds of validation will not be counted in the two rounds of validations.

CalHEERS Test and Load Deadlines
Contractor must participate in CalHEERS testing and provide certification of plan data and documents in the CalHEERS pre-production environment. The pre-production environment is the test environment where the parties can validate templates and documents prior to the Renewal and Open Enrollment Periods. Following Contractor's certification of the QHPs in the pre-production environment, any subsequent upload required to correct Contractor's errors in the production environment will result in liquidated damages in the amount of $25,000 beginning with uploads for the 2017 Plan Year, and each year thereafter. One upload, for purposes of this paragraph, includes all plan data and documents that must be resubmitted to correct Contractor's errors.

Liquidated damages will not apply to additional uploads resulting from errors in the instructions provided by the Exchange, or changes required by Covered California or Contractor's regulator.

If liquidated damages are applied by the Exchange under this Section then no other remedies under Section 7.2.4 will apply to the Contractor for that same or any related action.

Deadlines for Regulatory Approval
The Exchange reserves the right to require that the Contractor receives regulatory approval for Licensure, rates, products, SBCs/EOCs, policy documents, Network, and Service Area prior to participating in the CalHEERS pre-production environment.

Communication with Plan Manager and the Exchange
Contractor must notify the Exchange in a timely manner of changes with operational impacts to the Exchange, Enrollees or CalHEERS (e.g. Contractor changes vendors that interface with CalHEERS). Contractor shall attempt to avoid making any operational changes that may impact CalHEERS thirty (30) days prior to and during each Renewal and Open Enrollment Period.

3.2 Benefit Standards

3.2.1 Essential Health Benefits

Each QHP offered by Contractor under the terms of this Agreement shall provide essential health benefits in accordance with the Benefit Plan Design requirements set forth at Attachment 2, and as required under this Agreement, and applicable laws, rules and regulations, including California Health and Safety Code § 1367.005, California Insurance Code § 10112.27, California Government Code § 100503(e) and as applicable, 45 C.F.R. § 156.200(b).

3.2.2 Standard Benefit Designs

During the term of this Agreement, Contractor shall offer the QHPs identified in Attachment 1 and provide the benefits and services at the cost-sharing and actuarial cost levels described in the Benefit Plan Design summarized at Attachment 2 ("Benefit Plan Designs"), and as may be amended from time to time under applicable laws, rules and regulations or as otherwise authorized under this Agreement.

3.2.3 Offerings Outside of the Exchange

a) Contractor acknowledges and agrees that as required under State and Federal law, QHPs and substantially similar plans offered by Contractor outside the Exchange must be offered at the

same premium rate whether offered inside the Exchange or outside the Exchange directly from the issuer or through an Agent.

b) In the event that Contractor sells products outside the Exchange, Contractor shall fairly and affirmatively offer, market and sell all products made available to individuals in the Exchange to individuals seeking coverage outside the Exchange consistent with California law.

c) For purposes of this Section, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Department of Health Care Services (DHCS) and health care service plans for Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the DHCS and health care service plans for enrolled Medi-Cal beneficiaries.

3.2.4 Pediatric Dental Benefits

When Contractor elects to embed and offer Pediatric Dental Essential Health Benefit services either directly, or through a subcontract with a dental plan issuer authorized to provide Specialized Health Care Services, Contractor shall require its dental plan subcontractor to comply with all applicable provisions of this Agreement, including, but not limited to, standard benefit designs for the embedded pediatric dental benefit, as well as any network adequacy standards applicable to dental provider networks and any pediatric dental quality measures as determined by the Exchange.

Coordination of Benefits. If a Contractor's Qualified Health Plan provides coverage for the Pediatric Dental Essential Health Benefit, Contractor shall include a Coordination of Benefits (COB) provision in its Evidence of Coverage or Policy Form that (i) is consistent with Health and Safety Code § 1374.19 or Insurance Code § 10120.2 and (ii) provides that the Qualified Health Plan is the primary dental benefit plan or policy under that COB provision. This provision shall apply to Contractor's QHPs offered both inside and outside of the Individual Exchange, except where 28 CCR § 1300.67.13 or 10 CCR § 2232.56 provides for a different order of determination for COB in the small group market.

3.2.5 Segregation of Funds

Contractor shall comply with federal requirements relating to the required segregation of funds received for abortion services in accordance with the Affordable Care Act Section 1303 and 45 C.F.R. § 156.280.

3.2.6 Prescription Drugs

a) Formulary changes. Except in cases where patient safety is an issue, Contractor shall give affected Exchange Enrollees, and their prescribing physician(s), sixty (60) days written notice prior to the removal of a drug from formulary status, unless it is determined that a drug must be removed for safety purposes more quickly. If Contractor is not reasonably able to provide sixty (60) days written notice, the Contractor must provide affected Enrollees with a sixty (60) day period to access the drug as if was still on the formulary, that begins on the date the drug is removed from the formulary. This notice requirement shall apply only to single source brand drugs and the notice shall include information related to the appropriate substitute(s). The notice shall also comply with all requirements of the Health and Safety Code and Insurance Code, including provisions prohibiting Contractor from limiting or excluding coverage for a drug to a Plan Enrollee in cases where the drug had been previously approved for coverage by Contractor for a medical condition of the Plan Enrollee, except under specified conditions. To the extent permitted in State and Federal law, an exception to the notice requirement will be allowed when Contractor continues to cover a drug prescribed for a Plan Enrollee without interruption and under the same conditions, including copayment and limits that existed prior to the removal of the drug from formulary status.

b) Internet Link to Formularies. Contractor shall comply with applicable State and Federal laws relating to prescription drug formularies, including posting the formularies for each product offered on the Contractor's website as required by Health and Safety Code § 1367.205 and Insurance Code §10123.192. Contractor shall provide to the Exchange and regularly update information necessary for the Exchange to link to the Contractor's drug formularies for each of the QHPs Contractor offers so that the Exchange can ensure it complies with its obligation under Government Code § 100503.1.

c) Contractor shall have an opt-out retail option for mail order drugs to allow consumers to receive in-person assistance, and this option shall have no additional cost. However, as specified in the standard benefit designs, Contractor may offer mail order prescriptions at a reduced cost-share.

d) Contractor shall provide consumers with an estimate of the range of costs for specific drugs.

e) Contractor shall have a sufficient number of customer service representatives available during call center hours for consumers and advocates to obtain clarification on formularies and consumer cost-shares for drug benefits.

3.3 Network Requirements

3.3.1 Service Areas

a) Service Area Listing. During each year of this Agreement, in conjunction with the establishment of Monthly Rates payable to Contractor under Article 5 below for each of the Contract Years, the Service Area listing set forth in Attachment 4 ("Service Area Listing") shall be amended to reflect any changes in the Service Area of Issuer's QHPs. Any such changes shall be effective as of January 1 of the applicable Contract Year. In the event ZIP codes are added to the current Service Area by the United States Postal Service, the parties agree such added ZIP codes shall be automatically included in the Service Area and shall be reflected in the next scheduled update of the Service Area Listing.

Contractor shall comply with the Exchange's standards, developed in consultation with Health Insurance Issuers, regarding the development of Service Area listings based on ZIP code, including, those relating to: (i) the timing of such submissions prior to the Open Enrollment Period, (ii) the assignment of Enrollees residing in ZIP codes split across two rating regions, and (iii) required updates and notice of changes in ZIP Codes within Contractor's region.

b) Withdrawal. Contractor shall not withdraw from any geographic region (as defined in Health and Safety Code § 1357.512 and California Insurance Code § 10753.14) for the individual market or modify any portion of its Service Area where Contractor provides Covered Services to Enrollees without providing prior written notice to, and obtaining prior written approval from the Exchange, which shall not be unreasonably denied, and to the extent required, the Health Insurance Regulator with jurisdiction over Contractor.

c) Service Area Eligibility. In order to facilitate the Exchange's compliance with State and Federal law, Contractor shall monitor information it receives directly, or indirectly or through its subcontractors to assure continued compliance with eligibility requirements related to participation of Qualified Individuals in the Individual Exchange, including requirements related to residency in the Contractor's service area.

Contractor shall notify the Exchange if it becomes aware that an individual Enrollee enrolled in a QHP of Contractor no longer meets the requirements for eligibility, based on place of residence. The Exchange will evaluate, or cause CalHEERS to evaluate, such information to determine Enrollee's continuing enrollment in the Contractor's Service Area under the Exchange's policies which shall be established in accordance with applicable laws, rules and regulations.

3.3.2 Network Adequacy

a) Network standards. Contractor's QHPs shall comply with the network adequacy standards established by the applicable Health Insurance Regulator responsible for oversight of

Contractor, including, those set forth at Health and Safety Code § 1367.03 and 28 CCR § 1300.67.2 (if Contractor is a licensed health care service plan) or Insurance Code § 10133.5 and 10 CCR § 2240 et seq. (if Contractor is regulated by CDI), and, as applicable, other laws, rules and regulations, including, those set forth at 45 C.F.R. 156.230. Contractor shall cooperate with the Exchange to implement network changes as necessary to address concerns identified by the Exchange.

b) Participating Provider Stability. Contractor shall maintain policies and procedures that are designed to preserve and enhance Contractor's network development by facilitating the recruitment and retention of Participating Providers necessary to provide access to Covered Services. Such policies and procedures shall be consistent with applicable laws, rules and regulations and will include an ongoing assessment of turnover rates of its Participating Providers to ensure that the turnover rates do not disrupt the delivery of quality care.

c) Notice of material network changes.

Contractor shall notify the Exchange with respect to changes in its provider network as follows:

i. Contractor shall notify the Exchange of any pending material change in the composition of its provider network within any of the regions it covers, or its participating provider contracts, of and throughout the term of this Agreement at least 60 days prior to any change or immediately upon Contractor's knowledge of the change if knowledge is acquired less than 60 days prior to the change, and cooperate with the Exchange in planning for the orderly transfer of plan members; and

ii. Contractor shall ensure that Exchange Enrollees have access to care when there are changes in the provider network, including but not limited to, mid-year contract terminations between Contractor and Participating Providers.

3.3.3 Essential Community Providers

a) ECP standard. Unless the Exchange determines that Contractor has qualified under the alternate standard for essential community providers pursuant to the Affordable Care Act, Contractor shall maintain a network that includes a sufficient geographic distribution of care, including essential community providers ("ECP"), and other providers available to provide reasonable and timely access to Covered Services for low-income, vulnerable, or medically underserved populations in each geographic region where Contractor's QHPs provide services to Enrollees. Contractor shall comply with other laws, rules and regulations relating to arrangements with ECPs, as applicable, including, those rules set forth at 45 C.F.R. § 156.235.

b) Sufficient geographic distribution. The Exchange shall determine whether Contractor meets the requirement of a sufficient geographic distribution of care, including ECPs, and other providers in its reasonable discretion, in accordance with the conditions set forth in the

Application, and based on a consideration of various factors, including: (i) the nature, type and distribution of Contractor's ECP contracting arrangements in each geographic rating region in which Contractor's QHPs provides Covered Services to Enrollees, (ii) the balance of hospital and non-hospital ECPs in each geographic rating region, (iii) the inclusion in Contractor's provider contracting network of at least 15% of entities in each applicable geographic rating region that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B) ("340B Entity"), (iv) the inclusion of at least one ECP hospital in each region, (v) the inclusion of Federally Qualified Health Centers, and county hospitals, and (vi) other factors as mutually agreed upon by the Exchange and the Contractor regarding Contractor's ability to serve the low income population.

c) Low-income populations shall be defined for purposes of the ECP requirements as families living at or below 200% of Federal Poverty Level. ECPs shall consist of participating entities in the following programs: (i) 340B Entity, (ii) California Disproportionate Share Hospital Program, per the Final DSH Eligibility List FY (CA DHCS 2012-13), (iii) Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs, (iv) Community Clinic or health centers licensed as either a "community clinic" or "free clinic", by the State under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Health and Safety Code §1206, and (v) Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program. The Exchange will post a non-exhaustive essential community provider list annually.

d) Notice of changes to ECP network. Contractor shall notify the Exchange with respect to any material change as of and throughout the term of this Agreement to its ECP contracting arrangements, geographic distribution, percentage coverage, ECP classification type (e.g., 340B), and other information relating to ECPs within thirty (30) business days of any change in ECP contracts.

   Contractor shall notify the Exchange of any pending material change in its ECP contracting arrangements at least 60 days prior to any change or immediately upon Contractor's knowledge of the change if knowledge is acquired less than 60 days prior to the change, and cooperate with the Exchange in planning for the orderly transfer of plan members.

e) Indian Health Care Providers. For Contractor's provider contracts entered into on or after January 1, 2015, Contractor shall reference the Centers for Medicare & Medicaid Services Model QHP Addendum for Indian Health Care Providers ("Addendum") along with the Overview of the Model QHP Addendum for Indian Health Care Providers ("CMS Overview") attached hereto as Attachment 12. Contractor is encouraged to adopt the Addendum whenever it contracts with those Indian health care providers specified in the Addendum. Adoption of the Addendum is not required; it is offered as a resource to assist Contractor in including specified Indian providers in its provider networks.

3.3.4 Special Rules Governing American Indians and Alaskan Natives

Contractor shall comply with applicable laws, rules and regulations relating to the provision of Covered Services to any individual enrolled in Contractor's QHP in the Individual Exchange who is determined by the Exchange to be an eligible American Indian or Alaskan Native as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d). Such requirements include the following:

a) Contractor shall cover Covered Services furnished through a health care provider pursuant to a referral under contract for directly furnishing an item or service to an American Indian with no cost-sharing as described in the Affordable Care Act § 1402 (d)(2).

b) Contractor shall not impose any cost-sharing on such individuals under three hundred (300) percent of federal poverty level ("FPL") in accordance with the Affordable Care Act § 1401(d)(1). The Exchange will have a transparent process to identify Alaskan Natives and American Indians, including a specific identification of those under 300% of FPL so the Contractor has information necessary to comply with Federal law.

c) Contractor shall provide monthly Special Enrollment Periods for American Indians or Alaskan Natives enrolled through the Exchange.

d) Contractor shall comply with other applicable laws, rules and regulations relating to the provision of Covered Services to American Indians, including, the Indian Health Care Improvement Act Sections 206 (25 U.S.C. 1621e) and 408 (25 U.S.C. 1647a).

3.3.5 Network Stability

a) Contractor shall implement policies and practices designed (i) to reduce the potential for disruptions in Contractor's provider networks, and (ii) to minimize the amount of uncertainty, disruption, and inconvenience of Enrollees in the execution of the transition of care as required under State laws, rules and regulations in connection with any such disruption. Contractor agrees to maintain adequate records, reasonably satisfactory to the Exchange, documenting its policies and its compliance with these requirements by Contractor and Participating Providers.

b) Block Transfers. If Contractor experiences a termination of a Provider Group(s) or hospital(s) that constitutes a block transfer as defined in Health and Safety Code § 1373.65 and Title 28, C.C.R. § 1300.67.1.3, Contractor shall provide the Exchange with copies of the written notices the Contractor proposes to send to affected Enrollees, in compliance with the notice requirements of Health and Safety Code § 1373.65, prior to mailing the notices to Enrollees.

c) Network Disruptions. If Contractor experiences provider network disruptions or other similar circumstances that make it necessary for Enrollees to change QHPs or Participating Providers, Contractor agrees to provide prior notice to the Exchange and Health Insurance Regulator, in

accordance with advance notice, meeting, and other requirements set forth in applicable laws, rules and regulations, including Insurance Code § 10199.1 and Health and Safety Code § 1367.23 and § 1366.1.

d) Enrollee transfers. In the event of a change in Participating Providers or QHPs related to network disruption, block transfers or other similar circumstances, Contractor shall, and shall require Participating Providers to, cooperate with the Exchange in planning for the orderly transfer of Enrollees as necessary and as required under applicable laws, rules, and regulations including, those relating to continuity of care set forth at Health and Safety Code § 1373.95 and Insurance Code § 10133.55.

3.4 Participating Providers

3.4.1 Provider Contracts

a) Contractor shall include in all of its contracts with Participating Providers the requirement for all Covered Services to be provided by duly licensed, certified or accredited Participating Providers consistent with the scope of their license, certification or accreditation and in accordance with applicable laws, rules, regulations, the standards of medical practice in the community and the terms set forth in agreements entered into by and between Contractor and Participating Providers ("Provider Agreement").

b) Contractor shall include in each Provider Agreement a requirement that Participating Providers comply with all other applicable laws, rules and regulations.

c) Contractor shall use commercially reasonable efforts to require the provisions of subsection (d) to be included in each: (i) Provider Agreement entered into by and between Contractor and a Participating Provider, and (ii) any subcontracting arrangement entered into by a Participating Provider.

d) Provision of Covered Services. Contractor shall undertake commercially reasonable efforts to ensure that each Participating Provider Agreement and each subcontracting arrangement entered into by each Participating Provider complies with the applicable terms and conditions set forth in this Agreement, as mutually agreed upon by the Exchange and Contractor, and which may include the following:

i. Coordination with the Exchange and other programs and stakeholders;

ii. Relationship of the parties as independent contractors (Section 1.3(a)) and Contractor's exclusive responsibility for obligations under the Agreement (Section 1.3(b));

iii. Participating Provider directory requirements (Section 3.4.4);

iv. Implementation of processes to enhance stability and minimize disruption to provider network (Section 3.3.5);

v. Notices, network requirements and other obligations relating to costs of out-of-network services and other benefits (Section 3.4.3);

vi. Provider credentialing, including, maintenance of licensure and insurance (Section 3.4.2);

vii. Customer service standards (Section 3.6);

viii. Utilization review and appeal processes (Section 4.3);

ix. Maintenance of a corporate compliance program (Section 1.2);

x. Enrollment and eligibility determinations and collection practices (Article 2);

xi. Appeals and grievances (Section 3.6.2);

xii. Enrollee and marketing materials (Section 2.4);

xiii. Disclosure of information required by the Exchange, including, financial and clinical (Section 1.13; Quality, Network Management and Delivery System Standards (Article 4) and other data, books and records (Article 10));

xiv. Nondiscrimination (Section 1.11);

xv. Conflict of interest and integrity (Section 1.12);

xvi. Other laws (Section 1.14);

xvii. Quality, Network Management and Delivery System Standards to the extent applicable to Participating Providers (Article 4), including, disclosure of contracting arrangements with Participating Providers as required pursuant to Attachment 7;

xviii. Performance Measures, to the extent applicable to Participating Providers (Article 6);

xix. Continuity of care, coordination and cooperation upon termination of Agreement and transition of Enrollees (Section 3.35 and Article 7);

xx. Security and privacy requirements, including compliance with HIPAA (Article 9); and

xxi. Maintenance of books and records (Article 10).

3.4.2 Provider Credentialing

Contractor shall perform, or may delegate activities related to, credentialing and re-credentialing Participating Providers in accordance with a process reviewed and approved by the applicable regulator.

3.4.3 Enrollee costs; Disclosure

Contractor shall, and shall require Participating Providers to, comply with applicable laws, rules and regulations governing liability of Enrollees for Covered Services provided to Enrollees, including, those relating to holding an Enrollee harmless from liability in the event Contractor fails to pay an amount owing by Contractor to a Participating Provider as required by Federal and State laws, rules and regulations.

To the extent that Contractor's QHPs either (i) provide coverage for out-of-network services or (ii) impose additional fees for such services, Contractor shall disclose to the Enrollee, at the Enrollee's request, the amount Contractor will pay for covered proposed non-emergency out-of-network services.

Contractor shall require its Participating Providers to inform every Enrollee in a manner that allows the Enrollee the opportunity to act upon a Participating Provider's proposal or recommendation regarding (i) the use of a non-network provider or facility or (ii) the referral of an Enrollee to a non-network provider or facility for proposed non-emergency Covered Services. Contractor shall require Participating Providers to disclose to an Enrollee considering accessing non-emergency services from a network provider if a non-network provider or facility will be used as part of the network provider's plan of care. The Contractor's obligation for this provision can be met through routine updates to its provider manual. Participating Providers may rely on Contractor's provider directory in fulfilling their obligation under this provision.

3.4.4 Provider Directory

Contractor shall make its provider directory available to (i) the Exchange electronically for publication online in accordance with guidance from the Exchange, and (ii) in hard copy when potential Enrollees make such request. Contractor shall provide information describing all Participating Providers in its QHP networks in a format prescribed by the Exchange on a monthly basis to support the Exchange's planned centralized provider directory containing every QHP's network providers, this includes testing, implementation and continued evaluation. Contractor acknowledges that the Exchange may use Contractor's Participating Provider data for any non-commercial purposes. If the Exchange's centralized provider directory is not operational, QHP Issuers shall continue to provide Participating Provider information to the Exchange on a monthly basis.

The network and directory information provided to the Exchange shall take into consideration the ethnic and language diversity of providers available to serve Enrollees of the Exchange.

3.5 Premium Rate Setting

3.5.1 Rating Variations

Contractor shall charge the premium rate in each geographic rating area for each of Contractor's QHPs as agreed upon with the Exchange. Contractor may vary premiums by geographic area as permitted by State law, including the requirements of Health Insurance Regulators regarding rate setting and rate variation set forth at Health and Safety Code Sections 1357.512 and 1399.855, Insurance Code Sections 10753.14 and 10965.9, 10 CCR § 2222.12 and, as applicable, other laws, rules and regulations, including, 45 C.F.R. § 156.255(b).

Contractor shall comply with rate filing requirements imposed by Health Insurance Regulators, including, those set forth under Insurance Code § 10181 et seq. (if Contractor is an insurer regulated by CDI) or Health and Safety Code § 1385 et seq. (if Contractor is a licensed HCSP regulated by DMHC) and as applicable, other laws, rules and regulations.

3.5.2 Individual Exchange Rates

For the Individual Exchange, rates shall be established through an annual negotiation process between the Contractor and the Exchange for the following calendar year. The parties acknowledge that: (1) the Agreement does not contemplate any mid-year rate changes for the Individual Exchange in the ordinary course of business, and (2) the annual negotiation process must be supported by Contractor through the submission of information in such form and at such date as shall be established by the Exchange to provide the Exchange with sufficient time for necessary analysis and actuarial certification.

3.5.3 Rate Methodology

Contractor shall provide, upon the Exchange's request, in connection with any contract negotiation or recertification process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Contractor shall provide justification, documentation and support used to determine rate changes, including providing adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange specific rate development process. Information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare Provider costs may also be requested to support the assumptions made in forecasting and may be supported by information from the Plan's actuarial systems pertaining to the Exchange-specific account.

3.5.4 Provider Rates

To the extent permitted by law and by Contractor's contracts with Participating Providers, Contractor agrees that the information to be provided to the Exchange under this Agreement may

include information relating to contracted rates between Contractor and Participating Providers that is treated as confidential information by Health Insurance Regulators pursuant to Insurance Code § 10181.7(b) and/or Health and Safety Code § 1385.07(b).

To the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, the Contractor shall identify the Participating Provider(s) and shall, upon renewal of its contract, make commercially reasonable efforts to obtain agreement by the Participating Provider(s) to amend such provisions to allow disclosure. In entering into a new contract with a Participating Provider, Contractor agrees to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange.

3.6 Customer Service Standards

3.6.1 Basic Customer Service Requirements

Contractor acknowledges that superior customer service is a priority of the Exchange. Contractor shall work closely with the Exchange in an effort to ensure that the needs of Exchange Enrollees are met. Contractor shall provide and maintain all processes and systems required to ensure customer service, record protection and uninterrupted service to the Exchange and Contractor's Enrollees in the Exchange in accordance with the standards set forth in this Section 3.6, applicable laws, rules and regulations, including, those consumer assistance tools and programs required to be offered through the Exchange as set forth at 45 C.F.R. § 155.205 and 45 C.F.R. § 155.210.

800 Numbers: Contractor shall make information available regarding the Exchange pursuant to Contractor's toll-free hotline (i.e., 1-800 number) that shall be available to Enrollees of Contractor both inside and outside the Exchange. The hotline and information services shall be staffed and operated in accordance with the Customer Service Standards set forth in this section 3.6 to provide support to Exchange Enrollees and in a manner designed to assure compliance with these Performance Standards.

Contractor shall meet all State requirements for language assistance services applicable to its commercial lines of business. The Exchange and Contractor will continue to evaluate on an ongoing basis the adequacy of language services provided for verbal and written communications and consider the adoption of additional standards as appropriate. Contractor shall maintain call statistics for languages other than English similar to 1.3 – 1.5 in Group 1 of Attachment 14. The Contractor shall provide this information to the Exchange upon request.

3.6.2 Enrollee Appeals and Grievances

a) Internal Grievances and Appeals. Contractor shall maintain an internal review process to resolve an Enrollee's written or oral expression of dissatisfaction regarding the Contractor and

Participating Providers, including appeals of claim and benefit determinations, and complaints relating to the scope of Covered Services required to be covered under the QHP. Contractor's processes shall comply with State and Federal laws, rules and regulations relating to Enrollee rights and appeals processes, specifically including grievance requirements set forth at Health and Safety Code § 1368, regardless of the Health Insurance Regulator for the Contractor's QHPs.

b) External Review. Contractor shall comply with State and Federal laws, rules and regulations relating to the external review process, including independent medical review, available to Enrollees for Covered Services.

3.6.3 Applications and Notices

a) Contractor shall provide applications, forms and notices to applicants and Enrollees in plain language and in a manner that is accessible and timely to individuals: (1) living with disabilities, including accessible websites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act, or (2) with limited English language proficiency.

b) Contractor shall provide applications, forms, and notices, including correspondence, in a manner that is accessible and timely to individuals who are limited English proficient as required by Health and Safety Code Section 1367.04 and Insurance Code Section 10133.8. Contractor shall inform individuals of the availability of the services described in this Section and otherwise comply with notice requirements imposed under applicable laws, rules and regulations, including, those set forth at 45 C.F.R. § 156.250 and Government Code § 100503(k).

3.6.4 Customer Service Call Center

a) During Open Enrollment Period, Contractor's call center hours shall be Monday through Friday eight o'clock (8:00) a.m. to eight o'clock (8:00) p.m. and Saturday eight o'clock (8:00) a.m.) to six o'clock (6:00) p.m. (Pacific Standard Time), except on holidays observed by the Exchange. During non-Open Enrollment Periods, the Contractor shall maintain call center hours Monday through Friday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m. and Saturday eight o'clock (8:00) a.m. to five o'clock (5:00) p.m. (Pacific Standard Time), however, Contractor may adjust Saturday hours as required by customer demand. Contractor shall inform the Exchange of its standard call center hours and any changes to the call center hours during non-Open-Enrollment Periods.

b) Contractor's call center shall be staffed at levels reasonably necessary to handle call volume and achieve compliance with Performance Standards set forth in Article 6. Contractor shall staff the Call Center with highly trained individuals to provide detailed benefit information,

answer Enrollee questions about QHP benefits and coverage, and to resolve claim and benefit issues.

c) Contractor shall use a telephone system that includes welcome messages in English, Spanish and other languages as required by State and Federal laws, rules and regulations.

d) Contractor shall make oral interpreter services available at no cost for non-English speaking or hearing impaired Enrollees during regular business hours as required by Federal and State law. Contractor shall monitor the quality and accessibility of call center services on an ongoing basis. Contractor shall report to the Exchange monthly, in a format determined by the Exchange, on the volume of calls received by the call center and Contractor's rate of compliance with related Performance Standards as outlined in Attachment 14.

e) Contractor shall meet all State requirements for language assistance services for all of its commercial lines of business.

3.6.5 Customer Service Transfers

a) During Contractor's regularly scheduled customer service hours, Contractor shall have the capability to accept and handle calls transferred from the Exchange and respond to callers requesting additional information from Contractor. Contractor shall maintain staff resources to comply with Performance Standards and sufficient to facilitate a live transfer (from the Exchange to Contractor) of customers who call the Exchange with escalated issues or complaints that need to be addressed by Contractor. The Exchange shall maintain staff resources sufficient to facilitate a live transfer (from Contactor to the Exchange) of customers who call Contractor with escalated issues, complaints, or address changes that need to be addressed by the Exchange. Contractor and the Exchange shall establish a designated customer service team available to handle the live transfer of escalated calls.

b) Examples of issues or complaints include but are not limited to premium billing or claims issues; benefit coverage questions (before and after enrollment); complaints; network or provider details; and Issuer-specific questions or issues.

c) Contractor shall refer Enrollees and applicants with questions regarding premium tax credits and Exchange eligibility determinations to the Exchange's website or Service Center, as appropriate.

d) Contractor shall work with the Exchange to develop a mechanism to track handling and resolution of calls referred from the Exchange to Contractor (such as through the use of call reference numbers).

3.6.6 Customer Care

a) Contractor shall comply with the applicable requirements of the Americans with Disabilities Act and provide culturally competent customer service to all the Exchange Enrollees in accordance with the applicable provisions of 45 C.F.R. § 155.205 and § 155.210, which refer to consumer assistance tools and the provision of culturally and linguistically appropriate information and related products.

b) Contractor shall comply with HIPAA rules and other laws, rules and regulations respecting privacy and security, as well as establish protocols for handling the Exchange customers who have documented domestic violence or other security concerns. Contractor shall monitor compliance and file these protocols with the Exchange annually.

3.6.7 Notices

a) For all forms of notices required under Federal and State law to be sent to Enrollees regarding rates, benefit design, network changes, or security/HIPAA references, Contractor shall submit an electronic copy to the Exchange at least five (5) business days in advance of the message transaction. If Contractor is unable to notify the Exchange in advance due to Federal or State notice requirements, Contractor shall send the Exchange notification simultaneously.

b) Contractor shall provide a link to the Exchange website on its website.

c) When Contractor provides direct contacts for getting membership assistance, Contractor shall also include the Exchange website for Exchange-related issues.

d) Contractor shall use standardized member renewal language, developed by the Exchange, and approved by DMHC and CDI for all Enrollee renewal notices.

e) All legally required notices sent by Contractor to Enrollees shall be translated into and available in languages other than English as required under applicable Federal and State laws, rules and regulations, including, Health and Safety Code §§1367.04, 1367.041, Insurance Code §§10133.8, and 10133.10.

f) Contractor shall release notices in accordance with Federal and State law. All such notices shall meet the accessibility and readability standards in the Exchange regulations (45 C.F.R. Parts 155 and 156) located in 10 CCR Sections 6400 et. seq.

3.6.8 Issuer-Specific Information

Upon request, Contractor shall provide training materials and participate in the Exchange customer service staff training.

Contractor shall provide summary information about its administrative structure and the QHPs offered on the Exchange. This summary information will be used by the Exchange customer service staff when referencing Contractor or QHP information.

3.6.9 Enrollee Materials: Basic Requirements

a) Contractor shall provide or make available to Enrollees Plan materials required under the terms of the Agreement and applicable laws, rules and regulations. Such materials shall be available in languages as required by Federal and State law and receive any necessary regulatory approvals from the relevant Regulators, be provided to the Exchange as directed by the Exchange, and shall include information brochures, a summary of the Plan that accurately reflects the coverage available under the Plan (a Summary of Benefits and Coverage) and related communication materials. Contractor shall, upon request by the Exchange, provide copies of Enrollee communications and give the Exchange the opportunity to comment and suggest changes in such material.

b) Enrollee materials shall be available in English, Spanish and other languages as required by applicable laws, rules and regulations. Contractor shall comply with Federal and State laws, rules and regulations regarding language access. To the extent possible, Enrollee materials shall be written in plain language, as that term is defined in applicable laws, rules and regulations. Plan materials that require Exchange notification before usage are those that communicate specific eligibility and enrollment and other key information to Enrollees. Such materials may include, but are not limited to:

   i. Welcome letters;

   ii. Enrollee ID card with the same product name as used in the Covered CA and issuer websites;

   iii Billing notices and statements;

   iv. Notices of actions to be taken by Plan that may impact coverage or benefit letters;

   v. Termination Grievance process materials;

   vi. Drug formulary information;

   vii. Uniform Summary of Benefits and Coverage; and

   viii. Other materials required by the Exchange.

3.6.10 New Enrollee Enrollment Packets

a) Contractor shall mail or provide online enrollment packets to all new Individual Exchange Enrollees in individual Exchange QHPs within ten (10) business days of receiving complete

and accurate enrollment information from the Exchange and the binder payment. Contractor may deliver Enrollee materials pursuant to other methods that are consistent with: (1) Contractor's submission of materials to Enrollees of its other plans; (2) the needs of Enrollees; (3) the consent of the Enrollee; and (4) with applicable laws, rules and regulations. Contractor shall report to the Exchange monthly, in a format mutually agreed upon by the Exchange and Contractor, on the number and accuracy rate of identification cards that were sent to new Enrollees and Contractor's compliance with the Performance Standards set forth in this Agreement. The enrollment packet shall include, at the minimum, the following:

i. Welcome letter;

ii. Enrollee ID card, in a form approved by the Exchange;

iii. If Enrollee ID card is not included in the enrollment packet, Contractor must send a notice to the Enrollee that states the ID card will be sent separately, when the Enrollee should expect to receive it, and provide the information necessary for the Enrollee to receive services and for providers to file claims;

iv. Summary of Benefits and Coverage;

v. Pharmacy benefit information;

vi. Nurse advice line information; and

vii. Other materials required by the Exchange.

b) Contractor shall maintain access to enrollment packet materials; Summary of Benefits and Coverage ("SBC"); claim forms and other Plan-related documents in both English and Spanish and any other languages required by State and Federal laws, rules and regulations to the extent required to timely meet all requirements of this Agreement for timely mailing and delivery of Plan materials to Enrollees. Contractor shall be responsible for printing, storing and stocking, as applicable, all materials.

3.6.11 Summary of Benefits and Coverage

Contractor shall develop and maintain an SBC as required by Federal and State laws, rules and regulations. The SBC must be available online and the hard copy sent to Enrollees on request shall be available to Enrollees in English, Spanish, and other languages as required by Federal and State laws, rules and regulations. Contractor shall update the SBC annually and Contractor shall make the SBC available to Enrollees pursuant to Federal and State laws, rules and regulations.

3.6.12 Electronic Listing of Participating Providers

Contractor shall create and maintain a continually updated electronic listing of all Participating Providers and make it available online for Enrollees, potential Enrollees, and Participating Providers, 24 hours a day, 7 days a week as required by Federal and State laws, rules and regulations, including requirements to identify Providers who are not accepting new Enrollees.

3.6.13 Access to Medical Services Pending ID Card Receipt

Contractor shall promptly coordinate and ensure access to medical services for Enrollees who have not received ID cards but are eligible for services.

3.6.14 Explanation of Benefits

Contractor shall send each Enrollee, by mail, an Explanation of Benefits (EOB) to Enrollees in Plans that issue EOBs or similar documents as required by Federal and State laws, rules and regulations. The EOB and other documents shall be in a form that is consistent with industry standards.

3.6.15 Secure Plan Website for Enrollees and Providers

Contractor shall maintain a secure website, 24 hours, 7 days a week. All content on the secure Enrollee website shall be available in English and Spanish and any other languages required under State and Federal law. If Contractor is new to offering coverage on the Exchange, Contractor shall meet the requirements of this section within ninety (90) days after the Effective Date of this Agreement. The secure website shall contain information about the Plan, including, but not limited to, the following:

a) Upon implementation by Contractor, benefit descriptions, information relating to covered services, cost sharing and other information available;

b) Ability for Enrollees to view their claims status such as denied, paid, unpaid;

c) Ability to respond via e-mail to customer service issues posed by Enrollees and Participating Providers;

d) Ability to provide online eligibility and coverage information for Participating Providers;

e) Support for Enrollees to receive Plan information by e-mail; and

f) Enrollee education tools and literature to help Enrollees understand health costs and research condition information.

3.6.16 Standard Reports Contractor shall submit standard reports pursuant to Attachment 13. Upon request, Contractor shall submit standard reports as described below in a mutually agreed upon manner and time:

a) Enrollee customer service reports including phone demand and responsiveness, initial call resolution, response to written correspondence, and number/accuracy/timeliness of ID card distribution.

b) Contractor shall provide utilization data regarding its nurse advice line based on its current standard reporting. Contractor and the Exchange shall work together in good faith to identify mutually agreeable information for Contractor to provide to the Exchange that will be useful in identifying patterns of utilization, including regarding health conditions or symptoms that are frequent topics of calls from Contractor's members.

c) Use of Plan website;

d) Quality assurance activities;

e) Enrollment reports; and

f) Premiums collected.

3.6.17 Contractor Staff Training about the Exchange

Contractor shall arrange for and conduct staff training regarding the relevant laws, mission, administrative functions and operations of the Exchange, including Exchange program information and products in accordance with Federal and State laws, rules and regulations, using training materials developed by the Exchange.

Upon request by the Exchange, Contractor shall provide the Exchange with a list of upcoming staff trainings and make available training slots for Exchange staff to attend upon request.

3.6.18 Customer Service Training Process

Contractor shall demonstrate to the Exchange that it has in place initial and ongoing customer service protocols, training, and processes to appropriately interface with and participate in the Exchange. As part of this demonstration, Contractor shall permit the Exchange to inspect and review its training materials. The Exchange will share its customer service training modules with Contractor.

ARTICLE 4 – QUALITY, NETWORK MANAGEMENT AND DELIVERY SYSTEM STANDARDS

4.1 Exchange Quality Initiatives

The parties acknowledge and agree that furthering the goals of the Exchange require Contractor to work with the other QHP Issuers and its contracted providers to play an active role in building and supporting models of care to meet consumer and social needs for providing better care, promoting health and lowering per capita costs through improvement.

Contractor agrees to work with the Exchange to develop or participate in initiatives to promote models of care that (i) target excessive costs, (ii) minimize unpredictable quality, (iii) reduce inefficiencies of the current system, and (iv) promote a culture of continuous quality and value improvement, health promotion, and the reduction of health disparities to the benefit of all Enrollees and, to the extent feasible, other health care consumers.

In order to further the mission of the Exchange with respect to these objectives and provide the Covered Services required by Enrollees, the Exchange and Contractor shall coordinate and cooperate with respect to quality activities conducted by the Exchange in accordance with the mutually agreeable terms set forth in this Section and in the Exchange's Quality, Network Management and Delivery System Standards set forth at Attachment 7 ("Quality, Network Management and Delivery System Standards").

4.2 Quality Management Program

Contractor shall maintain a quality management program to review the quality of Covered Services provided by Participating Providers and other subcontractors. Contractor's quality management program shall be subject to review by the Exchange annually to evaluate Contractor's compliance with requirements set forth in the Quality, Network Management and Delivery System Standards.

Contractor shall coordinate and cooperate with the Exchange in developing the Quality, Network Management and Delivery System Standards, including (i) participating in meetings and other programs as reasonably requested from time to time by the Exchange, and (ii) providing mutually agreed upon data and other information required under the Quality, Network Management and Delivery System Standards and (iii) as otherwise reasonably requested by the Exchange. The parties acknowledge and agree that quality related activities contemplated under this Article 4 will be subject to and conducted in compliance with any and all applicable laws, rules and regulations including those relating the confidentiality of medical information and will preserve all privileges set forth at Health and Safety Code § 1370.

4.3 Utilization Management

Contractor shall maintain a utilization management program that complies with applicable laws, rules and regulations, including Health and Safety Code § 1367.01 and other requirements established by the applicable regulator responsible for oversight of Contractor.

4.4 Transparency and Quality Reporting

a) Pursuant to 45 C.F.R. § 156.220, Contractor shall provide the Exchange and Enrollees with information reasonably necessary to provide transparency in Contractor's coverage, and report to the Exchange and Enrollees, the data as required by the Exchange. This includes information relating to claims payment policies and practices, periodic financial disclosures, enrollment, disenrollment, claims denials, rating practices, cost-sharing, payments with respect to any out-of-network coverage, and Enrollee rights. Contractor shall provide information required under this Section to the Exchange and Enrollees in plain language.

b) Contractor shall timely respond to an Enrollee's request for cost sharing information and shall make cost sharing information available to individuals through the internet and pursuant to other means for individuals without internet access in a timely manner.

4.5 Quality Rating System

Contractor shall collect and annually report to the Exchange, for each QHP Product Type, its Health Care Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Health Care Providers and Systems (CAHPS) data and other performance data (numerators, denominators, and rates) as required for the federal Quality Rating System and as outlined in Attachments 7 and 14 of this Agreement.

4.6 Quality Improvement Strategy

As part of a new federal requirement in 2017, all health plans with two (2) years of state-based Exchange experience will participate in a Quality Improvement Strategy (QIS). (For more information, visit: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QIS-Technical-Guidance-and-User-Guide.pdf.)

The Exchange has harmonized federal QIS requirements to align with 2017 quality strategy and direction. As part of a federally mandated Quality Improvement Strategy, Contractor must identify the mechanisms planned to promote improvements in health care quality and access to care, population health outcomes, and making care more affordable for each QIS strategy initiative listed in Section 8 of the 2017 Application for Certification. Contractor shall annually report to the Exchange its Quality Improvement Strategy as part of the Application for Certification.

4.7 Data Submission Requirements

Contractor shall provide to the Exchange information regarding Contractor's membership through the Exchange in a consistent manner to that which Contractor currently provides to its major purchasers as described in 2.02 of Attachment 7.

ARTICLE 5 – FINANCIAL PROVISIONS

5.1 Individual Exchange

5.1.1 Rates and Payments

a) Schedule of Rates. The Exchange and Contractor have agreed upon monthly premium rates ("Monthly Rates") payable to Contractor as compensation for Services provided under this Agreement. The Monthly Rates for the Individual Exchange for Plan Year 2017 are set forth at Attachment 8 ("Monthly Rates - Individual Exchange"), and will be updated annually for Plan Years 2018 and 2019 in Attachment 9. The parties acknowledge and agree that the premium amounts set forth under the Monthly Rates are actuarially determined to ensure that premium revenues and cost sharing contributions will provide the total dollar amount necessary to support (i) the provision of Covered Services by Contractor through its QHPs, (ii) administrative expenses and reasonable reserves required by Contractor to meet the requirements outlined in this Agreement and in accordance with applicable laws, rules and regulations, and (iii) the payment by Contractor of the Participation Fee, as further described in Section 5.1.3.

b) Updates. If the Term of this Agreement is longer than one year and Contractor's QHPs are certified for another year, the Monthly Rates for each subsequent year of the Agreement will be established no more frequently than annually in accordance with the procedures set forth at and Section 3.5 and Attachment 9 ("Rate Updates - Individual Exchange").

c) Collection and Remittance. Contractor understands that Contractor is responsible for collection and the Enrollee is responsible for remittance of the agreed-upon premium rates to Contractor in a timely manner. Contractor understands that individual Enrollees will remit their monthly premium payments directly to Contractor and the Exchange will not aggregate premiums. The failure by an Enrollee to timely pay premiums may result in a termination of coverage pursuant to the terms set forth at Section 2.2.4. Contractor further understands that the premium payment collected by Contractor includes amounts allocated to the Participation Fee due to the Exchange. The Participation Fees shall be billed by the Exchange to Contractor and payable by Contractor to the Exchange in accordance with the requirements set forth at Section 5.1.3.

5.1.2 Financial Consequences of Non-Payment of Premium

a) Premium payment rules. Contractor is responsible for enforcement of premium payment rules at its own expense, as outlined in the terms set forth in the Evidence of Coverage regarding the failure by Enrollee to pay the premium in a timely manner as directed by the Enrollee policy agreement and in accordance with applicable laws, rules and regulations. Enforcement by Contractor shall include, but not be limited to, chargebacks, delinquency and termination

actions and notices, grace period requirements and partial payment rules. Such enforcement shall be conducted in accordance with requirements in this Agreement consistent with applicable laws, rules and regulations.

b) Enrollee Terminations. In the event Contractor terminates an Enrollee's coverage in a QHP due to non-payment of premiums, loss of eligibility, fraud or misrepresentation, change in Enrollees selection of QHP, decertification of Contractor's QHP or as otherwise authorized under Section 2.2.4, Contractor must include the applicable regulator-approved appeals language, and any Exchange-required appeals language, in its notice of termination of coverage to the Enrollee.

c) Grace Period. Contractor acknowledges and agrees that applicable laws, rules and regulations, including the Affordable Care Act and implementing regulations specify a grace period for individuals who receive advance payments of the premium tax credit through the Exchange and that the Knox-Keene Act and Insurance Code set a grace period for other individuals with respect to delinquent payments. Contractor agrees to abide by the requirements set forth at Section 2.2.4 and required under applicable laws, rules and regulations with respect to these grace periods.

5.1.3 Individual Exchange Participation Fees

a) Contractor understands and agrees that: (i) under the Affordable Care Act and the California Affordable Care Act, the Exchange may generate funds through a participation fee ("Participation Fees") on Contractor's QHPs and (ii) Contractor is responsible for the timely payment of any Participation Fees to the Exchange.

b) Contractor recognizes that the total cost of all Participation Fees for the Exchange must be spread across Contractor's entire book of business in the single risk pool (both inside and outside the Exchange) for the Individual Market.

c) The Participation Fee payable to the Exchange during each month of this Agreement shall be equal to four (4) percent of the gross premium attributable to each Enrollee in Contractor's QHPs for such month. The Participation Fee will be assessed by the Exchange and payable monthly by Contractor based on premiums paid by Enrollees in Contractor's QHPs sold through the Individual Exchange for 2017 - 2019. The Participation Fee will be reviewed each year as part of the Exchange's annual budget process. Should the Exchange need to collect or refund any premiums for year 2014-2016, the Participation Fee shall be calculated pursuant to the QHP Issuer Agreement that was in place during the applicable plan year or years.

d) Participation Fee invoices will be issued by the Exchange retroactively to Contractor on the 15th of the month for the previous month. Contractor's Participation Fee obligation will be determined and billed by evaluating Contractor's then-current QHP confirmed enrollment and may be subject to adjustment to reflect changes in enrollment that may have occurred in prior

months (including additions, terminations and cancellations of enrollment). Participation Fee payments will be due on the 25th of the following month the Participation Fee covers. For Participation Fees received after the 25th of the month in which the Participation Fee is due, the Exchange will charge, and Contractor shall owe, a 1% per month late fee on the unpaid balance as of that date.

e) In the event that Contractor disputes the amount of Participation Fees billed or deducted by the Exchange, Contractor shall submit a written notice of such dispute to the Exchange within thirty (30) days following receipt of such bill or deduction by the Exchange. Contractor's notice will document the nature of the discrepancies, including, reconciliation of any differences identified by Contractor in enrollment or premiums collected. The Exchange will respond to Contractor within forty-five (45) days of receipt of the notice by either (i) paying the amount claimed by Contractor or (ii) providing a detailed explanation for the denial of the refund. If the Contractor still disputes the findings of the Exchange, Contractor may pursue additional remedies in accordance with Section 12.1.

f) Subject to the provisions of Section 10.5, Contractor agrees to a periodic audit or other examination by the Exchange or its designee regarding the computation and payment of Participation Fees. In the case of material non-compliance with Participation Fee payments, Contractor shall implement any necessary corrective action. The Exchange may perform follow up audits or examinations more frequently than annually to monitor Contractor's implementation of such corrective actions.

g) Contractor acknowledges that the Exchange is required under Government Code §100520(c) to maintain a prudent reserve as determined by the Exchange.

ARTICLE 6 – PERFORMANCE STANDARDS

6.1 Standards

Contractor shall comply with the performance standards set forth in Attachment 14 ("Performance Standards"). The Exchange shall conduct or arrange for the conduct of a review of Contractor's performance under the Performance Measures. The Exchange shall be responsible for the actual and reasonable costs of the review, including the costs of any third-party designated by the Exchange to perform such review. The review shall be in addition to any ongoing monitoring that may be performed by the Exchange with respect to the Performance Measures.

The Exchange and Contractor shall agree to performance standards for the Exchange, which, if not satisfied, will provide credits to Contractor which can be applied to any penalties accrued to Contractor. Such credits may reduce up to 15% of Contractor's performance penalties that may be assessed under Section 6.2 below.

6.2 Penalties and Credits

The Exchange may impose penalties ("penalties") in the event that Contractor fails to comply or otherwise act in accordance with the Performance Measures. The Exchange shall also administer and calculate credits ("credits") that may offset or reduce the amount of any performance penalties, but in no event shall such credits exceed the total amount of the penalty levied. Penalties and credits will be calculated in accordance with Attachment 14.

6.3 No Waiver

The Exchange and Contractor agree that the failure to comply with the Performance Standards may cause damages to the Exchange and its Enrollees which may be uncertain and impractical or difficult to ascertain. The parties agree that the Exchange shall assess, and Contractor promises to pay the Exchange, in the event of such delayed, or failed performance that does not meet the Performance Standards, the amounts to be determined in accordance with the Performance Standards set forth at Attachment 14.

The assessment of fees relating to the failure to meet Performance Standards shall be subject to the following: (1) be determined in accordance with the amounts and other terms set forth in the Performance Standards, (2) be cumulative with other remedies available to the Exchange under the Agreement, (3) not be deemed an election of remedies, and (4) not constitute a waiver or release of any other remedy the Exchange may have under this Agreement for Contractor's breach of this Agreement, including, without limitation, the Exchange's right to terminate this Agreement. The Exchange shall be entitled, in its discretion, to recover actual damages caused by Contractor's failure to perform its obligations under this Agreement.

ARTICLE 7 – CONTRACT TERM; RECERTIFICATION AND DECERTIFICATION

7.1 Agreement Term

The term of this Agreement is specified on the STD 213, which is the signature page of this Agreement.

7.2 Agreement Termination

7.2.1 Exchange Termination

The Exchange may, by ninety (90) days' written notice to Contractor, and without prejudice to any other of the Exchange remedies, terminate this Agreement for cause based on one or more of the following occurrences:

a) Contractor fails to fulfill an obligation that is material to its status as a QHP Issuer or its performance under the Agreement;

b) Contractor no longer holds a license or certificate that is required for Contractor to perform its obligations under this Agreement /or Contractor otherwise fails to maintain compliance with the "good standing" requirements pursuant to Section 3.1.1 and which impairs Contractor's ability to provide Services under the Agreement;

c) Contractor breaches any material term, covenant, warranty, or obligation under this Agreement that is not cured or substantially cured to the reasonable satisfaction of the Exchange within forty-five (45) days after receipt of notice of default from the Exchange; provided, however, that such cure period may not be required and the Exchange may terminate the Agreement immediately if the Exchange determines pursuant to subparagraph (e) below that Contractor's breach threatens the health and safety of Enrollees;

d) Contractor knowingly has a director, officer, partner, or person with a beneficial ownership of more than five percent (5%) of Contractor's equity or has an employment, consulting or other subcontractor agreement for the provision of Services under this Agreement who is, or has been: (A) excluded, debarred, or suspended from participating in any federally funded health care program, (B) suspended or debarred from participation in any state contract or procurement process, or (C) convicted of a felony or misdemeanor (or entered a plea of nolo contendere) related to a crime or violation involving the acquisition or dispersal of funds or delivery of Covered Services to beneficiaries of any State or Federal health care program;

e) The Exchange reasonably determines that (i) the welfare of Enrollees is in jeopardy if this Agreement continues, as such determination shall be made in the reasonable discretion of the Exchange based on consideration of professionally recognized standards and benchmarks, requirements imposed by accreditation agencies and applicable laws, rules and regulations; or

(ii) Contractor fails to comply with a change in laws, rules or regulations occurring during the term of this Agreement and/or does not take any and all actions that may be required to amend the Agreement and otherwise establish and document compliance with any such changes; and (iii) the Exchange reasonably determines, based on consultation with legal counsel and/or other regulators and/or other State-based or Federal health benefit exchanges, that it may be at risk of being found noncompliant with Federal or State laws, rules or regulations.

7.2.2 Contractor Termination

Contractor may, by ninety (90) days' written notice to the Exchange, and without prejudice to any other of the remedies, terminate this Agreement for cause based on one or more of the following occurrences:

a) The Exchange breaches any material term, covenant, warranty, or obligation under this Agreement that is not cured or substantially cured to the reasonable satisfaction of the Contractor within forty-five (45) days after receipt by the Exchange of notice from the Contractor; or

b) The Exchange fails to comply with a change in laws, rules or regulations occurring during the term of this Agreement or does not take any and all actions that may be required to amend the Agreement and otherwise establish and document compliance with any such changes, and Contractor reasonably determines, based on consultation with legal counsel and/or other regulators and/or other State-based or Federal health benefit exchanges, that it may be at risk of being found noncompliant with Federal or State laws, rules or regulations.

7.2.3 Notice of Termination

If the Exchange determines, based on reliable information, that there is a substantial probability that Contractor will be unable to continue performance under this Agreement or Contractor will be in material breach of this Agreement in the next thirty (30) days, then the Exchange shall have the option to demand that Contractor provide the Exchange with a reasonable assurance of performance. Upon Contractor's receipt of such a demand from the Exchange, Contractor shall provide to the Exchange a reasonable assurance of performance responsive to the Exchange's demand. If Contractor fails to provide assurance within ten (10) days of the Exchange's demand that demonstrates Contractor's reasonable ability to avoid such default or cure within a reasonable time period not to exceed thirty (30) days, the failure shall constitute a breach by Contractor justifying termination of the Agreement by the Exchange.

In case a party elects to terminate this Agreement in whole or in part under Section 7.2, the notifying party shall give the other party ninety (90) days written notice of termination for default, specifying the default or defaults justifying the termination. The termination shall become effective after the expiration of such notice period if the defaults specified by the notifying party in its notice remain uncured at that time; provided, however, that the Exchange

may require Contractor to discontinue the provision of certain Services if the Exchange determines that the continuing provision of services may cause harm to Enrollees, Participating Providers or other stakeholders.

The Exchange shall be entitled to retain any disputed amounts that remain in the possession of the Exchange until final resolution of all claims by the parties against each other arising out of any Contractor default alleged by the Exchange.

7.2.4 Remedies in Case of Contractor Default or Breach

a) In addition to the termination provisions in section 7.2.1, the Exchange shall have full discretion to institute any of the following remedies, in accordance with subsection b) of this section, in case of Contractor's breach, whether material or not, or default:

   i. Changing the order in which Contractor's QHPs are displayed in CalHEERS or Shop and Compare;

   ii. Removing Contractor's provider directory from the Covered California website;

   iii. Freezing Contractor's Enrollment during Open or Special Enrollment Periods;

   iv. Recovery of damages to the Exchange caused by the breach or default; and

   v. Specific performance of particular covenants made by Contractor hereunder.

b) Prior to instituting any of the remedies in subsection a), the Exchange shall provide written notice to Contractor that Contractor is in breach or default of this Agreement, identify the basis for such breach or default, and provide Contractor with a thirty (30) day period to cure. During the cure period, the parties agree to meet and confer in an effort to informally resolve the breach or default. Contractor shall have thirty (30) days from the date Contractor received notice of the breach or default to fully cure the breach or default, unless the parties mutually agree to a longer cure period. If Contractor has not cured the breach or default within the thirty (30) day period, or a longer cure period that has been mutually agreed upon, the Exchange may institute any of the remedies identified in subsection a) of this section. All remedies of the Exchange under this Agreement for Contractor default or breach are cumulative to the extent permitted by law.

c) This section shall not apply to any contractual requirements that are associated with a performance guarantee in Attachment 14 or for failure to meet any quality targets in Attachment 7.

7.2.5 Contractor Insolvency

Contractor shall notify the Exchange immediately in writing in the event that Contractor files any federal bankruptcy action or state receivership action, any federal bankruptcy or state receivership

action is commenced against Contractor, Contractor is adjudicated bankrupt, or a receiver is appointed and qualifies. In case any of the foregoing events occurs, the Exchange may terminate this Agreement upon five (5) days written notice. If the Exchange does so, the Exchange shall have the right to recover damages from Contractor as though the Agreement had been terminated for Contractor default.

7.3 Recertification

7.3.1 Recertification Process

During each year of this Agreement, the Exchange will evaluate Contractor for recertification based on an assessment process conducted by the Exchange in accordance with its procedures and on a basis consistent with applicable laws, rules and regulations, including, the requirements set forth under the California Affordable Care Act, 10 CCR 6400 et seq., and the Affordable Care Act. The Exchange shall consider the Contractor for recertification unless (i) the Agreement is terminated sooner than the Expiration Date by the Exchange in accordance with the requirements set forth at Section 7.2 or pursuant to other terms set forth in the Agreement, or (ii) Contractor makes a Non-Recertification Election pursuant to Section 7.3.2.

7.3.2 Non-Recertification Election

a) Contractor election. Contractor shall provide the Exchange with notice on or before July 1 of each Plan Year whether Contractor will elect to not seek recertification of its QHPs for the following Plan Year ("Non-Recertification Election"). Contractor shall comply with conditions set forth in this Section 7.3.2 with respect to continuation of coverage and transition of Enrollees to new QHPs following the Exchange's receipt of Contractor's Non-Recertification Election.

b) Continuation and Transition of Care. Except as otherwise set forth in this Section 7.3.2, Contractor shall continue to provide Covered Services to Enrollees in accordance with the terms set forth in the Agreement from and after Contractor's Non-Recertification Election up through the termination of coverage for Enrollees, as such termination of coverage shall be determined in accordance with the requirements of this section.

   Contractor shall take any further action reasonably required by the Exchange to provide Covered Services to Enrollees and transition care following the Non-Recertification Election.

   Contractor shall coordinate and cooperate with respect to communications to Enrollees in the Individual Exchange and other stakeholders regarding the transition of Enrollees to another QHP.

c) Individual Exchange. The following provisions shall apply to the Individual Exchange:

i. During the thirty (30) day period following the Exchange's receipt of the Non-Recertification Election, Contractor may (i) be removed from the enrollment and eligibility assignment process, and (ii) no longer receive assignment of new Enrollees;

ii. Contractor will provide coverage for Enrollees assigned to Contractor as of the date of the Non-Recertification Election if coverage commences within the sixty (60) day period following the Notice of Non-Recertification. Contractor shall provide coverage for such Enrollees until the earlier of (i) the end of the Contract Year, or (ii) the Enrollee's transition to another QHP during the Special Enrollment Period; and

iii. Contractor shall provide coverage for Enrollees until the earlier of (i) the end of the Plan Year, or (ii) the Enrollee's transition to another QHP during a Special Enrollment Period.

7.4 Decertification

Notwithstanding any other language set forth in this Section 7.4, the Agreement shall expire on the Expiration Date set forth in Section 7.1 in the event that the Exchange elects to decertify Contractor's QHP based on the Exchange's evaluation of Contractor's QHP during the recertification process that shall be conducted by Exchange pursuant to Section 7.2.

7.5 Effect of Termination

a) This Agreement shall terminate on the Expiration Date unless otherwise terminated earlier in accordance with the provisions set forth in this Agreement.

b) Contractor's QHPs shall be deemed decertified and shall cease to operate as QHPs as defined at 10 CCR § 6410 immediately upon termination or expiration of this Agreement in the event uninterrupted continuation of agreement between the Exchange and Contractor is not achieved pursuant to either: (i) an extension of the term of the Agreement based upon the mutual agreement of the parties that is documented pursuant to a written amendment, or (ii) Contractor and the Exchange enter into a new agreement that is effective immediately upon the expiration of this Agreement. There shall be no automatic renewal of this Agreement or recertification of Contractor's QHPs upon expiration of the term of this Agreement. Contractor may appeal the decertification of its QHP that will result in connection with the termination of this Agreement and such appeal shall be conducted pursuant to the Exchange's process and in accordance with applicable laws, rules and regulations.

c) All duties and obligations of the Exchange and Contractor shall cease upon termination of the Agreement and the decertification of Contractor's QHPs that shall occur upon the termination of this Agreement, except as set forth below or otherwise provided in the Agreement:

i. Each party shall remain liable for any rights, obligations, or liabilities that have accrued or arise from activities carried on by it under this Agreement prior to the effective date of termination.

ii. Any information of the other party that is in the possession of the other party will be returned promptly, or upon the request of owner of such property, destroyed using reasonable measures to protect against unauthorized access to or use of the information in connection with its destruction, following the earlier of: (i) the termination of this Agreement, (ii) receipt of a written request to return or destroy the Information Assets, or (iii) the termination of the business relationship between the Parties. If both Parties agree that return or destruction of information is not feasible or necessary, the receiving Party will continue to extend the protections outlined in this Agreement to all assets in its possession and will limit further use of that information to those purposes that make the return or destruction of the information or assets. The Exchange reserves the right to inspect the storage, processes, and destruction of any Information Assets provided under this Agreement.

d) Contractor shall comply with the requirements set forth at Section 7.3.2 in the event that Contractor makes a Non-Recertification Election.

e) Contractor shall cooperate fully to effect an orderly transfer of Covered Services to another QHP during (i) any notice period set forth at Sections 7.2.3, 7.2.5 or 7.3.2, and (ii) if requested by the Exchange to facilitate the transition of care or otherwise required under Section 7.6, following the termination of this Agreement. Such cooperation shall include the following:

i. Upon termination, Contractor, if offering a HMO, shall complete the processing of all claims for benefit payments under the QHP for Covered Services other than Capitated Services, and if offering a PPO, shall complete the processing of all medical claims for benefit payments under Contractor's QHP for Covered Services rendered on or before the termination date.

ii. Contractor will provide communications developed or otherwise approved by the Exchange to communicate new QHP information to Enrollees in accordance with a timeline to be established by the Exchange.

iii. In order to ensure the proper transition of Services provided prior to, and subsequent to, termination, Contractor will forward to any new QHP Issuer the electronic and direct paper claims that are received by Contractor but which relate to Services provided by new contractor. Any such information shall be subject to compliance with applicable laws, rules and regulations and shall be sent at such time periods and in the manner requested by the Exchange for a period of up to three (3) months following the termination date.

iv. Contractor shall provide customer service to support the processing of claims for Covered Services rendered on or before the termination date for a period of two (2) months or such

other longer period reasonably requested by the Exchange at a cost to be mutually agreed upon per Enrollee.

v. If so instructed by the Exchange in the termination notice, Contractor shall promptly discontinue the provision of Services requested by the Exchange to be discontinued as of the date requested by the Exchange.

vi. Contractor will perform reasonable and necessary acts requested by the Exchange and as required under applicable laws, rules, regulations, and consistent with industry standards to facilitate transfer of Covered Services herewith to a succeeding Contractor. Contractor shall comply with requirements reasonably imposed by the Exchange relating to (i) the discontinuation of new enrollment or re-enrollment in Contractor's QHP, (ii) the transfer of Enrollee coverages to another QHP prior to the commencement date, (iii) the expiration of existing quotes, and (iv) such other protocols that may reasonably be established by the Exchange.

vii. Contractor will reasonably cooperate with the Exchange and any successor QHP Issuer in good faith with respect to taking such actions that are reasonably determined to be the best interest of the QHP Issuer, and Enrollees.

f) Contractor shall cooperate with the Exchange's conduct of an accounting of amounts paid or payable and Enrollees enrolled during the month in which termination is effective in order to assure an appropriate determination of premiums earned by and payable to Contractor for Services rendered prior to the date of termination, which shall be accomplished as follows:

1) Mid-Month Termination: For a termination of this Agreement that occurs during the middle of any month, the premium for that month shall be apportioned on a pro rata basis. Contractor shall be entitled to premiums from Enrollees for the period of time prior to the date of termination and Enrollees shall be entitled to a refund of the balance of the month.

2) Responsibility to Complete Contractual Obligations: Contractor is responsible for completing submission and corrections to Encounter Data for Covered Services received by Enrollees during the period of the Agreement. Contractor is responsible for submitting any outstanding financial or other reports required for Covered Services rendered or Claims paid during the term of the Agreement.

g) Contractor shall (i) provide such other information to the Exchange, Enrollees and/or the succeeding QHP Issuer, and/or (ii) take any such further action as is required to effect an orderly transition of Enrollees to another QHP in accordance with requirements set forth under this Agreement and/or necessary to the continuity and transition of care in accordance with applicable laws, rules and regulations.

7.6 Coverage Following Termination and Decertification

a) Upon the termination of the Agreement or decertification of one or more of Contractor's QHPs, Contractor shall cooperate fully with the Exchange in order to effect an orderly transition of Enrollees to another QHP as directed by the Exchange. This cooperation shall include: (i) attending post-termination meetings, (ii) providing or arranging for the provision of Covered Services as may be deemed necessary by Participating Providers to assure the appropriate continuity of care, and (iii) communicating with affected Enrollees in cooperation with the Exchange and the succeeding contractor as applicable, as reasonably requested by the Exchange.

b) In the event the termination or expiration of the Agreement requires the transfer of some or all Enrollees into any other health plan, the terms of coverage under Contractor's QHP shall not be carried over to the replacement QHP, but rather the transferred Enrollees shall be entitled only to the extent of coverage offered through the replacement QHP as of the effective date of transfer to the new QHP.

c) Notwithstanding the foregoing, the coverage of Enrollee under Contractor's QHP may be extended to the extent that an Enrollee qualifies for an extension of benefits including, those to effect the continuity of care required due to hospitalization or disability pursuant to Health and Safety Code section 1399.62. For purposes of this Agreement, "disability" means that the Enrollee has been certified as being totally disabled by the Enrollee's treating physician, and the certification is approved by Contractor. Such certification must be submitted for approval within thirty (30) days from the date coverage is terminated. Recertification of Enrollee's disability status must be furnished by the treating Provider not less frequently than at sixty (60) calendar day intervals during the period that the extension of benefits is in effect. The extension of benefits shall be solely in connection with the condition causing total disability. This extension, which is contingent upon payment of the applicable premiums, shall be provided for the shortest of the following periods:

   i. Until total disability ceases;

   ii. For a maximum period of twelve (12) months after the date of termination, subject to plan maximums;

   iii. Until the Enrollee's enrollment in a replacement plan; or

   iv. Recertification.

ARTICLE 8 –INSURANCE AND INDEMNIFICATION

8.1 Contractor Insurance

8.1.1 Required Coverage

a) Without limiting the Exchange's right to obtain indemnification or other forms of remedies or relief from Contractor or other third-parties, Contractor shall, at its sole cost and expense, obtain, and during the term of this Agreement, maintain in full force and effect, the insurance coverage described in this Section and as otherwise required by law, including, without limitation, coverage required to be provided and documented pursuant to Section 1351 (o) of the Health and Safety Code and relating to insurance coverage or self-insurance: (i) to respond to claims for damages arising out of the furnishing of Covered Services, (ii) to protect against losses of facilities where required by the director, and (iii) to protect against workers' compensation claims arising out of work-related injuries that might be brought by the employees and staff of Contractor. All insurance shall be adequate to provide coverage against losses and liabilities attributable to the acts or omissions of Contractor in performance of this Agreement and to otherwise protect and maintain the resources necessary to fulfill Contractor's obligations under this Agreement. The minimum acceptable limits shall be as indicated below:

i. Commercial general liability or equivalent self-insurance covering the risks of bodily injury (including death), property damage and personal injury, including coverage for contractual liability, with a limit of not less than $1 million per occurrence/$2 million general aggregate;

ii. Comprehensive business automobile liability (owned, hired, or non-owned vehicles used by Contractor in connection with performance of its obligations under this Agreement) covering the risks of bodily injury (including death) and property damage, including coverage for contractual liability, with a limit of not less than $1 million per accident;

iii. Employers liability insurance covering the risks of Contractor's employees and employees' bodily injury by accident or disease with limits of not less than $1 million per accident for bodily injury by accident and $1 million per employee for bodily injury by disease and $1 million disease policy limit;

iv. Umbrella policy providing excess limits over the primary general liability, automobile liability and employer's liability policies in an amount not less than $10 million per occurrence and in the aggregate;

v. Crime coverage at such levels consistent with industry standards and reasonably determined by Contractor to cover occurrences falling in the following categories: computer and funds transfer fraud; forgery; money and securities; and employee theft; and

vi. Professional liability or errors and omissions with coverage of not less than $1 million per claim/$2 million general aggregate.

8.1.2 Workers' Compensation

Contractor shall, in full compliance with State law, provide or purchase, at its sole cost and expense, and, statutory California's workers' compensation coverage which shall remain in full force and effect during the term of this Agreement.

8.1.3 Subcontractor Coverage

Contractor shall require all subcontractors that may be authorized to provide Services on behalf of Contractor or otherwise under this Agreement to maintain insurance commensurate with the nature of such subcontractors' work and all coverage for subcontractors shall be subject to all the requirements set forth in this Agreement and applicable laws, rules and regulations. Failure of subcontractor(s) to comply with insurance requirements does not limit Contractor's liability or responsibility.

8.1.4 Continuation of Required Coverage

For professional liability and errors and omissions coverage and crime coverage, Contractor shall continue such coverage beyond the expiration or termination of this Agreement. In the event Contractor procures a claim made policy as distinguished from an occurrence policy, Contractor shall procure and maintain prior to termination of such insurance, continuing extended reporting coverage for the maximum terms provided in the policy so as to cover any incidents arising during the term of this Agreement. Contractor shall arrange for continuous insurance coverage throughout the term of this Agreement.

8.1.5 Premium Payments and Disclosure

Premium on all insurance policies shall be paid by Contractor or its subcontractors. Contractor shall provide thirty (30) days' notice of cancellation to the Exchange. Contractor shall furnish to the Exchange copies of certificates of all required insurance prior to the Execution Date, and copies of renewal certificates of all required insurance within thirty (30) days after the renewal date. The Exchange reserves the right to review the insurance requirements contained herein to ensure that there is appropriate coverage that is in accordance with this Agreement. The Exchange is to be notified by Contractor promptly if any aggregate insurance limit is exceeded. In such event, Contractor must purchase additional coverage to meet these requirements.

8.2 Indemnification

Contractor shall indemnify, defend and hold harmless the Exchange, the State, and all of the officers, trustees, agents and employees of the foregoing, from and against any and all demands, claims, actions, losses, costs, liabilities, damages or deficiencies, including interest, penalties and attorneys' fees, related to any of the following:

a) Arise out of or are due to a breach by Contractor of any of its representations, warranties, covenants or other obligations contained in this Agreement; or

b) Are caused by or resulting from Contractor's acts or omissions constituting bad faith, willful misfeasance, negligence or reckless disregard of its duties under this Agreement or applicable laws, rules and regulations; or

c) Accrue or result to any of Contractor's subcontractors, material men, laborers or any other person, firm or entity furnishing or supplying services, material or supplies in connection with the performance of this Agreement.

The obligation to provide indemnification under this Agreement shall be contingent upon the Exchange:

a) Providing Contractor with reasonable written notice of any claim for which indemnification is sought;

b) Allowing Contractor to control the defense and settlement of such claim; provided, however, that the Contractor consults with the Exchange regarding the defense of the claim and any possible settlements and agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on the Exchange without the Exchange's prior written consent, which will not be unreasonably withheld; and,

c) Cooperating fully with the Contractor in connection with such defense and settlement. Indemnification under this section is limited as described herein.

ARTICLE 9 – PRIVACY AND SECURITY

9.1 Privacy and Security Requirements for Personally Identifiable Data

a) HIPAA Requirements. Contractor agrees to comply with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Administrative Simplification Provisions of HIPAA, as codified at 42 U.S.C. § 1320d et seq., the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), and any current and future regulations promulgated under HITECH or HIPAA, all as amended from time to time and collectively referred to herein as the "HIPAA Requirements". Contractor agrees not to use or further disclose any Protected Health Information, other than as permitted or required by the HIPAA Requirements and the terms of this Agreement.

b) Exchange Requirements. With respect to Contractor Exchange Functions, Contractor agrees to comply with following privacy and security requirements and standards applicable to Personally Identifiable Information which have been established and implemented by the Exchange in accordance with the requirements of 45 C.F.R. Part 155 (collectively, "the Exchange Requirements"):

i. Uses and Disclosures. Pursuant to the terms of this Agreement, Contractor may receive from the Exchange Protected Health Information and/or Personally Identifiable Information in connection with Contractor Exchange Functions that is protected under applicable Federal and State laws and regulations. Contractor shall not use or disclose such Protected Health Information or Personally Identifiable Information obtained in connection with Contractor Exchange Functions other than as is expressly permitted under the Exchange Requirements and only to the extent necessary to perform the functions called for within this Agreement.

ii. Fair Information Practices. Contractor shall implement reasonable and appropriate fair information practices to ensure:

1. Individual Access. Contractor shall provide access to, and permit inspection and copying of Protected Health Information and Personally Identifiable Information in either an electronic or hard copy format as specified by the individual and as required by law, within thirty (30) days of such request from the individual. If the Contractor denies access, in whole or in part, the Contractor must provide a written denial within the time limits for providing access, which includes the basis for the denial and a statement of the individual's review rights, if applicable. In the event any individual requests access to Protected Health Information or Personally Identifiable Information maintained by the Exchange or another health plan directly from Contractor, Contractor shall within five (5) days forward such request to the Exchange and the relevant health plan as needed.

2. Amendment. Contractor shall provide an individual with the right to request an amendment of inaccurate Protected Health Information and Personally Identifiable Information. Contractor shall respond to such individual within sixty (60) days of such a request either by making the correction and informing the individual of such correction or notifying the individual in writing that the request was denied, which notice shall provide an explanation for the denial and explain that the individual may submit a statement of disagreement with the denial.

3. Openness and Transparency. Contractor shall make available to individuals applicable policies, procedures, and technologies that directly affect such individuals and/or their Protected Health Information and Personally Identifiable Information.

4. Choice. Contractor shall provide individuals with a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their Protected Health Information and Personally Identifiable Information.

5. Limitations. Contractor represents and warrants that all Protected Health Information and Personally Identifiable Information shall be collected, used, and/or disclosed under this Agreement only to the extent necessary to accomplish a specified purpose under the terms of this Agreement or as permitted by the Exchange Requirements and never to discriminate inappropriately.

6. Data Integrity. Contractor shall implement policies and procedures reasonably intended to ensure that Protected Health Information and Personally Identifiable Information in its possession is complete, accurate, and current, to the extent necessary for the Contractor's intended purposes, and has not been altered or destroyed in an unauthorized manner.

7. Safeguards. Contractor shall have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Protected Health Information and Personally Identifiable Information that it creates, receives, maintains or transmits pursuant to the Agreement and to prevent the use or disclosure of Protected Health Information and/or Personally Identifiable Information other than as provided for in this Agreement, or as required by law. In furtherance of compliance with such requirements, Contractor shall:

   a. Encrypt all Protected Health Information and/or Personally Identifiable Information that is in motion or at rest, including but not limited to data on portable media devices, using commercially reasonable means, consistent with applicable Federal and State laws, regulations and agency guidance, including but not limited to the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies That Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements or issued by the National Institute for

Standards and Technology ("NIST") concerning the protection of identifiable data such as Protected Health Information and/or Personally Identifiable Information. Data centers shall be encrypted or shall otherwise comply with industry data security best practices;

b. Implement a contingency plan for responding to emergencies and/or disruptions to business that in any way affect the use, access, disclosure or other handling of Protected Health Information and/or Personally Identifiable Information;

c. Maintain and exercise a plan to respond to internal and external security threats and violations;

d. Maintain an incident response plan;

e. Maintain technology policies and procedures that provide reasonable safeguards for the protection of Protected Health Information and Personally Identifiable Information stored, maintained or accessed on hardware and software utilized by Contractor and its subcontractors and Agents;

f. Mitigate to the extent practicable, any harmful effect that is known to Contractor of any Security Incident related to Protected Health Information and/or Personally Identifiable Information or of any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Contractor or its subcontractors or Agents in violation of the requirements of this Agreement or applicable privacy and security laws and regulations and agency guidance;

g. Destroy Protected Health Information and Personally Identifiable Information in a manner consistent with applicable State and Federal laws, regulations, and agency guidance on the destruction of Protected Health Information and Personally Identifiable Information; and

h. Comply with all applicable Exchange policies within Section 9.2. Protection of Information Assets, including, but not limited to, executing non-disclosure agreements and other documents required by such policies. Contractor shall also require any subcontractors and Agents to comply with all such Exchange policies.

c) California Requirements. With respect to all provisions of information under this Agreement, Contractor agrees to comply with all applicable California state health information privacy and security laws applicable to Personally Identifiable Information, including but not limited to the confidentiality of the Medical Information Act, the California Insurance Information and Privacy Protection Act, and the Information Practices Act, all collectively referred to as "California Requirements."

d) Interpretation. Notwithstanding any other provisions in this section, to the extent a conflict arises between the permissibility of a use or disclosure of Protected Health Information or

Personally Identifiable Information under the HIPAA Requirements, the Exchange Requirements, or California Requirements with respect to Contractor Exchange Functions, the applicable requirements imposing the more stringent privacy and security standards to such uses and disclosures shall apply. In addition, any ambiguity in this Agreement regarding the privacy and security of Protected Health Information and/or Personally Identifiable Information shall be resolved to permit the Exchange and Contractor to comply with the most stringent of the applicable privacy and security laws or regulations.

e) Breach Notification.

i. Contractor shall report to the Exchange: (i) any use or disclosure of Protected Health Information and/or Personally Identifiable Information not permitted by this Agreement; (ii) any Security Incident involving Protected Health Information and/or Personally Identifiable Information created or received in connection with Contractor Exchange Functions; and/or (iii) any breach as defined in the HIPAA Requirements or California Requirements – in connection with Protected Health Information and/or Personally Identifiable Information created or received in connection with Contractor Exchange Functions (each of which shall be referred to herein as a "Breach").

ii. Contractor shall, without unreasonable delay, but no later than within three (3) days after Contractor's discovery of a Breach, report such Breach to the Exchange. In addition, Contractor shall, without unreasonable delay, but no later than within five (5) days after Contractor's discovery of a successful Security Incident not involving Protected Health Information and/or Personally Identifiable Information, report such successful Security Incident not involving Protected Health Information and/or Personally Identifiable Information to the Exchange. Any such report will be made on a form made available to Contractor, or by such other reasonable means of reporting as may be communicated to Contractor by the Exchange.

iii. Contractor shall cooperate with the Exchange in investigating the Breach and/or successful Security Incident not involving Protected Health Information and/or Personally Identifiable Information and in meeting the Exchange's obligations, if any, under applicable State and Federal security breach notification laws, regulatory obligations or agency requirements. If the cause of the Breach or the successful Security Incident not involving Protected Health Information and/or Personally Identifiable Information is attributable to Contractor or its Agents or subcontractors, Contractor shall be responsible for Breach notifications and reporting as required under applicable Federal and State laws, regulations and agency guidance. Such notification(s) and required reporting shall be done in cooperation with the Exchange.

iv. To the extent possible, Contractor's initial report shall include: (a) the names of the individual(s) whose Protected Health Information and/or Personally Identifiable Information has been, or is reasonably believed by Contractor to have been accessed, acquired, used or disclosed or in the event of a successful Security Incident not involving

Protected Health Information and/or Personally Identifiable Information, provide such information regarding the nature of the information system intrusion and any systems potentially compromised; (b) a brief description of what happened including the date of the incident and the date of the discovery of the incident, if known; (c) a description of the types of Protected Health Information and/or Personally Identifiable Information that were involved in the incident, as applicable; (d) a brief description of what Contractor is doing or will be doing to investigate, to mitigate harm to the individual(s) and to its information systems, and to protect against recurrences; and (e) any other information that the Exchange determines it needs to include in notifications to the individual(s) or relevant regulatory authorities under applicable privacy and security requirements.

v. After conducting its investigation, and within fifteen (15) days, unless an extension is granted by the Exchange, Contractor shall file a complete report with the information listed above, if available. Contractor shall make all reasonable efforts to obtain the information listed above and shall provide an explanation if any information cannot be obtained. Contractor and the Exchange will cooperate in developing content for any public statements.

vi. Contractor also shall, on at least a quarterly basis, report to the Exchange the occurrence and nature of attempted but Unsuccessful Security Incidents (as defined herein). "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Contractor's firewall, port scans, unsuccessful log-on attempts, or denials of service which, if successful, could be reasonably calculated to jeopardize the integrity of CalHEERS or the confidentiality of any PII/PHI subject to this Agreement, and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Protected Health Information and/or Personally Identifiable Information.

f) Other Obligations. The following additional obligations apply to Contractor:

i. Subcontractors and Agents. Contractor shall enter into an agreement with any Agent or subcontractor that will have access to Protected Health Information and/or Personally Identifiable Information that is received from, or created or received by, Contractor on behalf of the Exchange or in connection with this Agreement, or any of its contracting Plans pursuant to which such Agent or subcontractor agrees to be bound by the same or more stringent restrictions, terms and conditions as those that apply to Contractor pursuant to this Agreement with respect to such Protected Health Information and Personally Identifiable Information.

ii. Exchange Operations. Unless otherwise agreed to by the Contractor and the Exchange, Contractor shall provide de-identified patient medical and pharmaceutical information needed by the Exchange to effectively oversee and administer the Plans. As used in this Subsection (f), the term "de-identified" shall have the meaning set forth in 45 C.F.R. § 164.514.

iii. Records and Audit. Contractor agrees to make its internal practices, books and records relating to the use and disclosure of Protected Health Information and/or Personally Identifiable Information received from the Exchange, or created or received by Contractor on behalf of the Exchange or in connection with this Agreement available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Contractor's and/or the Exchange's compliance with HIPAA Requirements. In addition, Contractor shall provide the Exchange with information concerning its safeguards described throughout this Section and/or other information security practices as they pertain to the protection of Protected Health Information and Personally Identifiable Information, as the Exchange may from time to time request. Failure of Contractor to complete or to respond to the Exchange's request for information within the reasonable timeframe specified by the Exchange shall constitute a material breach of this Agreement. In the event of a Breach or Security Incident related to Protected Health Information and/or Personally Identifiable Information or any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Contractor in violation of the requirements of this Agreement, the Exchange will be permitted access to Contractor's facilities in order to review policies, procedures and controls relating solely to compliance with the terms of this Agreement.

iv. Electronic Transactions Rule. In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of any Plan, Contractor agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 C.F.R. Part 162. Contractor agrees to require that any Agent, including a subcontractor, of Contractor that conducts standard transactions with Protected Health Information and/or Personally Identifiable Information of the Plan comply with all applicable requirements of the Electronic Transactions Rule.

v. Minimum Necessary. Contractor agrees to request and use only the minimum necessary type and amount of Protected Health Information required to perform its services and will comply with any regulations promulgated under the HIPAA Requirements and agency guidance concerning the minimum necessary standard pertaining to Protected Health Information. Contractor will collect, use and disclose Personally Identifiable Information only to the extent necessary to accomplish a specified purpose under this Agreement.

vi. Indemnification. Contractor shall indemnify, hold harmless, and defend the Exchange from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs the Exchange determines to be reasonable), losses, penalties, fines, and liabilities arising from or due to a Breach or other non-permitted use or disclosure of Protected Health Information and/or Personally Identifiable Information by Contractor or its subcontractors or Agents, including without limitation, (1) damages resulting from any action under applicable (a) HIPAA Requirements, (b) the Exchange Requirements or (c) California Requirements, and (2) the costs of the Exchange actions taken to: (i) notify the affected individual(s) and other entities of and to respond to the

Breach; (ii) mitigate harm to the affected individual(s); and (iii) respond to questions or requests for information about the Breach or other impermissible use or disclosure of Protected Health Information and/or Personally Identifiable Information.

g) Privacy Policy. The Exchange shall notify Contractor of any limitation(s) in its Privacy Policy, to the extent that such limitation may affect Contractor's use or disclosure of Protected Health Information and/or Personally Identifiable Information.

h) Reporting Violations of Law. Contractor may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(2), other provisions within the HIPAA Requirements, or any other applicable State or Federal laws or regulations.

i) Survival. Notwithstanding anything to the contrary in the Agreement, the provisions of this Section 9.1 on the Protection of Personally Identifiable Information shall survive termination of the Agreement with respect to information that relates to Contractor Exchange functions until such time as all Personally Identifiable Information and Protected Health Information is destroyed by assuring that hard copy Personally Identifiable Information and Protected Health Information will be shredded and electronic media will be cleared, purged, or destroyed consistent with National Institute of Standards and Technology Guidelines for Media Sanitization, or is returned to the Exchange, in a manner that is reasonably acceptable to the Exchange.

j) Contract Breach. Without limiting the rights of the parties pursuant to this Agreement, if Contractor breaches its obligations under this Section, the Exchange may, at its option: (a) exercise any of its rights of access and inspection under this Agreement; (b) require Contractor to submit to a plan of monitoring and reporting, as the Exchange may determine necessary to maintain compliance with this Agreement and such plan shall be made part of this Agreement; or (c) notwithstanding any other provisions of this Agreement, after giving Contractor opportunity to cure the breach, terminate this Agreement. If Contractor materially breaches its obligations under this Section, the Exchange may terminate this Agreement, with or without opportunity to cure the breach. The Exchange's remedies under this Section and any other part of this Agreement or provision of law shall be cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

9.2 Protection of Information Assets.

a) The following terms shall apply as defined below:

i. "Information Assets" means any information, including Confidential Information, necessary to the operation of either party that is created, stored, transmitted, processed or managed on any hardware, software, network components, or any printed form or is communicated orally. "Information Assets" does not include information that has been transferred from the Disclosing Party to the Receiving Party under applicable laws, regulations and agency

guidance, and that is being maintained and used by the Receiving Party solely for purposes that are not Contractor Exchange Functions.

ii. "Confidential Information" includes, but is not limited, to any information (whether oral, written, visual or fixed in any tangible medium of expression), relating to either party's services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers (excluding the Exchange), cost and pricing data, trade secrets, know-how, processes, plans, reports, designs and any other information of or relating to the business or either party, including Contractor's programs, but does not include information that (a) is described in the Evidence of Coverage booklets; (b) was known to the Receiving Party before it was disclosed to the Receiving Party by the Disclosing Party, (c) was or becomes available to the Receiving Party from a source other than the Disclosing Party, provided such fact is evidenced in writing and the source is not bound by a confidentiality obligation regarding such information to Disclosing Party, or (d) is developed by either party independently of the other party's Confidential Information, provided that such fact can be adequately documented.

iii. "Disclosing Party" means the party who sends Information Assets that it owns to the other party for the purposes outlined in this Agreement.

iv. "Receiving Party" means the party who receives Information Assets owned by the other.

b) The Receiving Party shall hold all Information Assets of the Disclosing Party in confidence and will not use any of the Disclosing Party's Information Assets for any purpose, except as set forth in this Agreement, or as otherwise required by law, regulation or compulsory process.

c) The Receiving Party must take all reasonable and necessary steps to prevent the unauthorized disclosure, modification or destruction of the Disclosing Party's Information Assets. The Receiving Party must, at a minimum, use the same degree of care to protect the Disclosing Party's Information Assets that it uses to protect its own Information Assets.

d) The Receiving Party agrees not to disclose the Disclosing Party's Information Assets to anyone, except to employees or third parties who require access to the Information Assets pursuant to this Agreement, but only where such third parties have signed agreements regarding the Information Assets containing terms that are equivalent to, or stricter than, the terms of this Section, or as otherwise required by law.

e) In the event the Receiving Party is requested to disclose the Disclosing Party's Information Assets pursuant to a request under the California Public Records Act (PRA), a summons, subpoena or in connection with any litigation, or to comply with any law, regulation, ruling or government or public agency request, the Receiving Party shall, to the extent it may do so lawfully, give the Disclosing Party five (5) business days notice of such requested disclosure and afford the Disclosing Party the opportunity to review the request before Receiving Party discloses the Information Assets. The Disclosing Party shall, in accordance with applicable

law, have the right to take such action as it reasonably believes may be necessary to protect the Information Assets, and such action shall not be restricted by the dispute resolution process of this Agreement. If such request is pursuant to the PRA, the Exchange shall give Contractor five (5) business days notice to permit Contractor to consult with the Exchange prior to disclosure of any Confidential Information. This subdivision shall not apply to restrict disclosure of any information to the State or in connection with a dispute between the Exchange and Contractor or any audit or review conducted pursuant to this Agreement.

f) The Receiving Party shall notify the Disclosing Party in writing of any unauthorized disclosure, modification or destruction of the Disclosing Party's Information Assets by the Receiving Party, its officers, directors, employees, contractors, Agents, or third parties. The Receiving Party shall make this notification promptly upon becoming aware of such disclosure, modification or destruction, but in any event, not later than four (4) days after becoming aware of the unauthorized disclosure, modification or destruction. After such notification, the Receiving Party agrees to cooperate reasonably, at the Receiving Party's expense, with the Disclosing Party to remedy or limit the unauthorized disclosure, modification or destruction and/or its effects.

g) The Receiving Party understands and agrees the Disclosing Party may suffer immediate, irreparable harm in the event the Receiving Party fails to comply with any of its obligations under this Section, that monetary damages will be inadequate to compensate the Disclosing Party for such breach and that the Disclosing Party shall have the right to enforce this section by injunctive or other equitable remedies. The provisions of this Section shall survive the expiration or termination, for any reason, of this Agreement.

h) To the extent that information subject to this Section on Protection of Information Assets is also subject to HIPAA Requirements, the Exchange Requirements or California Requirements in Section 9.1(b) and (c), such information shall be governed by the provisions of Section 9.1. In the event of a conflict or inconsistency between the requirements of the various applicable sections and attachments of this Agreement, including Section 9.1 and this Section 9.2, Contractor shall comply with the provisions that provide the greatest protection against access, use or disclosure.

i) Survival. Notwithstanding anything to the contrary in the Agreement, the provisions of this Section 9.2 on Information Assets shall survive termination of the Agreement until such time as all Information Assets provided by the Exchange to Contractor, or created, received or maintained by Contractor on behalf of the Exchange, is destroyed by assuring that hard copy Information Assets will be shredded and electronic media will be cleared, purged, or destroyed consistent with National Institute of Standards and Technology Guidelines for Media Sanitization or is returned to the Exchange, in a manner that is reasonably acceptable to the Exchange.

ARTICLE 10 – RECORDKEEPING

10.1 Clinical Records

Except with respect to any longer periods that may be required under applicable laws, rules and regulations, Contractor shall maintain, and require each Participating Provider and subcontractor to maintain, a medical record documentation system adequate to fully disclose and document the medical condition of each Enrollee and the extent of Covered Services provided to Enrollees. Clinical records shall be retained for at least seven (7) years following the year of the final Claims payment. Except as otherwise required by State and Federal laws, rules and regulations, if an audit, litigation, research, evaluation, claim or other action involving the records has not been concluded before the end of the seven (7) year minimum retention period, the clinical records must be retained until all issues arising out of the action have been resolved. If responsibility for maintenance of medical records is delegated by Contractor to a Participating Provider or subcontractor, Contractor shall require such Participating Provider or other subcontractor to comply with the document retention requirements set forth in this Agreement and as otherwise required by applicable laws, rules and regulations.

10.2 Financial Records

a) Except as otherwise required to be maintained for a longer period by law or this Agreement, financial records, supporting documents, statistical records and all other records pertinent to amounts paid to or by Contractor in connection with this Agreement shall be retained by Contractor for at least ten (10) years from the date of the final claims payment. Contractor shall maintain accurate books, accounts, and records and prepare all financial statements in accordance with Generally Accepted Accounting Principles, applicable laws, rules and regulations and requirements imposed by any governmental or regulatory authority having jurisdiction over Contractor.

b) Contractor shall maintain adequate data customarily maintained and reasonably necessary to properly document each of its transactions with Participating Providers, the Exchange, and Enrollees during the period this Agreement remains in force and will keep records of claims, including medical review and high dollar special audit claims, for a period of ten (10) years or for such length of time as required by Federal or State law, whichever is longer. Subject to compliance with applicable laws, rules and regulations, including, those relating to confidentiality and privacy, at the end of the ten (10) year retention period, at the option of the Exchange, records shall either be transferred to the Exchange at its request or destroyed.

c) Contractor shall maintain historical claims data and other records and data relating to the utilization of Covered Services by Enrollees on-line for two (2) years from date that the Agreement is terminated with respect to Covered Services provided to Enrollees during the term of this Agreement. These records shall include, but are not limited to, the data elements

necessary to produce specific reports mutually agreed upon by the Exchange and Contractor and in such form reasonably required by the Exchange that is consistent with industry standards and requirements of Health Insurance Regulators regarding statistical, financial and/or data reporting requirements, including information relating to diagnosis, treatment, amounts billed (allowed and paid), dates of service, procedure numbers, deductible, out-of-pocket and other cost sharing for each claim.

10.3 Storage

Such books and records shall be kept in a secure location at the Contractor's office(s), and books and records related to this Agreement shall be available for inspection and copying by the Exchange, the Exchange representatives, and such consultants and specialists as designated by the Exchange, at any time during normal business hours as provided in Section 10.5 hereof and upon reasonable notice. Contractor shall also ensure that related books and records of Participating Providers and subcontractors shall be accurately maintained. If any inquiry, audit, investigation, litigation, claim or other action involving the records is ongoing and has not been finally concluded before the end of the ten (10) year minimum retention period, the applicable financial records must be retained until all issues arising out of the action have been resolved.

10.4 Back-Up

Contractor shall maintain a separate back-up system for its electronic data processing functions and a duplicate data file which is updated regularly and stored off-site in a secured, controlled environment. Contractor's back-up system shall comply with applicable laws, rules and regulations, including, those relating to privacy and confidentiality and shall be designed to meet or exceed industry standards regarding the preservation of access to data.

10.5 Examination and Audit Results

a) Contractor shall immediately submit to the Exchange the results of final financial, market conduct, or special audits/reviews performed by the Department of Managed Health Care, California Department of Health Care Services, California Department of Insurance, US Department of Health and Human Services, and/or any other regulatory entity within the State of California that has jurisdiction where Contractor serves Enrollees.

b) Contractor agrees to subject itself to the Exchange for audits/reviews, either by the Exchange or its designee, or the Department of General Services, the Bureau of State Audits or their designee, as they deem necessary to determine the correctness of premium rate setting, the Exchange's payments to Agents based on the Contractor's report, questions pertaining to Enrollee premium payments and advance premium tax credit payments and participation fee payments Contractor made to the Exchange. Contractor also agrees to all audits subject to

applicable State and Federal law regarding the confidentiality of and release of confidential Protected Health Information of Enrollees.

c) Contractor agrees that the Exchange, the Department of General Services, the Bureau of State Audits, or their designated representative, shall, subject to applicable State and Federal law regarding the confidentiality and release of Protected Health Information of Enrollees, have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement.

d) Contractor agrees to take corrective actions of an audit/review findings within 90 days. In the instance Contractor cannot complete the corrective action of a finding within 90 days, it shall submit a status report to the Exchange stating why it cannot correct the finding within the specified time frame and shall propose another date for correction. In all instances, Contractor and the Exchange will do their best to resolve an audit/review finding within 160 days. Should Contractor disagree with the Exchange's management decision on an audit/review finding, it may appeal such management decision to the Exchange Executive Director whose decision is final and binding on the parties, in terms of administrative due process.

10.6 Notice

Contractor shall promptly notify the Exchange in writing of any inquiry, audit, investigation, litigation, claim, examination, or other proceeding involving Contractor, or any Contractor personnel, Participating Provider or other authorized subcontractor, that is threatened or commenced by any regulatory agency or other party that a reasonable person might believe could materially affect the ability of Contractor to perform in accordance with the terms set forth in this Agreement. Such notice shall be provided by Contractor to the Exchange within ten (10) days of Contractor's receipt of notice regarding such action; provided, however, that any such exchange of information shall be subject to compliance with applicable laws, rules and regulations, and shall not occur to the extent prohibited by order of the court, administrative agency, or other tribunal or regulatory authority having jurisdiction over the matter or by the laws and regulations governing the action. This section shall not be required with respect to disputes relating to claims and other matters noticed to the Exchange in the ordinary course of business pursuant to other terms and conditions set forth in this Agreement or required by law.

10.7 Confidentiality

The Exchange understands and agrees that Contractor shall only be obligated to provide access to such information to the extent that: (1) access to such information is permitted by applicable State and Federal law and regulation, including, but not limited to, State and Federal law or regulation relating to confidential or private information; and (2) it would not cause Contractor to breach the terms of any contract to which Contractor is a party. Contractor shall use efforts reasonably acceptable to obtain any necessary consents relating to Contractor's access to information.

10.8 Tax Reporting

Contractor shall provide such information to the Exchange upon request and in such form as mutually agreed upon by the parties and reasonably required to document Contractor's compliance with, and/or to fulfill the Exchange's obligations with respect to, income tax eligibility, computation and reporting requirements required under applicable laws, rules and regulations that applicable to the operation of the Exchange, including, those relating premium tax credit and other operations of the Exchange set forth at 45 C.F.R. Part 155.

10.9 Electronic Commerce

Contractor shall use commercially reasonable efforts, which shall include, without limitation, Contractor's development, implementation and maintenance of processes and systems consistent with industry standards, to comply with the requirements of the Exchange and applicable laws, rules and regulations relating to Contractor's participation in electronic commerce activities required under the terms of this Agreement. Contractor shall comply with service levels and system interface specifications documented by the Exchange in appropriate CalHEERS documentation and sign an appropriate Trading Partner Agreement that describes the transaction set of files needed by the CalHEERS solution.

ARTICLE 11 – INTELLECTUAL PROPERTY

11.1 Warranties

a) Contractor represents, warrants and covenants to the best of its knowledge that:

i. It has secured and will secure all rights and licenses necessary for its performance of this Agreement, including but not limited to consents, waivers, releases from all authors of or owners of any copyright interests in music or performances used, individuals, and talent (radio, television, and motion picture talent), owners of any interest in and to real estate site, locations, property, or props that may be used or shown.

ii. To the best of the Contractor's knowledge, neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary or contractual right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.

iii. Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute false or misleading advertising or a libel or slander against any person or entity.

iv. It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to the Exchange in this Agreement.

v. It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

vi. It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this agreement.

b) EXCEPT AS EXPRESSLY STATED ELSEWHERE IN THIS AGREEMENT, THE EXCHANGE AND CONTRACTOR MAKE NO WARRANTY AND EXPRESSLY DISCLAIM ANY WARRANTY, EXPRESS OR IMPLIED, THAT THEIR INTELLECTUAL PROPERTY OR THE INTELLECTUAL PROPERTY RESULTING

FROM THIS AGREEMENT IS MERCHANTABLE, FIT FOR A PARTICULAR PURPOSE, OR DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

11.2 Intellectual Property Indemnity

a) Subject to subsection (c) hereof, Contractor agrees to indemnify and hold the Exchange harmless from any expense, loss, damage or injury; to defend at its own expense any and all claims, suits and actions; and to pay any judgments or settlements against the Exchange to the extent they arise or are due to infringement of third-party intellectual property rights enforceable in the U.S., misuse of third-party confidential or trade secret information, failure to obtain necessary third-party consents, waivers or releases, violation of the right of privacy or publicity, false or misleading advertising, libel or slander, or misuse of social media, by Contractor or any Contractor Intellectual Property. Contractor's indemnification obligations under this section are subject to Contractor receiving prompt notice of the claim after the Exchange becomes aware of such claim and being given the right to control the defense of such claim. Should any Intellectual Property licensed by the Contractor to the Exchange under this Agreement become the subject of an Intellectual Property infringement claim or other claim for which Contractor is obligated to indemnify the Exchange, Contractor will promptly take steps reasonably and in good faith to preserve the Exchange's right to use the licensed Intellectual Property in accordance with this Agreement at no expense or disruption to the Exchange, except as otherwise stated in this Agreement. The Exchange shall have the right to monitor and appear through its own counsel (at Exchange's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for the Exchange to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property, as its sole remedy.

b) Notwithstanding anything to the contrary in this Agreement, any such indemnification obligation of Contractor shall not extend to any infringement or alleged infringement to the extent that such infringement or alleged infringement resulted from (i) specific instructions to use certain Intellectual Property given to Contractor by the Exchange; (ii) the Exchange's unauthorized modification of Contractor Intellectual Property; (iii) the Exchange's use of Contractor Intellectual Property in combination with any service or product not supplied, recommended or approved by Contractor, or used by the Exchange in a manner for which it was not authorized; or (iv) Intellectual Property created or derived by the Exchange.

c) Contractor agrees that damages alone would be inadequate to compensate the Exchange for breach of any term of this Article by Contractor. Contractor acknowledges the Exchange would suffer irreparable harm in the event of such breach and agrees the Exchange shall be entitled to seek equitable relief, including without limitation an injunction, from a court of

competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

11.3 Federal Funding

If this agreement is funded in whole or in part by the federal government, the Exchange may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the agreement; except as provided in 37 C.F.R. § 401.14 and except as stated herein. However, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

11.4 Ownership and Cross-Licenses

a) Intellectual Property Ownership. As between Contractor and the Exchange, each Party shall remain at all times the sole and exclusive owner of all right, title and interest in and to the Intellectual Property that it owned or used prior to entry into this Agreement, or that it developed in the course of performance of this Agreement. Any Intellectual Property created by either Party in the performance of this Agreement shall not be considered a "work made for hire" of the other Party, as "work made for hire" is defined in the United States Copyright Act, 17 U.S.C. § 101. Any rights not licensed to the other Party hereunder are expressly reserved exclusively by the originating Party.

b) License of Intellectual Property. Each Party (a "Licensor") grants the other Party (a "Licensee") the non-exclusive, royalty-free, paid-up, worldwide, irrevocable, right, during the term of this Agreement, to use the Licensor's Intellectual Property solely for the purposes of this Agreement and to carry out the Party's functions consistent with its responsibilities and authority as set forth in the enable legislation and regulations. Such licenses shall not give the Licensee any ownership interest in or rights to the Intellectual Property of the Licensor. Each Licensee agrees to abide by all third-party license and confidentiality restrictions or obligations applicable to the Licensor's Intellectual Property of which the Licensor has notified the Licensee in writing.

c) Definition of Intellectual Property. For purposes of this Agreement, "Intellectual Property" means recognized protectable rights and interests such as: patents (whether or not issued), copyrights, trademarks, service marks, applications for any of the foregoing, inventions, Confidential Information, trade secrets, trade dress, domain names, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or hereafter come into existence, and all registrations, renewals and extensions, regardless of whether

those rights arise under the laws of the United States, or any other state, country or jurisdiction. For the avoidance of doubt, Protected Health Information and Personally Identifiable Information are not included in the definition of Intellectual Property, and are addressed under Article 9.

d) Definition of Works. For purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and nay materials and information developed for the purposes of producing those final products. Works do not include articles submitted to peer review or reference journals or independent research projects.

11.5 Survival

The provisions set forth in this Section shall survive any termination or expiration of this Agreement.

ARTICLE 12 – SPECIAL TERMS AND CONDITIONS

12.1 Dispute Resolution

a) If any dispute arising out of or in connection with this Agreement is not resolved within thirty (30) days, or such other reasonable period of time determined by Contractor and the Exchange staff normally responsible for the administration of this Agreement, the parties shall attempt to resolve the dispute through the submission of the matter for executive level involvement. The executive officer of each party or his or her designated representative shall meet and confer to attempt to resolve the dispute. If the parties agree, a neutral third party mediator may be engaged to assist in dispute resolution at either the line employee level or the executive level, or both. If after expending reasonable efforts at executive level resolution of the dispute, no resolution can be reached within thirty (30) days or such other reasonable period determined by Contractor and the Exchange, then either party may seek its rights and remedies in a court of competent jurisdiction or otherwise available under this Agreement or applicable laws, rules and regulations.

b) Each party shall document in writing the nature of each dispute and the actions taken to resolve any disputes utilizing this dispute resolution procedure. Each party shall act in good faith to resolve such disputes. Neither party may seek its rights and remedies in court respecting any such notice of termination for default without first following the dispute resolution process stated in this section.

c) The Exchange and Contractor agree that the existence of a dispute notwithstanding, they will continue without delay to carry out all their responsibilities under this Agreement which are not affected by the dispute.

d) Either party may request an expedited resolution process if such party determines that irreparable harm will be caused by following the timelines set forth in Section 12.1(a). If the other party does not consent to such expedited process, the requesting party will hire, at its sole cost and expense, an independent mediator to determine whether such an expedited process is necessary to avoid or reduce irreparable harm. In the event that the mediator determines that irreparable harm may result from delays required under the thirty (30) day period required under Section 12.1(a), the parties will engage in an expedited process that will require the parties to resolve the dispute within five (5) business days or such other period as mutually agreed upon by the parties.

e) This section shall survive the termination or expiration of this Agreement.

12.2 Attorneys' Fees

In the event of any litigation between the parties to enforce or interpret the provisions of this Agreement, the non-prevailing party shall, unless both parties agree, in writing, to the contrary,

pay the reasonable attorneys' fees and costs of the prevailing party arising from such litigation, including outside attorneys' fees and allocated costs for services of in-house counsel, and court costs. These attorneys' fees and costs shall be in addition to any other relief to which the prevailing party may be entitled.

12.3 Notices

Any notice or other written communication that may or must be given hereunder shall be deemed given when delivered personally, or if it is mailed, three (3) days after the date of mailing, unless delivery is by express mail, telecopy, electronic mail or telegraph, and then upon the date of the confirmed receipt, to either the representative executing the STD 213 or the following representatives:

For the Exchange: Covered California, the California Health Benefit Exchange

Attention: James DeBenedetti
1601 Exposition Blvd.
Sacramento, CA 95815
Telephone No. (916) 228-8665
Email: James DeBenedetti@covered.ca.gov

For Contractor:

Name:
Address:
City, State, Zip Code:
Telephone No. _____ FAX No.
Email: _____

Either party hereto may, from time to time by notice in writing served upon the other as aforesaid, designate a different mailing address or a different or additional person to which all such notices or other communications thereafter are to be addressed.

12.4 Amendments

a) By the Exchange. In the event that any law or regulation is enacted or any decision, opinion, interpretive policy or guidance of a court or governmental agency is issued (any of the foregoing, a "Change in Law") that the Exchange determines, based on its consultation with legal counsel, other regulators or other state-based or Federal health benefit exchanges: (i) affects or may affect the legality of this Agreement or any provision hereof or cause this Agreement or any provision hereof to prevent or hinder compliance with laws, rules or regulations, or (ii) adversely affects or may adversely affect the operations of the Exchange or the ability of the Exchange or Contractor to perform its respective obligations hereunder or receive the benefits intended hereunder, the Exchange may, by written notice to Contractor,

amend this Agreement to comply with or otherwise address the Change in Law in a manner reasonably determined by the Exchange to carry out the original intent of the parties to the extent practical in light of such Change in Law. Such amendment shall become effective upon sixty (60) days' notice, or such lesser period as required for compliance or consistency with the Change in Law or to avoid the adverse effect of the Change in Law. If Contractor objects to such amendment, it must notify the Exchange in writing within twenty (20) days of receipt of notice from the Exchange. If the parties are unable to agree on an amendment within thirty (30) days thereafter, the Exchange may terminate this Agreement effective immediately.

b) Other Amendments. Except as provided in Section 12.4(a), this Agreement may be amended only by mutual consent of the parties. Except as provided herein, no alteration or variation of the terms of this Agreement shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein shall be binding on any of the parties hereto.

12.5 Time is of the Essence

Time is of the essence in this Agreement.

12.6 Publicity

Contractor shall coordinate with the Exchange with respect to communications to third parties regarding this Agreement; provided, however, that no external publicity release or announcement or other such communication concerning this Agreement or the transactions contemplated herein shall be issued by Contractor without advance written approval by the Exchange unless such communication complies with standards that may be issued by the Exchange to Contractor based on consultation with Contractor from time to time.

12.7 Force Majeure

Except as prohibited by applicable laws, rules and regulations, neither party to this Agreement shall be in default of its obligations hereunder for delay or failure in performing that arises out of causes beyond the control and without the fault or negligence of either party and arising from a catastrophic occurrence or natural disaster, such as Acts of God or of the public enemy, acts of the State in its sovereign capacity, acts of the State Controller's Office or other State agency having an impact on the Exchange's ability to pay its obligations, acts of the State legislature, fires, floods, power failure, disabling strikes, epidemics, quarantine restrictions, and freight embargoes. However, each party shall utilize its best good faith efforts to perform under this Agreement in the event of any such occurrence.

12.8 Further Assurances

Contractor and the Exchange agree to execute such additional documents, and perform such further acts, as may be reasonable and necessary to carry out the provisions of this Agreement.

12.9 Binding Effect

This Agreement, any instrument or agreement executed pursuant to this Agreement, and the rights, covenants, conditions, and obligations of Contractor and the Exchange contained therein, shall be binding upon the parties and their successors, assigns, and legal representatives.

12.10 Titles/Section Headings

Titles or headings are not part of this Agreement, are for convenience of reference only, and shall have no effect on the construction or legal effect of this Agreement.

12.11 Severability

Should one or more provisions of this Agreement be held by any court to be invalid, void, or unenforceable, such provision(s) will be deemed to be restated to affect the original intentions of the parties as nearly as possible in accordance with applicable law. The remaining provisions shall nevertheless remain and continue in full force and effect.

12.12 Entire Agreement/Incorporated Documents/Order of Precedence

This Agreement represents the entire understanding between the parties hereto with respect to the subject matter hereof. Any prior correspondence, memoranda, or agreements are replaced in total by this Agreement. This Agreement shall consist of:

a) The terms of this Agreement, including obligations set forth in other documents that are referenced herein;

b) All attached documents, which are expressly incorporated herein;

c) Terms and conditions set forth in the Application, to the extent that such terms are expressly incorporated by reference in specific sections of this Agreement and/or otherwise not inconsistent with the Agreement or Proposal; and,

d) The Proposal, which is expressly incorporated herein to the extent that such terms are not superseded by the terms set forth in this Agreement.

e) In the event there are any inconsistencies or ambiguities among the terms of this Agreement and incorporated documents, the following order of precedence shall be used:

f) Applicable laws, rules and regulations;

g) The terms and conditions of this Agreement, including attachments; and

h) Application.

12.13 Waivers

No delay on the part of either party in exercising any right, power, or privilege hereunder shall operate as a waiver thereof. No waiver on the part of either party of any right, power, or privilege hereunder, nor any single or partial exercise of any right, power, or privilege hereunder shall preclude any other or further exercise thereof or the exercise of any other right, power, or privilege hereunder.

12.14 Incorporation of Amendments to Applicable Laws

Any references to sections of Federal or State statutes or regulations shall be deemed to include a reference to any subsequent amendments thereof and any successor provisions thereto made from time to time from and after the date of this Agreement.

12.15 Choice of Law, Jurisdiction, and Venue

This Agreement shall be administered, construed, and enforced according to the laws of the State (without regard to any conflict of law provisions) to the extent such laws have not been preempted by applicable Federal law. Any suit brought hereunder shall be brought in the state or federal courts sitting in Sacramento, California, the parties hereby waiving any claim or defense that such forum is not convenient or proper. Each party agrees that any such court shall have in person jurisdiction over it and consents to service of process in any manner authorized by California law.

12.16 Counterparts

This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

12.17 Days

Wherever in this Agreement a set number of days is stated or allowed for a particular event to occur, the days are understood to include all calendar days, including weekends and holidays, unless otherwise specified.

12.18 Ambiguities Not Held Against Drafter

This Agreement having been freely and voluntarily negotiated by all parties, the rule that ambiguous contractual provisions are construed against the drafter of the provision shall be inapplicable to this Agreement.

12.19 Clerical Error

No clerical error shall operate to defeat or alter any terms of this Agreement or defeat or alter any of the rights, privileges or benefits of any Enrollee or Employer.

12.20 Administration of Agreement

a) The Exchange may adopt policies, procedures, rules and interpretations that are consistent with applicable laws, rules and regulations and deemed advisable by the Exchange to promote orderly and efficient administration of this Agreement. The parties shall perform in accordance with such policies and procedures; provided, however, that any changes to policies and procedures that are not disclosed to Contractor prior to the Agreement Effective Date shall not result in additional obligations and risks to Contractor existing at the Agreement Effective Date except as otherwise mutually agreed upon by the parties.

b) The Exchange shall provide ninety (90) days prior written notice by letter, newsletter, electronic mail or other media of any material change (as defined below) in Exchange's policies, procedures or other operating guidance applicable to Contractor's performance of Services. The failure by Contractor to object in writing to any material change within thirty (30) days following the Contractor's receipt of such notice shall constitute Contractor's acceptance of such material change. For purposes of this Section, "material change" shall refer to any change that could reasonably be expected to have a material impact on the Contractor's compensation, Contractor's performance of Services under this Agreement, or the delivery of Covered Services to Enrollees.

12.21 Performance of Requirements

To the extent the Agreement requires performance under the Agreement by Contractor but does not specifically specify a date, the date of performance shall be based on the mutual agreement of Contractor and Exchange.

ARTICLE 13 – DEFINITIONS

Except as otherwise expressly defined, capitalized terms used in the Agreement and/or the Attachments shall have the meaning set forth below.

Affordable Care Act (Act) – The Federal Patient Protection and Affordable Care Act, (P.L. 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (P.L. 111 -152), known collectively as the Affordable Care Act.

Agent(s) - Individuals who are licensed and in good standing as a life licensee under Insurance Code § 1626 by the California Department of Insurance to transact in accident and health insurance. The term used in this Agreement will only apply to Agents certified by the Exchange to transact business in the individual and CCSB Exchanges.

Agreement – This Agreement attached hereto, including attachments and documents incorporated by reference, entered into between the Exchange and Contractor.

Agreement Effective Date – The effective date of this Agreement established pursuant to Section 7.1 of this Agreement.

Accreditation Association for Ambulatory Health Care (AAAHC) – A nonprofit accrediting agency for ambulatory health care settings.

Application –The application for certification for plan years 2017 - 2019.

Behavioral Health – A group of interdisciplinary services concerned with the prevention, diagnosis, treatment, and rehabilitation of mental health and substance abuse disorders.

Board – The executive board responsible for governing the Exchange under Government Code Section 100500.

California Affordable Care Act – The California Patient Protection and Affordable Care Act, AB 1602 and SB 900 (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010).

CAL COBRA – The California Continuation Benefits Replacement Act, or Health and Safety Code § 1366.20 et seq.

CalHEERS – The California Healthcare Eligibility, Enrollment and Retention System, a project jointly sponsored by the Exchange and DHCS, with the assistance of the Office of Systems Integration to maintain processes to make the eligibility determinations regarding the Exchange and other State health care programs and assist Enrollees in selection of health plan.

COBRA – Federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) requiring continuing coverage of group health benefits to employees and their families upon the occurrence of certain qualifying events where such coverage would otherwise be terminated.

Covered California for Small Business (CCSB) - the marketplace formerly referred to as the Small Business Health Options Program (SHOP), which offers Qualified Health Plans to small employers and their Employees.

CCR – The California Code of Regulations.

CDI – The California Department of Insurance.

Confidentiality of Medical Information Act (CMIA) – The Confidentiality of Medical Information Act (California Civil Code section 56 et seq.) and the regulations issued pursuant thereto or as thereafter amended, to the extent applicable to operation of Contractor.

Contract Year – The full twelve (12) month period commencing on the effective date and ending on the day immediately prior to the first anniversary thereof and each full consecutive twelve (12) month period thereafter during which the Agreement remains in effect.

Contractor – The Health Insurance Issuer contracting with the Exchange under this Agreement to operate a QHP and perform in accordance with the terms set forth in this Agreement.

Contractor Exchange Function – Any function that Contractor performs pursuant to this Agreement during which Contractor receives, maintains, creates, discloses or transmits PHI and/ or Personally Identifiable Information gathered from the Exchange, applicants, Qualified Individuals or Enrollees in the process of assisting individuals and entities with the purchase of health insurance coverage in QHPs or other functions under the California exchange program.

Covered California for Small Business – The Exchange program providing coverage to eligible small businesses, also referred to as the Small Business Health Options Program and described in Government Code 100502(m).

Covered Services – The Covered Services that are covered benefits under the applicable QHP and described in the EOC.

DHCS – The California Department of Health Care Services.

DHHS – The United States Department of Health and Human Services.

DMHC – The California Department of Managed Health Care.

Effective Date – The date on which a Plan's coverage goes into effect.

Eligibility Information – The information that establishes an Enrollee's eligibility.

Eligibility File – The compilation of all Eligibility Data for an Enrollee or group of Enrollees into a single electronic format used to store or transmit the data.

Employee – A "qualified employee," as defined in 45 C.F.R. 155.20.

Employer – A "qualified employer," as defined in section 1312(f)(2) of the Act.

Encounter – Any Health Care Service or bundle of related Covered Services provided to one Enrollee by one Health Care Professional within one time period. Any Covered Services provided must be recorded in the Enrollee's health record.

Encounter Data – Encounter information Contractor can use to demonstrate the provision of Covered Services to Enrollees.

Enrollee – Enrollee means each and every individual and each of their Family Members enrolled in a QHP offered through the Exchange for the purpose of receiving health benefits.

Enrollment –An Enrollee who has completed their application and for whom the initial premium payment has been received and acknowledged by the Contractor has completed Enrollment.

Evidence of Coverage (EOC) and Disclosure Form – The document which describes the benefits, exclusions, limitations, conditions, and the benefit levels of the applicable Plans.

The Exchange – The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.

Explanation of Benefits (EOB) – A statement sent from the Contractor to an Enrollee listing services provided, amount billed, eligible expenses and payment made by the Plan.

Explanation of Payment (EOP) – A statement sent from the Contractor to Providers detailing payments made for Covered Services.

Family Member – An individual who is within an Enrollee's family, as defined in 26 U.S.C. § 36B (d)(1).

Formulary – A list of outpatient prescription drugs, selected by the Plan(s) and revised periodically, which are available to Enrollees in a specific QHP.

Grace Period – A specified time following the premium due date during which coverage remains in force and an Enrollee or Employer or other authorized person or entity may pay the premium without penalty.

Health Care Professional – An individual with current and appropriate licensure, certification, or accreditation in a medical or behavioral health profession, including without limitation, medical doctors (including psychiatrists), dentists, osteopathic physicians, psychologists, registered nurses, nurse practitioners, licensed practical nurses, certified medical assistants, licensed physician assistants, mental health professionals, chemical dependency counselors, clinical laboratory professionals, allied health care professionals, pharmacists, social workers, physical therapists, occupational therapists, and others to provide Covered Services.

Health Information Technology for Economic and Clinical Health Act (HITECH Act) – The Health Information Technology for Economic and Clinical Health Act, which was enacted as part of the

American Recovery and Reinvestment Act of 2009, and the regulations issued pursuant thereto or as thereafter amended.

Health Insurance Issuer – Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. § 300gg-91 and 45 C.F.R. § 144.103.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – The Health Insurance Portability and Accountability Act of 1996 and the regulations issued pursuant thereto or as thereafter amended.

Health Insurance Regulators – CDI and DMHC, as applicable.

Health Plan Employer Data and Information Set (HEDIS) – The data as reported and updated annually by the National Committee for Quality Assurance (NCQA).

Individual Exchange – The Exchange through which Qualified Individuals may purchase Qualified Health Plans.

Individually Identifiable Health Information (IIHI) – The "individually identifiable health information" as defined under HIPAA.

Information Practices Act (IPA) – The California Information Practices Act, Civil Code section 1798, *et seq.* and the regulations issued pursuant thereto or as thereafter amended.

Insurance Information and Privacy Protection Act (IIPPA) – The California Insurance Information and Privacy Protection Act, Insurance Code Sections 791-791.28, *et seq.*, and the regulations issued pursuant thereto or as thereafter amended.

Medicaid – The program of medical care coverage set forth in Title XIX of the Social Security Act and the regulations issued pursuant thereto or as thereafter amended.

Medicare – The program of medical care coverage set forth in Title XVIII of the Social Security Act and the regulations issued pursuant thereto or as thereafter amended.

Medicare Part D – The Medicare prescription drug program authorized under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), effective January 1, 2006, and the regulations issued pursuant thereto or as thereafter amended.

Monthly Rates – The rates of compensation payable in accordance with the terms set forth at Article 5 to Contractor for Services rendered under this Agreement.

NCQA – The National Committee for Quality Assurance, a nonprofit accreditation agency.

Nurse Advice Line – An advice line staffed by registered nurses (RNs) who assess symptoms (using triage guidelines approved by the Plan to determine if and when the caller needs to be seen by a Provider); provide health information regarding diseases, medical procedures, medication usage and side effects; and give care advice for managing an illness or problem at home.

Open Enrollment or Open Enrollment Period – The fixed time period as set forth in 45 C.F.R. § 155.410 for individual applicants and Enrollees to initiate enrollment or to change enrollment from one health benefits plan to another.

Participating Hospital – A hospital that, at the time of an Enrollee's admission, has a contract in effect with Contractor to provide Covered Services to Enrollees.

Participating Physician – A physician or a member of a Medical Group that has a contract in effect with Contractor to provide Covered Services to Enrollees.

Participating Provider – An individual Health Care Professional, hospital, clinic, facility, entity, or any other person or organization that provides Covered Services and that, at the time care is rendered to a Enrollee, has (or is a member of a Medical Group that has) a contract in effect with Contractor to provide Covered Services to Enrollees and accept copayments for Covered Services.

Participation Fee – The user fee on Qualified Health Plans authorized under Section 1311(d)(5) of the Act, 45 C.F.R. §§ 155.160(b)(1) and 156.50(b), and Government Code § 100503(n) to support the Exchange operations.

Performance Standard – A financial assurance of service delivery at levels agreed upon between the Exchange and Contractor.

Personally Identifiable Information – Any information that identifies or describes an individual, including, but not limited to, his or her name, social security number, physical description, home address, home telephone number, education, financial matters, medical or employment history, and statements made by, or attributed to, the individual. It also includes any identifiable information collected from or about an individual for purposes of determining eligibility for enrollment in a Qualified Health Plan, determining eligibility for other insurance affordability programs, determining eligibility for exemptions from the individual responsibility provisions, or any other use of such individual's identifiable information in connection with the Exchange.

Pharmacy Benefit Manager (PBM) – The vendor responsible for administering the Plan's outpatient prescription drug program. The PBM provides a retail pharmacy network, mail order pharmacy, specialty pharmacy services, and coverage management programs.

Plan(s) – The Qualified Health Plans the Exchange has entered into a contract with a Health Insurance Issuer to provide, hereinafter referred to as the Plan(s).

Plan Data – All the utilization, fiscal, and eligibility information gathered by Contractor about the Plans exclusive programs, policies, procedures, practices, systems and information developed by Contractor and used in the normal conduct of business.

Plan Year – Plan Year has the same definition as that term is defined in 45 C.F.R. § 155.20.

Premium – The dollar amount payable by the Enrollee after any advanced premium tax credits are applied, if any, to the Issuer to effectuate and maintain coverage.

Premium Rate or Monthly Rate – The monthly premium due during a Plan Year, as agreed upon by the parties.

Primary Care - The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1978) Contractors may allow Enrollees to select Nurse Practitioners and Physician Assistants to serve as their Primary Care clinician. Covered California does not require that Primary Care clinicians serve as a "gatekeeper" or the source of referral and access to specialty care. Covered California recognizes Internal Medicine, Pediatrics, and Family Medicine as primary care specialties.

Proposal – The proposal submitted by Contractor in response to the Application.

Protected Health Information or Personal Health Information – Protected health information, including electronic protected health information (EPersonal Health Information) as defined in HIPAA that relates to an Enrollee. Protected Health Information also includes "medical information" as defined by the California Confidentiality of Medical Information Act (CMIA) at California Civil Code section 56, *et seq.*

Provider – A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.

Provider Claim(s) – Any bill, invoice, or statement from a specific Provider for Covered Services or supplies provided to Enrollees.

Provider Group – A group of physicians or other Health Care Professionals that is clinically integrated, financially integrated, or that contract together to provide care to patients in a coordinated manner.

Qualified Health Plan or QHP – QHP has the same meaning as that term is defined in Government Code §100501(f).

Qualified Individual – Qualified Individual has the same meaning as that term is defined in § 1312(f)(1) of the Act.

Quality Management and Improvement – The process for conducting outcome reviews, data analysis, policy evaluation, and technical assistance internally and externally to improve the quality of care to Enrollees.

Quarterly Business Review or QBR – Quarterly in-person meetings between the Exchange and Contractor at the Exchange headquarters to report and review program performance results including all Services and components of the program, i.e., clinical, financial, contractual reporting requirements, customer service, appeals and any other program recommendations.

Regulations – The regulations adopted by the Exchange Board. (California Code of Regulations, Title 10, Chapter 12, section 6400, et seq.)

Risk-Adjusted Premiums – Actuarially calculated premiums utilizing risk adjustment.

Risk-Based Capital or RBC – The approach to determine the minimum level of capital needed for protection from insolvency based on an organization's size, structure, and retained risk. Factors in the RBC formula are applied to assets, premium, and expense items. The factors vary depending on the level of risk related to each item. The higher the risk related to the item, the higher the factor, and vice versa.

Risk Adjustment – An actuarial tool used to calibrate premiums paid to Health Benefits Plans or carriers based on geographical differences in the cost of health care and the relative differences in the health risk characteristics of Enrollees enrolled in each plan. Risk adjustment establishes premiums, in part, by assuming an equal distribution of health risk among Health Benefits Plans in order to avoid penalizing Enrollees for enrolling in a Health Benefits Plan with higher than average health risk characteristics.

Run-Out Claims – All claims presented and adjudicated after the end of a specified time period where the health care service was provided before the end of the specified time period.

Security Incident – The attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

Service Area – The designated geographical areas where Contractor provides Covered Services to Enrollees and comprised of the ZIP codes listed in Attachment 4.

Services – The provision of Services by Contractors and subcontractors required under the terms of the Agreement, including, those relating the provision of Covered Services and the administrative functions required to carry out the Agreement.

State – The State of California

Special Enrollment Period – The period during which a Qualified Individual or Enrollee who experiences certain qualifying events, as defined in applicable Federal and State laws, rules and regulations, may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and annual Open Enrollment Periods.

Utilization Management – Pre-service, concurrent or retrospective review which determines the Medical Necessity of hospital and skilled nursing facility admissions and selected Covered Services provided on an outpatient basis.

Utilization Review Accreditation Commission (URAC) – The independent and nonprofit organization that promotes health care quality through its accreditation and certification programs. It offers a wide range of quality benchmarking programs and Services and validates health care industry organizations on their commitment to quality and accountability.

Virtual Interactive Physician/Patient Capabilities – Capabilities allowing Enrollees to have short encounters with a physician on a scheduled or urgent basis via telephone or video chat from the Enrollee's home or other appropriate location.

COVERED CALIFORNIA
QUALIFIED HEALTH PLAN ISSUER CONTRACT THROUGH 2017-2019 FOR THE INDIVIDUAL MARKET

between

Covered California, the California Health Benefit Exchange (the "Exchange")

and

("Contractor")

List of Attachments to Qualified Health Plan Model Contract

Attachment 1 – Contractor's Qualified Health Plan List

Attachment 2 – 2017 Standard Benefit Plan Designs

2017 Standard Benefit Plan Designs

June 16, 2016

Final Board-approved

2017 Standard Benefit Plan Designs
10.0 EHB
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COVERED CALIFORNIA™

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	89.7%	90.3%
Plan design includes a deductible?	No	No
Integrated Individual deductible	$0	$0
Integrated Family deductible	$0	$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Individual Out–of–pocket maximum	$4,000	$4,000
Family Out-of-pocket maximum	$8,000	$8,000
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$15		$15	
	Other practitioner office visit		$15		$15	
	Specialist visit		$40		$40	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
Drugs to treat illness or condition	Tier 1		$5		$5	
	Tier 2		$15		$15	
	Tier 3		$25		$25	
	Tier 4		10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%		$40	
	Outpatient visit		10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$150		$150	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$150		$150	
	Urgent care		$15		$15	
Hospital stay	Facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%		$40	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$15		$15	
	Mental/Behavioral health other outpatient items and services		$15		$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		10%		$40	
	Substance Use disorder outpatient office visits		$15		$15	
	Substance Use disorder other outpatient items and services		$15		$15	
	Substance Use inpatient facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Substance use disorder inpatient physician fee		10%		$40	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%		$40	
Help recovering or other special health needs	Home health care		10%		$20	
	Outpatient Rehabilitation services		$15		$15	
	Outpatient Habilitation services		$15		$15	
	Skilled nursing care		10%		$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		See 2017 Dental Copay Schedule	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	80.9%	81.2%
Plan design includes a deductible?	No	No
Integrated Individual deductible	$0	$0
Integrated Family deductible	$0	$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Individual Out–of–pocket maximum	$6,750	$6,750
Family Out-of-pocket maximum	$13,500	$13,500
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$30		$30	
	Other practitioner office visit		$30		$30	
	Specialist visit		$55		$55	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$35		$35	
	X-rays and Diagnostic Imaging		$55		$55	
	Imaging (CT/PET scans, MRIs)		20%		$275	
Drugs to treat illness or condition	Tier 1		$15		$15	
	Tier 2		$55		$55	
	Tier 3		$75		$75	
	Tier 4		20% up to $250 per script		20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%		$55	
	Outpatient visit		20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$325		$325	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$250		$250	
	Urgent care		$30		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%		$55	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$30		$30	
	Mental/Behavioral health other outpatient items and services		$30		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%		$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		20%		$55	
	Substance Use disorder outpatient office visits		$30		$30	
	Substance Use disorder other outpatient items and services		$30		$30	
	Substance Use inpatient facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Substance use disorder inpatient physician fee		20%		$55	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%		$600 per day up to 5 days	
		Professional	20%		$55	
Help recovering or other special health needs	Home health care		20%		$30	
	Outpatient Rehabilitation services		$30		$30	
	Outpatient Habilitation services		$30		$30	
	Skilled nursing care		20%		$300 per day up to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		See 2017 Dental Copay Schedule	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage	Individual
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan
Actuarial Value - AV Calculator	71.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,500/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$5,000/ $500 / $0
Individual Out–of–pocket maximum	$6,800
Family Out-of-pocket maximum	$13,600
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$35	
	Other practitioner office visit		$35	
	Specialist visit		$70	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$70	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$55	Pharmacy deductible
	Tier 3		$80	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$35	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$35	
	Mental/Behavioral health other outpatient items and services		$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$35	
	Substance Use disorder other outpatient items and services		$35	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$45	
	Outpatient Rehabilitation services		$35	
	Outpatient Habilitation services		$35	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		20%	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		50%	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	CCSB Silver Coinsurance Plan	CCSB Silver Copay Plan
Actuarial Value - AV Calculator	71.6%	71.3%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,000/ $250 / $0	$2,000/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,000 / $500 / $0	$4,000 / $500 / $0
Individual Out–of–pocket maximum	$6,800	$6,800
Family Out-of-pocket maximum	$13,600	$13,600
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$45		$45	
	Other practitioner office visit		$45		$45	
	Specialist visit		$75		$75	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$40		$40	
	X-rays and Diagnostic Imaging		$70		$70	
	Imaging (CT/PET scans, MRIs)		20%		$300	
Drugs to treat illness or condition	Tier 1		$15		$15	
	Tier 2		$55	Pharmacy deductible	$55	Pharmacy deductible
	Tier 3		$85	Pharmacy deductible	$85	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
	Outpatient visit		20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350		$350	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$45		$45	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$45		$45	
	Mental/Behavioral health other outpatient items and services		$45		$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X	20%	X
	Mental/Behavioral health inpatient physician fee		20%	X	20%	X
	Substance Use disorder outpatient office visits		$45		$45	
	Substance Use disorder other outpatient items and services		$45		$45	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X	20%	X
	Substance use disorder inpatient physician fee		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		See 2017 Dental Copay Schedule	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage	CCSB
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver HDHP Plan
Actuarial Value - AV Calculator	71.3%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$2,000 integrated
Integrated Family deductible	$4,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$6,550
Family Out-of-pocket maximum	$13,100
HSA plan: Self-only coverage deductible	$2,000
HSA family plan: Individual deductible	$2,600

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		20%	X
	Other practitioner office visit		20%	X
	Specialist visit		20%	X
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Tier 1		20% up to $250 per script	X
	Tier 2		20% up to $250 per script	X
	Tier 3		20% up to $250 per script	X
	Tier 4		20% up to $250 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
	Outpatient visit		20%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		20%	X
	Emergency room physician fee (waived if admitted)		0%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		20%	X
	Mental/Behavioral health other outpatient items and services		20%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		20%	X
	Substance Use disorder other outpatient items and services		20%	X
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Outpatient Rehabilitation services		20%	X
	Outpatient Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		20%	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		50%	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan 100%-150% FPL	Silver Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.1%	87.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$75 / $0 / $0	$650 / $50 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$150 / $0 / $0	$1,300 / $100 / $0
Individual Out–of–pocket maximum	$2,350	$2,350
Family Out-of-pocket maximum	$4,700	$4,700
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$5		$10	
	Other practitioner office visit		$5		$10	
	Specialist visit		$8		$25	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$8		$15	
	X-rays and Diagnostic Imaging		$8		$25	
	Imaging (CT/PET scans, MRIs)		$50		$100	
Drugs to treat illness or condition	Tier 1		$3		$5	
	Tier 2		$10		$20	Pharmacy deductible
	Tier 3		$15		$35	Pharmacy deductible
	Tier 4		10% up to $150 per script		15% up to $150 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
	Outpatient visit		10%		15%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$50		$100	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$30	X	$75	X
	Urgent care		$5		$10	
Hospital stay	Facility fee (e.g. hospital room)		10%	X	15%	X
	Physician/surgeon fee		10%	X	15%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$5		$10	
	Mental/Behavioral health other outpatient items and services		$5		$10	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%	X	15%	X
	Mental/Behavioral health inpatient physician fee		10%	X	15%	X
	Substance Use disorder outpatient office visits		$5		$10	
	Substance Use disorder other outpatient items and services		$5		$10	
	Substance Use inpatient facility fee (e.g. hospital room)		10%	X	15%	X
	Substance use disorder inpatient physician fee		10%	X	15%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care		$3		$15	
	Outpatient Rehabilitation services		$5		$10	
	Outpatient Habilitation services		$5		$10	
	Skilled nursing care		10%	X	15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		20%	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		50%	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		50%	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.7%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,200 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,400 / $500 / $0
Individual Out–of–pocket maximum	$5,700
Family Out-of-pocket maximum	$11,400
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$30	
	Other practitioner office visit		$30	
	Specialist visit		$55	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$65	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$50	Pharmacy deductible
	Tier 3		$75	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$30	
	Mental/Behavioral health other outpatient items and services		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$30	
	Substance Use disorder other outpatient items and services		$30	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$40	
	Outpatient Rehabilitation services		$30	
	Outpatient Habilitation services		$30	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		20%	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		50%	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	61.9%	62.0%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	$4,800 integrated
Integrated Family deductible	N/A	$9,600 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$6,300 / $500 / $0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$12,600 / $1,000 / $0	N/A
Individual Out–of–pocket maximum	$6,800	$6,550
Family Out-of-pocket maximum	$13,600	$13,100
HSA plan: Self-only coverage deductible	N/A	$4,800
HSA family plan: Individual deductible	N/A	$4,800

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$75	After 1st three non-preventive visits	40%	X
	Other practitioner office visit	$75	After 1st three non-preventive visits	40%	X
	Specialist visit	$105	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$40		40%	X
	X-rays and Diagnostic Imaging	100%	X	40%	X
	Imaging (CT/PET scans, MRIs)	100%	X	40%	X
Drugs to treat illness or condition	Tier 1	100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 2	100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 3	100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 4	100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)	100%	X	40%	X
	Physician/surgeon fees	100%	X	40%	X
	Outpatient visit	100%	X	40%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	100%	X	40%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
	Emergency medical transportation	100%	X	40%	X
	Urgent care	$75	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)	100%	X	40%	X
	Physician/surgeon fee	100%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	$75	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services	$75	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	X	40%	X
	Mental/Behavioral health inpatient physician fee	100%	X	40%	X
	Substance Use disorder outpatient office visits	$75	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services	$75	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)	100%	X	40%	X
	Substance use disorder inpatient physician fee	100%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services – Hospital	100%	X	40%	X
	Delivery and all inpatient services – Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care	100%	X	40%	X
	Outpatient Rehabilitation services	$75		40%	X
	Outpatient Habilitation services	$75		40%	X
	Skilled nursing care	100%	X	40%	X
	Durable medical equipment	100%	X	40%	X
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures	20%		20%	
	Periodontal Maintenance Services				
Child Dental Major Services	Crowns and Casts	50%		50%	
	Endodontics				
	Periodontics (other than maintenance)				
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		50%	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$7,150 integrated
Integrated Family deductible	$14,300 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$7,150
Family Out-of-pocket maximum	$14,300
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		0%	After 1st three non-preventive visits
	Other practitioner office visit		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Tier 1		0%	X
	Tier 2		0%	X
	Tier 3		0%	X
	Tier 4		0%	X
Outpatient services	Surgery facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
	Outpatient visit		0%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		0%	X
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services		0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		0%	X
	Mental/Behavioral health inpatient physician fee		0%	X
	Substance Use disorder outpatient office visits		0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services		0%	After 1st three non-preventive visits
	Substance Use inpatient facility fee (e.g. hospital room)		0%	X
	Substance use disorder inpatient physician fee		0%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care		0%	X
	Outpatient Rehabilitation services		0%	X
	Outpatient Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		0%	X
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		0%	X
	Periodontal Maintenance Services			X
Child Dental Major Services	Crowns and Casts		0%	X
	Endodontics			X
	Periodontics (other than maintenance)			X
	Prosthodontics			X
	Oral Surgery			X
Child Orthodontics	Medically necessary orthodontics		0%	X

See endnotes.

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COVERED CALIFORNIA™

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	89.7%	90.3%
Plan design includes a deductible?	No	No
Integrated Individual deductible	$0	$0
Integrated Family deductible	$0	$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Individual Out–of–pocket maximum	$4,000	$4,000
Family Out-of-pocket maximum	$8,000	$8,000
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$15		$15	
	Other practitioner office visit		$15		$15	
	Specialist visit		$40		$40	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
Drugs to treat illness or condition	Tier 1		$5		$5	
	Tier 2		$15		$15	
	Tier 3		$25		$25	
	Tier 4		10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%		$40	
	Outpatient visit		10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$150		$150	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$150		$150	
	Urgent care		$15		$15	
Hospital stay	Facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%		$40	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$15		$15	
	Mental/Behavioral health other outpatient items and services		$15		$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		10%		$40	
	Substance Use disorder outpatient office visits		$15		$15	
	Substance Use disorder other outpatient items and services		$15		$15	
	Substance Use inpatient facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Substance use disorder inpatient physician fee		10%		$40	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%		$40	
Help recovering or other special health needs	Home health care		10%		$20	
	Outpatient Rehabilitation services		$15		$15	
	Outpatient Habilitation services		$15		$15	
	Skilled nursing care		10%		$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics				Not Covered	
	Periodontics (other than maintenance)				Not Covered	
	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	80.9%	81.2%
Plan design includes a deductible?	No	No
Integrated Individual deductible	$0	$0
Integrated Family deductible	$0	$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Individual Out–of–pocket maximum	$6,750	$6,750
Family Out-of-pocket maximum	$13,500	$13,500
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$30		$30	
	Other practitioner office visit		$30		$30	
	Specialist visit		$55		$55	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$35		$35	
	X-rays and Diagnostic Imaging		$55		$55	
	Imaging (CT/PET scans, MRIs)		20%		$275	
Drugs to treat illness or condition	Tier 1		$15		$15	
	Tier 2		$55		$55	
	Tier 3		$75		$75	
	Tier 4		20% up to $250 per script		20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%		$55	
	Outpatient visit		20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$325		$325	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$250		$250	
	Urgent care		$30		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%		$55	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$30		$30	
	Mental/Behavioral health other outpatient items and services		$30		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%		$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		20%		$55	
	Substance Use disorder outpatient office visits		$30		$30	
	Substance Use disorder other outpatient items and services		$30		$30	
	Substance Use inpatient facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Substance use disorder inpatient physician fee		20%		$55	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%		$600 per day up to 5 days	
		Professional	20%		$55	
Help recovering or other special health needs	Home health care		20%		$30	
	Outpatient Rehabilitation services		$30		$30	
	Outpatient Habilitation services		$30		$30	
	Skilled nursing care		20%		$300 per day up to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics				Not Covered	
	Periodontics (other than maintenance)				Not Covered	
	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage	Individual
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan
Actuarial Value - AV Calculator	71.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,500/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$5,000/ $500 / $0
Individual Out–of–pocket maximum	$6,800
Family Out-of-pocket maximum	$13,600
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$35	
	Other practitioner office visit		$35	
	Specialist visit		$70	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$70	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$55	Pharmacy deductible
	Tier 3		$80	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$35	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$35	
	Mental/Behavioral health other outpatient items and services		$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$35	
	Substance Use disorder other outpatient items and services		$35	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$45	
	Outpatient Rehabilitation services		$35	
	Outpatient Habilitation services		$35	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	**CCSB** **Silver** **Coinsurance Plan**	**CCSB** **Silver** **Copay Plan**
Actuarial Value - AV Calculator	71.6%	71.3%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,000/ $250 / $0	$2,000/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,000 / $500 / $0	$4,000 / $500 / $0
Individual Out–of–pocket maximum	$6,800	$6,800
Family Out-of-pocket maximum	$13,600	$13,600
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: individual deductible	N/A	N/A

Common Medical Event	**Service Type**		**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$45		$45	
	Other practitioner office visit		$45		$45	
	Specialist visit		$75		$75	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$40		$40	
	X-rays and Diagnostic Imaging		$70		$70	
	Imaging (CT/PET scans, MRIs)		20%		$300	
Drugs to treat illness or condition	Tier 1		$15		$15	
	Tier 2		$55	Pharmacy deductible	$55	Pharmacy deductible
	Tier 3		$85	Pharmacy deductible	$85	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
	Outpatient visit		20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350		$350	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$45		$45	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$45		$45	
	Mental/Behavioral health other outpatient items and services		$45		$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X	20%	X
	Mental/Behavioral health inpatient physician fee		20%	X	20%	X
	Substance Use disorder outpatient office visits		$45		$45	
	Substance Use disorder other outpatient items and services		$45		$45	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X	20%	X
	Substance use disorder inpatient physician fee		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics				Not Covered	
	Periodontics (other than maintenance)				Not Covered	
	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage	CCSB Silver HDHP Plan
Member Cost Share amounts describe the Enrollee's out of pocket costs.	
Actuarial Value - AV Calculator	71.3%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$2,000 integrated
Integrated Family deductible	$4,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$6,550
Family Out-of-pocket maximum	$13,100
HSA plan: Self-only coverage deductible	$2,000
HSA family plan: Individual deductible	$2,600

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		20%	X
	Other practitioner office visit		20%	X
	Specialist visit		20%	X
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Tier 1		20% up to $250 per script	X
	Tier 2		20% up to $250 per script	X
	Tier 3		20% up to $250 per script	X
	Tier 4		20% up to $250 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
	Outpatient visit		20%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		20%	X
	Emergency room physician fee (waived if admitted)		0%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		20%	X
	Mental/Behavioral health other outpatient items and services		20%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		20%	X
	Substance Use disorder other outpatient items and services		20%	X
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Outpatient Rehabilitation services		20%	X
	Outpatient Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan 100%-150% FPL	Silver Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.1%	87.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$75 / $0 / $0	$650 / $50 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$150 / $0 / $0	$1,300 / $100 / $0
Individual Out–of–pocket maximum	$2,350	$2,350
Family Out-of-pocket maximum	$4,700	$4,700
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$5		$10	
	Other practitioner office visit		$5		$10	
	Specialist visit		$8		$25	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$8		$15	
	X-rays and Diagnostic Imaging		$8		$25	
	Imaging (CT/PET scans, MRIs)		$50		$100	
Drugs to treat illness or condition	Tier 1		$3		$5	
	Tier 2		$10		$20	Pharmacy deductible
	Tier 3		$15		$35	Pharmacy deductible
	Tier 4		10% up to $150 per script		15% up to $150 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
	Outpatient visit		10%		15%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$50		$100	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$30	X	$75	X
	Urgent care		$5		$10	
Hospital stay	Facility fee (e.g. hospital room)		10%	X	15%	X
	Physician/surgeon fee		10%	X	15%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$5		$10	
	Mental/Behavioral health other outpatient items and services		$5		$10	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%	X	15%	X
	Mental/Behavioral health inpatient physician fee		10%	X	15%	X
	Substance Use disorder outpatient office visits		$5		$10	
	Substance Use disorder other outpatient items and services		$5		$10	
	Substance Use inpatient facility fee (e.g. hospital room)		10%	X	15%	X
	Substance use disorder inpatient physician fee		10%	X	15%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care		$3		$15	
	Outpatient Rehabilitation services		$5		$10	
	Outpatient Habilitation services		$5		$10	
	Skilled nursing care		10%	X	15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.7%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,200 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,400 / $500 / $0
Individual Out–of–pocket maximum	$5,700
Family Out-of-pocket maximum	$11,400
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$30	
	Other practitioner office visit		$30	
	Specialist visit		$55	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$65	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$50	Pharmacy deductible
	Tier 3		$75	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$30	
	Mental/Behavioral health other outpatient items and services		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$30	
	Substance Use disorder other outpatient items and services		$30	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$40	
	Outpatient Rehabilitation services		$30	
	Outpatient Habilitation services		$30	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	61.9%	62.0%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	$4,800 integrated
Integrated Family deductible	N/A	$9,600 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$6,300 / $500 / $0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$12,600 / $1,000 / $0	N/A
Individual Out–of–pocket maximum	$6,800	$6,550
Family Out-of-pocket maximum	$13,600	$13,100
HSA plan: Self-only coverage deductible	N/A	$4,800
HSA family plan: Individual deductible	N/A	$4,800

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$75	After 1st three non-preventive visits	40%	X
	Other practitioner office visit		$75	After 1st three non-preventive visits	40%	X
	Specialist visit		$105	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$40		40%	X
	X-rays and Diagnostic Imaging		100%	X	40%	X
	Imaging (CT/PET scans, MRIs)		100%	X	40%	X
Drugs to treat illness or condition	Tier 1		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 2		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 3		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
	Tier 4		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40% up to $500 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)		100%	X	40%	X
	Physician/surgeon fees		100%	X	40%	X
	Outpatient visit		100%	X	40%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		100%	X	40%	X
	Emergency room physician fee (waived if admitted)		No charge		0%	X
	Emergency medical transportation		100%	X	40%	X
	Urgent care		$75	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)		100%	X	40%	X
	Physician/surgeon fee		100%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$75	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services		$75	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		100%	X	40%	X
	Mental/Behavioral health inpatient physician fee		100%	X	40%	X
	Substance Use disorder outpatient office visits		$75	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services		$75	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)		100%	X	40%	X
	Substance use disorder inpatient physician fee		100%	X	40%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care		100%	X	40%	X
	Outpatient Rehabilitation services		$75		40%	X
	Outpatient Habilitation services		$75		40%	X
	Skilled nursing care		100%	X	40%	X
	Durable medical equipment		100%	X	40%	X
	Hospice service		No charge		0%	X
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$7,150 integrated
Integrated Family deductible	$14,300 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$7,150
Family Out-of-pocket maximum	$14,300
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		0%	After 1st three non-preventive visits
	Other practitioner office visit		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Tier 1		0%	X
	Tier 2		0%	X
	Tier 3		0%	X
	Tier 4		0%	X
Outpatient services	Surgery facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
	Outpatient visit		0%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		0%	X
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services		0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		0%	X
	Mental/Behavioral health inpatient physician fee		0%	X
	Substance Use disorder outpatient office visits		0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services		0%	After 1st three non-preventive visits
	Substance Use inpatient facility fee (e.g. hospital room)		0%	X
	Substance use disorder inpatient physician fee		0%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care		0%	X
	Outpatient Rehabilitation services		0%	X
	Outpatient Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		0%	X
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

Endnotes to 2017 Standard Benefit Plan Designs

These endnotes and the Standard Benefit Plan Designs apply only to covered services.

Notes:

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the issuer.
2) For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or $2,600 for Plan Year 2017. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.
7) For the Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits, which may include urgent care visits or outpatient Mental Health/Substance Use Disorder visits.
8) Member cost-share for oral anti-cancer drugs shall not exceed $200 per month per state law.
9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design

for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.

12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2017 Dental Copay Schedule.
13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Standard Benefit Plan Designs.
15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate.
18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than specialist for a service provided by one of these practitioners.
19) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
20) The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.

21) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
22) Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
23) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
	3) Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or;
	2) Self administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is >$600.

24) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.

25) A plan’s formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan’s formulary.

26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member’s physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.

Attachment 3 – Reserved for future use

Attachment 4 – Service Area Listing

Attachment 5 – Health Carrier Evaluation

Covered California Plan Management
Carrier Evaluation

Carrier:
Name: Account team member's name and title

1. Understanding of the Exchange business needs	1	0.5	0
a. Understands the purpose of the Exchange, including laws, policies, and mission			
b. Understands the Exchange's organization, culture and core values			
c. Demonstrates knowledge of political, social and economic issues affecting the Exchange			
2. Understanding of products and services provided to the Exchange enrollees	1	0.5	0
a. Demonstrates a clear understanding of the Standard Benefit Designs			
b. Understands the Exchange appeal process			
c. Follows all polices set by the Exchange			
3. Communication	1	0.5	0
a. Expresses questions and ideas clearly and concisely			
b. Ensures regular communication takes place with the Exchange Plan Manager			
c. Keeps the Exchange Plan Manager involved in all communication			
d. Has a single point of contact who reaches out to the Exchange for all matters to keep the communication accurate			
e. Understands the provisions of the Exchange Contract and agrees to resolve issues at the lowest level			
f. Does not make requests for information that are not pertinent to the task or goal			
g. Alerts the Exchange Plan Manager immediately upon identifying problems or concerns			
h. Keeps the Exchange staff involved and informed about operational changes that affect the Exchange			
i. Makes attempts to coordinate efforts when multiple Exchange staff are involved in the same or similar task			
j. Comes to meetings prepared			
4. Responsive to the Exchange's issues and requests	1	0.5	0
a. Follows through on commitments, responds timely to Exchange requests and meets deadlines			
c. Respects the confidentiality of information shared between the Carrier and the Exchange			
d. Ensures a backup staff person is available to cover for extended absences			
e. Elevates issues appropriately when not resolved at the lowest level			
f. Rapidly adapts to new information, changing conditions, or unexpected obstacles			

g. Ensures requests for system changes are communicated to the Exchange Plan Manager to allow lead time for implementation			
h. Provides timely responses when resolving customer service issues and prioritizes escalations			
5. Provides information accurately and efficiently	1	0.5	0
a. Takes steps to validate information before submitting to the Exchange			
b. Follows up and responds timely if there is additional information needed			
c. Follows templates and instructions provided by the Exchange to assist with specific enrollment requests			
d. Follows the Exchange Reconciliation Process and provides accurate responses in the time frame requested by the Exchange			
6. Demonstrates honesty, integrity, and credibility	1	0.5	0
a. Behaves in an honest and trustworthy manner			
b. Shows consistency in words and actions			
c. Models high standards of ethics			
d. Fosters an environment conductive to open, transparent communication among all levels			
e. Demonstrates a high level of commitment to superior customer service			
7. Demonstrates forward thinking	1	0.5	0
a. Anticipates possible problems and develops contingency plans in advance			
b. Notices trends and develops plans to prepare for opportunities or problems			
c. Confers with the Exchange staff to test new ideas			
d. Maximizes partnership opportunities to improve joint processes and streamline operations			
Subtotal			
Total			

Attachment 6 – Reserved for future use

Attachment 7 – Quality, Network Management, Delivery System Standards and Improvement Strategy

Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

Covered California's "Triple Aim" framework seeks to lower costs, improve quality, and improve health outcomes, while ensuring a good choice of plans for consumers. Covered California and Contractor recognize that promoting better quality and value will be contingent upon supporting Providers and strategic, collaborative efforts to align with other major purchasers and payors to support delivery system reform. Qualified Health Plan (QHP) Issuers are integral to Covered California achieving its mission:

> *The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and Providers that give them the best value.*

By entering into this Agreement with Covered California, Contractor agrees to work with Covered California to develop and implement policies and practices that will promote the Triple Aim, impacting not just the Enrollees of Covered California but Contractor's entire California membership. All QHP Issuers have the opportunity to take a leading role in helping Covered California support new models of care which promote the vision of the Affordable Care Act and meet consumer needs and expectations. At the same time, the Contractor and Covered California can promote improvements in the entire care delivery system. Covered California will seek to promote care that reduces excessive costs, minimizes unpredictable quality and reduces inefficiencies of the current system. In addition, Covered California expects all QHP Issuers to balance the need for accountability and transparency at the Provider-level with the need to reduce administrative burdens on Providers as much as possible. For there to be a meaningful impact on overall healthcare cost and quality, solutions and successes need to be sustainable, scalable and expand beyond local markets or specific groups of individuals. Covered California expects its QHP Issuers to support their Providers to engage in a culture of continuous quality and value improvement, which will benefit both Covered California Enrollees and all individuals covered by the QHP Issuers.

This Quality, Network Management, Delivery System Standards and Improvement Strategy outlines the ways that Covered California and the Contractor will focus on the promotion of better care and higher value for Enrollees and for other California health care consumers. This focus will require both Covered California and Contractor to coordinate with and promote alignment with other organizations and groups that seek to deliver better care and higher value. By entering into the Agreement with Covered California, Contractor affirms its commitment to be an active and engaged partner with Covered California and to work collaboratively to define and implement additional initiatives and programs to continuously improve quality and value.

Covered California and Contractor recognize that driving the significant improvements needed to ensure better quality care is delivered at lower cost will require tactics and strategies that extend beyond the term

of this agreement. Success will depend on establishing targets based on current performance, national benchmarks and the best improvement science conducting rigorous evaluation of progress and adjusting goals annually based on experience. This Attachment 7 contains numerous reports that will be required as part of the annual certification and contracting process with QHP Issuers. This information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

ARTICLE 1
IMPROVING CARE, PROMOTING BETTER HEALTH AND LOWERING COSTS

1.01 Coordination and Cooperation

Contractor and Covered California agree that the Quality, Network Management, Delivery System Standards and Improvement Strategy serve as a starting point for what must be ongoing, refined and expanded efforts to promote improvements in care for Enrollees and across Contractor's California members. Improving and building on these efforts to improve care and reduce administrative burdens will require active partnership between Covered California and Contractor, but also with Providers, consumers and other important stakeholders.

1) Covered California shall facilitate ongoing discussions with Contractor and other stakeholders through Covered California's Plan Management and Delivery System Reform Advisory Group and through other forums as may be appropriate to work with Contractors to assess the elements of this Section and their impact, and ways to improve upon them, on:

   (a) Enrollees and other consumers;

   (b) Providers in terms of burden, changes in payment and rewarding the triple aim of improving care, promoting better health and lowering costs; and

   (c) Contractors in terms of the burden of reporting and participating in quality or delivery system efforts.

2) Contractor agrees to participate in Covered California advisory and planning processes, including participating in the Plan Management and Delivery System Reform Advisory Group.

1.02 Ensuring Networks are Based on Value

Central to its contractual requirements of its QHP Issuers, Covered California requirements include multiple elements related to ensuring that QHP Issuers' plans and networks provide quality care, including Network Design (Section 3.3.2), the inclusion of Essential Community Providers (Section3.3.3) and a wide range of elements detailed in this Attachment. To complement these provisions and to promote accountability and transparency of Covered California's expectation that network design and Provider selection considers quality and patient experience in addition to cost and efficiency, the Contractor shall:

1) Include quality, which may include clinical quality, patient safety and patient experience and cost in all Provider and facility selection criteria when designing and composing networks for inclusion in Covered California products

2) Contractor will be required to report to Covered California as part of its annual application for certification for purposes of negotiations, how it meets this requirement and the basis for the selection of Providers or facilities in networks available to Enrollees. This will include a detailed description of how cost, clinical quality, patient reported experience or other factors are considered in network design and Provider or facility selection. Information submitted for the application for certification in 2019 may be made publicly

available by Covered California.

3) Covered California expects Contractor to only contract with Providers and hospitals that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price. To meet this expectation, by contract year 2018, Covered California will work with its QHP Issuers to identify areas of "outlier poor performance" based on variation analysis. As part of this process, Covered California will engage experts in quality and cost variation and shall consult with Providers throughout California. For contract year 2019, QHP Issuers will be expected to either exclude those Providers that are "outlier poor performers" on either cost or quality from Covered California Provider networks or to document each year in its application for certification the rationale for continued contracting with each Provider that is identified as a "poor performing outlier" and efforts the Provider is undertaking to improve performance. Rationales for continued inclusion of Providers may include the impact on consumers in terms of geographical access and their out-of-pocket costs, or other justification provided by the QHP Issuer. QHP Issuer's rationale for inclusion of outliers on cost or quality will be released to the public by Covered California. Selection of specific measures of cost and quality, as well as criteria for defining "outlier poor performance" in a way that can be implemented consistently across Contractors will be established by Covered California based on national benchmarks, analysis of variation in California performance which shall include consideration of hospital case mix and services provided, best existing science of quality improvement, and effective engagement of stakeholders. Contractor agrees to participate in these collaborative processes to establish definitions. Reports from Contractor must detail implementation of such criteria through contractual requirements and enforcement, monitoring and evaluation of performance, consequences of noncompliance, corrective action and improvement plans if appropriate, and plans to transition patients from the care of Providers with poor performance. Such information may be made publicly available by Covered California.

4) Contractor will be required to report each year as part of the annual negotiation and certification process, starting with its application for certification for 2017, how Enrollees with conditions that require highly specialized management (e.g. transplant patients and burn patients) are managed by Providers with documented special experience and proficiency based on volume and outcome data, such as Centers of Excellence. In addition, to the extent that the Contractor uses Centers of Excellence more broadly, it will be required to include in its application for certification for 2017 and annually thereafter, the basis for inclusion of such Centers of Excellence, the method used to promote consumers' usage of these Centers, and the utilization of these Centers by Enrollees.

5) While Covered California welcomes QHP Issuers' use of Centers of Excellence, which may include design incentives for consumers, the current standard benefit designs do not envision or allow for "tiered" in-network Providers.

1.03 Demonstrating Action on High Cost Providers

Affordability is core to Covered California's mission to expand the availability of insurance coverage and promoting the Triple Aim. The wide variation in unit price and total costs of care

charged by Providers, with some Providers charging far more for care irrespective of quality, is one of the biggest contributors to high costs of medical services.

1) Contractor will be required to report to Covered California as part of its application for certification for 2017, and annually thereafter, which will be used for negotiation purposes:

   (a) The factors it considers in assessing the relative unit prices and total costs of care;

   (b) The extent to which it adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care) or other factors;

   (c) How such factors are used in the selection of Providers or facilities in networks available to Enrollees; and

   (d) The identification of specific hospitals and their distribution by cost deciles or describe other ways Providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs; and the percentage of costs for Contractor that are expended in each cost decile. Contractor understands that it is the desire and intention of Covered California to expand this identification process to include other Providers and facilities in future years.

2) In its application for certification for 2017, and annually thereafter, which will be used for negotiation purposes, Contractor will be required to report on its strategies to ensure that contracted Providers are not charging unduly high prices, and for what portions of its entire enrolled population it applies each strategy, which may include:

   (a) Telemedicine;

   (b) Use of Centers of Excellence; and

   (c) Design of Networks (see Article 1.02)

   (d) Reference Pricing; and

   (e) Efforts to make variation in Provider or facility cost transparent to consumers and the use of such tools by consumers.

3) For contract year 2019, Contractor will be expected to exclude hospitals and other facilities that demonstrate outlier high cost from Provider networks serving Covered California or to document each year in its application for certification the rationale for continued contracting with each hospital that is identified as a high cost outlier and efforts that the hospital or facility is undertaking to lower its costs.

1.04 Demonstrating Action on High Cost Pharmaceuticals

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life threatening conditions. Covered California

expects its Contractor to ensure that its Enrollees get timely access to appropriate prescription medications. At the same time, Covered California is concerned with the trend in rising prescription drug costs, including those in Specialty Pharmacy, and compounding increases in costs of generic drugs, which reflect a growing driver of total cost of care.

Contractor will be required to report in its annual application for certification for negotiation purposes, a description of its approach to achieving value in delivery of pharmacy services, which should include a strategy in each of the following areas:

1) Contractor must describe how it considers value in its selection of medications for use in its formulary, including the extent to which it applies value assessment methodology developed by independent groups or uses independent drug assessment reports on comparative effectiveness and value to design benefits, negotiate prices, develop pricing for consumers, and determine formulary placement and tiering within Covered California standard benefit designs. Contractor shall report the specific ways they use a value assessment methodology or independent reports to improve value in pharmacy services and indicate which of the following sources it relies upon:

   (a) Drug Effectiveness Review Project (DERP)

   (b) NCCN Resource Stratification Framework (NCCN-RF)

   (c) NCCN Evidence Blocks (NCCN-EB)

   (d) ASCO Value of Cancer Treatment Options (ASCO- VF)

   (e) ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines

   (f) Oregon State Health Evidence Review Commission Prioritization Methodology

   (g) Premera Value-Based Drug Formulary (Premera VBF)

   (h) DrugAbacus (MSKCC) (DAbacus)

   (i) The ICER Value Assessment Framework (ICER-VF)

   (j) Real Endpoints

   (k) Blue Cross/Blue Shield Technology Evaluation Center

   (l) International Assessment Processes (e.g., United Kingdom's National Institute for Health and Care Excellence – "NICE")

   (m) Other (please identify)

2) Contractor shall describe how its construction of formularies is based on total cost of care rather than on drug cost alone

3) Contractor shall describe how it monitors off-label use of pharmaceuticals and what efforts are undertaken to assure any off-label prescriptions are evidence-based;

4) Contractor must describe how it provides decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

1.05 Quality Improvement Strategy

Starting with the application for certification for 2017, Contractor is required under the Affordable Care Act and regulations from CMS to implement a Quality Improvement Strategy (QIS). The core CMS requirement for the QIS is to align Provider and enrollee market-based incentives with delivery system and quality targets.

Contractor agrees to align its QIS with the contractual requirements and initiatives of Covered California and to report on its multi-year strategy and first-year plan for implementing each initiative through the annual certification application submitted to Covered California, which will be used for negotiation purposes during the application process. Contractor understands that the application serves as the reporting mechanism and measurement tool for assessing Contractor QIS work plans and progress in achieving improvement targets with respect to each of Covered California quality and delivery system reform initiatives.

Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of each initiative which will include:

(a) The percentage, number and performance of total participating Providers;

(b) The number and percent of Enrollees participating in the initiative;

(c) The number and percent of all the Contractor's covered lives participating in the initiative; and

(d) The results of Contractor's participation in this initiative, including clinical, patient experience and cost impacts.

1.06 Participation in Collaborative Quality Initiatives

Covered California believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians and other Providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by Covered California with requirements specified below.

1) Effective January 1, 2017, Contractor must participate in two such collaboratives:

(a) CalSIM Maternity Initiative: Sponsored by Covered California, DHCS and CalPERS as well as other major purchasers with support from the California Maternal Quality Care Collaborative (CMQCC) which provides statewide analysis of variation and promotes the appropriate use of C-sections with associated

reductions in maternal and newborn mortality and morbidity. http://www.chhs.ca.gov/PRI/_CalSIM%20Maternity%20Initiative%20WriteUp%20April%202014.pdf (See Article 5, Section 5.03)

(b) Statewide workgroup on Overuse: Sponsored by Covered California, DHCS and CalPERS, this multi-stakeholder work group facilitated by the Integrated Healthcare Association (IHA), will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of C-sections, prescription of opioids and low back imaging. http://www.iha.org/grants-projects-reducing-overuse-workgroup.html (See Article 7, Section 7.05)

2) Covered California is interested in Contractors' participation in other collaborative initiatives. As part of the application for certification for 2017, and annually thereafter, for negotiation purposes, Contractor will be required to report to Covered California its participation in any of the following collaboratives, or other similar activities not listed:

(a) CMMI's Transforming Clinical Practices, administered by:

i. Children's Hospital of Orange County,

ii. LA Care,

iii. National Rural Accountable Care Consortium,

iv. California Quality Collaborative of PBGH, and

v. VHA/UHC Alliance NewCo, Inc.

All five of these collaboratives are coaching accessible, data-driven, team-based care over the course of the grant 2015-2019. https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/ (See Article 4, section 4.02)

(b) Partnership for Patients: The CMS Innovation Center (CMMI) implemented this program focused on hospital patient safety, which between 2012 and 2014 resulted in 87,000 fewer deaths, mostly in 2013-14. (http://www.ahrq.gov/professionals/quality-patient safety/pfp/interimhacrate2014.html See article 5, section 5.02)

Awardees working with California hospitals for 2015-2016 are:

i. Hospital Quality Initiative subsidiary of the California Hospital Association.

ii. Dignity Hospitals,

iii. VHA/UHC, and

iv. Children's Hospitals' Solutions for Patient Safety

v. Premiere, Inc.

(c) 1115 Medicaid Waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program

(d) California Joint Replacement Registry developed by the California Healthcare Foundation (CHCF), California Orthopedic Association (COA) and PBGH

(e) California Immunization Registry (CAIR)

(f) Any IHA or CMMI sponsored payment reform program

(g) CMMI ACO Program (including Pioneer, Savings Sharing, Next Gen ACO, and other models)

(h) California Perinatal Quality Care Collaborative

(i) California Quality Collaborative

(l) Leapfrog

(m) A Federally Qualified Patient Safety Organization such as CHPSO

(n) The IHA Encounter Standardization Project

3) When reporting this information to Covered California, such information shall be in a form that is mutually agreed upon by the Contractor and may include copies of reports used by Contractor for other purposes. Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of these programs which will include: (1) the percentage of total Participating Providers, as well as the percentage of Covered California specific Providers participating in the programs; (2) the number and percentage of potentially eligible Plan Enrollees who participate through the Contractor in the Quality Initiative; (3) the results of Contractors' participation in each program, including clinical, patient experience and cost impacts; and (4) such other information as Covered California and the Contractor identify as important to identify programs worth expanding.

4) Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees and Covered California may require participation in specific collaboratives in future years.

1.07 Data Exchange with Providers

Covered California and Contractor recognize the critical role of sharing data across specialties and institutional boundaries as well as between health plans and contracted Providers in improving quality of care and successfully managing total costs of care.

1) Contractor will be required to report in its annual application for certification for negotiation purposes, the initiatives Contractor has undertaken to improve routine exchange of timely information with Providers to support their delivery of high quality care. Examples that could impact the Contractor's success under this contract may include:

(a) Notifying Primary Care clinicians when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without the

knowledge of either the primary care or specialty Providers who have been managing the patient on an ambulatory basis.

(b) Developing systems to collect clinical data as a supplement to the annual HEDIS process, such as HbA1c lab results and blood pressure readings which are important under Article 3 below.

(c) Racial and ethnic self-reported identity collected at every patient contact.

2) Contractor will be required to describe its participation in statewide or regional initiatives that seek to make data exchange routine, including, but not limited to the following Health Information Exchanges:

(a) Inland Empire Health Information Exchange (IEHIE)

(b) Los Angeles Network for Enhanced Services (LANES)

(c) Orange County Partnership Regional Health Information Organization (OCPRHIO)

(d) San Diego Health Connect

(e) Santa Cruz Health Information Exchange

(f) CalIndex

1.08 Data Aggregation across Health Plans

Covered California and Contractor recognize the importance of aggregating data across purchasers and payors to more accurately understand the performance of Providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a Provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting.

1) Contractor will be required to report in its annual application for certification for negotiation purposes, its participation in initiatives to support the aggregation of claims and clinical data. Contractor must include its assessment of additional opportunities to improve measurement and reduce the burden of data collection on Providers through such proposals as a statewide All Payor Claims Database.

Examples include but are not limited to:

(a) The Integrated Health Association (IHA) for Medical Groups

(b) The California Healthcare Performance Information System (CHPI)

(c) The CMS Physician Quality Reporting System

(d) CMS Hospital Compare or

(e) CalHospital Compare

ARTICLE 2
PROVISION AND USE OF DATA AND INFORMATION FOR QUALITY OF CARE

2.01 HEDIS and CAHPS Reporting

Contractor shall annually collect and report to Covered California, for each QHP Issuer product type, its Quality Rating System HEDIS, CAHPS and other performance data (numerators, denominators, and rates). Contractor must provide such data to Covered California each year regardless of the extent to which CMS uses the data for public reporting or other purposes.

Contractor shall submit to Covered California HEDIS and CAHPS scores to include the measure numerator, denominator and rate for the required measures set that is reported to NCQA Quality Compass and DHCS, for each Product Type for which it collects data in California. The timeline for Contractor's HEDIS and CAHPS quality data must be submitted at the same time as Contractor submits this to the NCQA Quality Compass and DHCS. Covered California reserves the right to use the Contractor-reported measures to construct Contractor summary quality ratings that Covered California may use for such purposes as supporting consumer choice and Covered California's oversight of Contractor's QHPs.

2.02 Data Submission Requirements

Contractor and Covered California agree that the assessment of quality and value offered by a QHP to enrollees is dependent on consistent, normalized data, so that the Contractor and Covered California can evaluate the experience of Contractor's membership, and compare that experience to the experience of Enrollees covered by other QHP issuers, and to the Covered California population as a whole. In order to conduct this assessment, Contractor shall provide certain information currently captured in contractor's information systems related to its participation in the Exchange EAS Vendor in a manner consistent to that which Contractor currently provides to its major purchasers.

1) Disclosures to Enterprise Analytics Vendor:

(a) Covered California has entered into a contract with an Enterprise Analytics Vendor ("EAS Vendor") to support its oversight and management of health exchange. EAS Vendor has provided Contractor with a written list of data elements ("EAS Dataset") and a data submission template that defines the data elements and format for transmitting the data. Contractor shall provide EAS Vendor with the data identified in the EAS Dataset on a monthly basis, which is attached as Appendix 1 to this Attachment 7. The parties may modify the data fields in Appendix 1 to Attachment 7 upon mutual agreement of the parties, and without formal amendment to this Agreement.

(b) To enable the submission of the EAS Dataset to EAS Vendor, Contractor has executed a Business Associate Agreement ("BAA"), and any other agreements that Contractor determines are required for the submission of the EAS Dataset to EAS Vendor. Contractor's obligation to provide any data to EAS Vendor is contingent on a BAA being in force at the time information is to be provided to EAS Vendor. Covered California may, upon request to Contractor, review such BAA and any other agreements between Contractor and EAS Vendor related to the submission of the EAS Dataset.

2) Disclosures to Covered California:

(a) EAS Vendor must protect the EAS Dataset submitted to it by Contractor pursuant to the BAA and any other agreements entered into with Contractor, applicable federal and state laws, rules and regulations, including the HIPAA Privacy and Security Rules. Any data extract or report ("EAS Output") provided to Covered California and generated from the EAS Dataset shall at all times be limited to de-identified data. Covered California shall not request any Personally Identifiable Health Information from EAS Vendor or attempt to use the de-identified data it receives from EAS Vendor to re-identify any person.

3) EAS Vendor Designation:

(a) Truven Health Analytics ("Truven") is Covered California's current EAS Vendor. In the event that Covered California terminates its contract with Truven during the term of this Agreement, Covered California shall provide notice to Contractor pursuant to section 12.3 of the Agreement. Any such termination of the agreement with Truven shall excuse any performance of Contractor under this section 2.02 effective on the date of termination of the agreement with Truven until a replacement EAS Vendor is designated.

4) Covered California is a Health Oversight Agency:

(a) Covered California continues to maintain that it operates as a Health Oversight Agency as described by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. As such, Contractor may disclose protected health information to Covered California, or its vendor, in order for Covered California to perform its mandated oversight activities. At such time that Covered California receives technical assistance from the Office for Civil Rights, or otherwise receives guidance from the federal government, that reasonably confirms Covered California's status as a Health Oversight Agency, Contractor shall provide Covered California, or its vendor, with the necessary data elements, including protected health information as permitted by state and federal laws, in order for Covered California to perform its mandated oversight activities.

2.03 eValue8 Submission

For measurement year 2017, Contractor will be required to respond to those eValue8 questions identified and required by Covered California in the Covered California eValue8 Health Plan Request for Information as part of the application for certification for 2019.

Such information will be used by Covered California to evaluate Contractor's performance under the terms of the Quality, Network Management, Delivery System Standards and Improvement Strategy and in connection with the evaluation regarding any extension of this Agreement and the recertification process for subsequent years. The timing, nature and extent of such responses will be established by Covered California based on its evaluation of various quality-related factors.

Contractor's response shall include information relating to all of Contractor's then-current Covered California-based business and any information that reflects California-based business when data on Covered California-specific business is not available. If applicable, Contractor must report data separately for HMO/POS, PPO and EPO product lines.

Contractor will be required to provide Covered California information regarding their quality improvement and delivery system reform efforts through annual reporting in the Covered California eValue8 Health Plan RFI in the annual application for certification. Such information in connection with the evaluation regarding any extension of this Agreement and the recertification process for subsequent years and may include copies of reports used by the Contractor for other purposes.

2.04 Data Measurement Specifications

The measurement specifications for data reporting requirements in this attachment are included in Appendix 2 to this attachment.

ARTICLE 3
REDUCING HEALTH DISPARITIES AND ENSURING HEALTH EQUITY

Mitigation of health disparities is central to the mission of Covered California, and the California Language Assistance Act adopted as SB 853 in 2003. In alignment with these principles, Covered California and Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Covered California will require Contractor to track, trend and reduce health disparities with the phased approach outlined below.

3.01 Measuring Care to Address Health Equity

Contractor must track and trend quality measures by racial or ethnic group, or both, and by gender for the Contractor's full book of business, excluding Medicare.

1) Identification:

(a) By the end of 2019, Contractor must achieve 80 percent self-identification of racial/ethnic identity for Covered California enrollees.

(b) In the application for certification for 2017, Contractor will be required to report the percent of self-reported racial or ethnic identity for Covered California enrollees.

(c) Covered California and Contractor will negotiate annual targets to be reported in the applications for certification for 2018 and beyond.

(d) To the extent Contractor does not have self-reported information on racial or ethnic identity, or both, it shall use a standardized tool for proxy identification through the use of zip code and surname to fill any gaps in information.

2) Measures for Improvement:

(a) Disparities in care by racial and ethnic identity and by gender will be reported by QHP Issuers in the annual application for certification based on its Enrollees. The tool for proxy identification shall be used to supplement self-reported racial or ethnic identity. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business where comparative data can offer meaningful reference points.

(b) Measures selected for improvement beginning in plan year 2017 include Diabetes, Hypertension, Asthma (control plus hospital admission and ER visit rates) and Depression (HEDIS appropriate use of medications and all-cause ER utilization).

(c) Covered California will consider adding additional measures for plan year 2020 and beyond.

3.02 Narrowing Disparities

While Covered California and Contractor recognize that some level of disparity is determined by social and economic factors beyond the control of the health care delivery system, there is agreement that health care disparities can be narrowed through quality improvement activities tailored to specific populations and targeting select measures at the health plan level. Covered California and the Contractor agree that collection of data on clinical measures for the purpose of population health improvement requires development and adoption of systems for enhanced information exchange (see Section 1.07).

1) In the application for certification for 2017, Contractor reported baseline measurements from plan year 2015 on the measures listed in 3.01(2)(a) of this Attachment, based either on self-reported identity or on proxy identification on its Enrollees. Covered California anticipates that this baseline data may be incomplete.

2) Targets for 2019 and for annual intermediate milestones in reduction of disparities will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

3.03 Expanded Measurement

Contractor and Covered California will work together to assess the feasibility and impact of extending the disparity identification and improvement program over time. Areas for consideration include:

1) Income

2) Disability status

3) Sexual orientation

4) Gender identity

5) Limited English Proficiency (LEP)

3.04 NCQA Certification

Meeting the standards for Multicultural Health Care Distinction by NCQA is encouraged as a way to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies. To the extent Contractor has applied for or received NCQA Certification, Contractor must provide this information with its annual application for certification. Covered California may publicly recognize this achievement and include it in information provided to consumers.

ARTICLE 4
PROMOTING DEVELOPMENT AND USE OF EFFECTIVE CARE MODELS

Covered California and Contractor agree that promoting the triple aim requires a foundation of effectively delivered primary care and integrated services for patients that is data driven, team based and crosses specialties and institutional boundaries. Contractor agrees to actively promote the development and use of care models that promote access, care coordination and early identification of at-risk enrollees and consideration of total costs of care. Contractor agrees to design networks and payment models for Providers serving Enrollees to reflect these priorities.

In particular, the Covered California's priority models which align with the CMS requirements under the QIS, are:

1) Effective primary care services, including ensuring that all enrollees have a Primary Care clinician.

2) Promotion of Patient-Centered Medical Homes (PCMH), which use a patient-centered, accessible, team-based approach to care delivery, member engagement, and data-driven improvement as well as integration of care management for patients with complex conditions, and

3) Integrated Healthcare Models (IHM) or Accountable Care Organizations, such as those referenced by the Berkeley Forum (2013) that coordinate care for patients across conditions, Providers, settings and time, and are paid to deliver good outcomes, quality and patient satisfaction at an affordable cost.

4.01 Primary Care

Contractor must ensure that all Enrollees either select or be provisionally assigned to a Primary Care clinican by January 1, 2017 or within 60 days of effectuation into the plan, whichever is sooner. If an Enrollee does not select a Primary Care clinician, Contractor must provisionally assign the Enrollee to a Primary Care clinician, inform the Enrollee of the assignment and provide the enrollee with an opportunity to select a different Primary Care clinician. When assigning a Primary Care clinician, Contractor shall use commercially reasonable efforts to assign a Primary Care clinician consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, geographic accessibility, existing family member assignment, and any prior Primary Care clinician. Contractor will be required to report on this requirement annually in the application for certification for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.02 Patient-Centered Medical Homes

A growing body of evidence shows that advanced models of primary care, often called Patient-Centered Medical Homes (PCMH), greatly improve the care delivered to patients and support triple aim goals.

1) Contractor agrees to cooperate with Covered California in evaluating various PCMH accreditation and certification programs promulgated by national entities, as well as other frameworks for determining clinical practice transformation, with the goal of adopting a consistent standard definition across covered QHP Issuers for determining which Providers or practices meet the standards for redesigned primary care in Covered

California networks. Covered California and Contractor agree to engage interested stakeholders, including Providers and other purchasers, such as CalPERS, the Department of Health Care Services (DHCS) and private employers, in the process of developing this standard definition in preparation for use in the application for certification for 2018. As part of this effort, Contractor agrees to work with Covered California to limit the reporting burden on Providers.

2) Contractor will be required to describe in its application for certification for 2017, a payment strategy for adoption and progressive expansion among Providers caring for Enrollees, that creates a business case for Primary Care Providers to adopt accessible, data-driven, team-based care (alternatives to face-to-face visits and care provided by non-MDs) with accountability for meeting the goals of the triple aim, including total cost of care.

3) Contractor will be required to report in the application for certification for 2018:

   (a) The number and percent of Covered California enrollees who obtain their primary care in a PCMH.

   (b) Based on the data provided in the 2018 Application, Covered California will establish targets for 2019 for the percent of Covered California enrollees obtaining primary care in a PCMH based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

   (c) A baseline of the percent of Primary Care clinicians whose contracts for Covered California Enrollees are based on the payment strategy defined in 4.02(2) for primary care services.

   (d) Methods for enrolling or attributing members to a PCMH including whether the plan engages in formal enrollment and or outreach to members based on a risk algorithm.

   (e) How Contractor's payment to PCMH practices differs from those payments made to practices that have not met PCMH standards.

4) Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points. The non-Covered California lines of business data is to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be submitted as part of Contractor's annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.03 Integrated Healthcare Models (IHM) or Accountable Care Organizations (ACO)

Covered California places great importance on the adoption and expansion of integrated, coordinated and accountable systems of care and is adopting a modified version of the CalPERS definition for Integrated HealthCare Models also known as Accountable Care Organizations (ACOs):

1) The IHM is defined as:

(a) A system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary Providers.

(b) Having at least Level three (3) integration, as defined by the Institutes of Medicine (IOM), of certified Electronic Health Record (EHR) technology in both a hospital inpatient and ambulatory setting provided either by a Provider organization or by Contractor:

i. Ambulatory level of integration will include, at minimum, electronic charts, a data repository of lab results, connectivity to hospitals, partial or operational point of care technology, electronic assistance for ordering, computerized disease registries (CDR), and e-mail.

ii. Hospital inpatient level of integration will include, at minimum, lab, radiology, pharmacy, CDR, clinical decision support, and prescription documentation.

iii. There must be Stage two (2) (Advanced Clinical Processes) of Meaningful Use of the certified EHR within the IHM including:

a. Health Information and Data,

b. Results Management,

c. Order Entry/Management,

d. Clinical Decision Support

e. Electronic Communications and Connectivity, and

f. Patient Support.

(c) Having combined risk sharing arrangements and incentives between Contractor and Providers, and among Providers across specialties and institutional boundaries, holding the IHM accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes. As Providers accept more accountability under this provision, Contractors shall be aware of their obligations in the Health and Safety Code and Insurance Code to ensure that Providers have the capacity to manage the risk.

2) Contractor must provide Covered California with details on its existing or planned integrated systems of care describing how the systems meet the criteria in Article 4.03(1), including the number and percent of Enrollees who are managed under IHMs in its response to the annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years..

3) Targets for 2017-2019 for the percentage of Enrollees who select or are attributed to IHMs will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

4) Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points. The non-Covered California lines of business data is to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be required as part of Contractor's annual application for certification.

4.04 Mental and Behavioral Health

Covered California and Contractor recognize the critical importance of Mental and Behavioral Health Services as part of the broader set of medical services provided to Enrollees.

Contractor will be required to report in its annual application for certification on the strategies Contractor has implemented and its progress in:

1) Making behavioral health services available to Enrollees;

2) How it is integrating Behavioral Health Services with Medical Services; and

3) Reports must include documenting the percent of services provided under an integrated behavioral health-medical model for Enrollees and the reports should include the percent for Contractor's overall covered lives, where such information is useful for comparison purposes and informing future Covered California requirements. These reports should also include whether these models are implemented in association with PCMH and IHM models or are independently implemented and will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.05 Telemedicine and Remote Monitoring

In the annual application for certification, Contractor will be required to report the extent to which the Contractor is supporting and using technology to assist in higher quality, accessible, patient-centered care, and the utilization for Enrollees on the number of unique patients and number of separate servicing provided for telemedicine and remote home monitoring. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

Reporting requirements will be met through eValue8 in the annual application for certification, but contractor may supplement such reports with data on the efficacy and impact of such utilization. These reports must include whether these models are implemented in association with PCMH and IHM models or are independently implemented.

ARTICLE 5
HOSPITAL QUALITY

Covered California and Contractor recognize that hospitals have contracts with multiple health plans and are engaged in an array of quality improvement and efficiency initiatives. Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers.

5.01 Hospital Payments to Promote Quality and Value

Covered California expects its Contractors to pay differently to promote and reward better quality care rather than pay for volume. Contractor shall:

1) Adopt a hospital payment methodology that incrementally places at least six percent of reimbursement to hospitals for Contractor's Covered California business with each general acute care hospital at-risk or subject to a bonus payment for quality performance. At minimum, this methodology shall include two percent of reimbursement by January 1, 2019 with a plan for satisfying future increases in reimbursement, four percent of reimbursement by January 1, 2021 and six percent by January 1, 2023. Contractor may structure this strategy according to its own priorities such as:

   (a) The extent to which the payments "at risk" take the form of bonuses, withholds or other penalties; or

   (b) The selection of specific metrics upon which performance based payments are made may include, but are not limited to, Hospital Acquired Conditions (HACs), readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS), but Contractor must use standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum – with the goal of limiting measurement burden on hospitals.

   (c) Contract arrangements with hospitals that participate in Integrated Healthcare Models or Accountable Care Organizations, whether sponsored by the QHP Issuer or by Provider organizations, which include accountability or shared risk for total cost of care shall be considered to have met this requirement.

2) Because there is some evidence that readmissions may be influenced by social determinants beyond the control of the health care system or social supports that a hospital can provide at discharge, if Contractor includes readmissions as a measure under this provision, it shall not be the only measure. Additionally, Contractor must adopt balancing measures to track, address, and prevent unintended consequences from at-risk payments including exacerbation of health care disparities. Contractor shall report what strategies it is implementing to support hospitals serving at-risk populations in achieving target performance. In alignment with CMS rules on payments to hospitals for inpatient hospital services, Critical Access Hospitals as defined by the Centers for Medicare and Medicaid, are excluded from this requirement. In addition, the following types of hospitals are excluded from this requirement:

   a) Long Term Care hospitals

   b) Inpatient Psychiatric hospitals

c) Rehabilitation hospitals

d) Children's hospitals

Contractor shall still be accountable for the quality of care and safety of Covered California members receiving care in the aforementioned hospitals. Implementation of this requirement may differ for integrated delivery systems and require alternative mechanisms for tying payment to performance.

3) Report in its annual application for certification for negotiation purposes, for Enrollees, the:

(a) Amount, structure and metrics for its hospital payment strategy;

(b) The percent of network hospitals operating under contracts reflecting this payment methodology;

(c) The total dollars and percent or best estimate of hospital payments that are tied to this strategy; and

(d) The dollars and percent, or best estimate that is respectively paid or withheld to reflect value. The hospital payments to promote value must be distinct from shared-risk and performance payments to hospitalization related to participation in IHMs as described in Article 4.03.

Additionally, Contractor agrees to work with Covered California to provide comparison reporting for Contractor's entire book of business where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

5.02 Hospital Patient Safety

1) Contractor agrees to work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients. Exclusions for this requirement include CMS Critical Access Hospitals as defined by the Centers for Medicare and Medicaid. In addition, the following types of hospitals are excluded:

(a) Long Term Care hospitals

(b) Inpatient Psychiatric hospitals

(c) Rehabilitation hospitals

(d) Children's hospitals

2) Contractor will be required to report in its annual application for certification, baseline rates of specified HACs for each of its network hospitals. In order to obtain the most reliable measurement, minimize the burden on hospitals and in the interest of promoting common measurement, Contractor must employ best efforts to base this report on clinical data, such as is reported by hospitals to the National Healthcare Safety Network (NHSN),

California Department of Public Health (CDPH) and to CMS under the Partnership for Patients initiative. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

3) Prior to the application for certification for 2018, target rates for 2019 and for annual intermediate milestones for each HAC measured at each hospital will be established by Covered California, based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

4) Covered California has identified an initial set of HACs for focus in 2017. Certain HACs may be substituted for others in the event that a common data source cannot be found. The decision to substitute HACs would be made transparently and collaboratively through the advisory process. The HACs that are currently the subject of the 2017 hospital safety initiatives are listed below:

   (a) Catheter Associated Urinary Tract Infection (CAUTI);

   (b) Central Line Associated Blood Stream Infection (CLABSI);

   (c) Surgical Site Infection (SSI) with focus on colon;

   (d) Adverse Drug Events (ADE) with first-year focus on opioid overuse; and

   (e) Clostridium difficile colitis (C. Diff) infection.

5) The subject HACs may be revised in future years. Covered California expects to include additional ADEs including hypoglycemia and inappropriate use of blood thinners as well as Sepsis Mortality at such time as the standardized CMS definition and measurement strategy has been tested and validated.

6) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. To meet this expectation, by year end 2017, Covered California will work with QHP Issuers and with California's hospitals to identify areas of "outlier poor performance" based on variation analysis of HAC rates. For contract year 2019, as detailed in Article 1.02(3), Contractors must either exclude hospitals that demonstrate outlier poor performance on safety from Provider networks serving Covered California or to document each year in its application for certification the rationale for continued contracting with each hospital that is identified as a poor performing outlier on safety and efforts the hospital is undertaking to improve its performance.

5.03 Appropriate Use of C-Sections

Contractor agrees to actively participate in the statewide effort to promote the appropriate use of C-sections. This ongoing initiative sponsored by Covered California, DHCS and CalPERS as well as major employers is coordinated with CalSIM, and has adopted the goal of reducing NTSV (Nulliparous, Term Singleton, Vertex) C-section rates to meet or exceed the national Healthy

People 2020 target of 23.9 percent for each hospital in the state by 2019. In addition to actively participating in this collaborative, Contractor shall:

1) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to enroll in the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC).

2) Annually report in its application for certification the C-section rate for NTSV deliveries and the overall C-Section rate for each of its network hospitals for the hospital's entire census. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

3) Adopt a payment methodology progressively to include all contracted physicians and hospitals serving Enrollees, such that by 2019, payment is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Contractor must report on its design and the percent of hospitals contracted under this model in its annual application for certification.

4) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. Beginning with the application for certification for 2019, As detailed in Article 1.02(3), Contractors must either exclude hospitals from networks serving Enrollees that are unable to achieve an NTSV C-section rate below 23.9 percent from Provider networks or to document each year in its application for certification the rationale for continued contracting with each hospital that has an NTSV C-Section rate above 23.9 percent and efforts the hospital is undertaking to improve its performance.

ARTICLE 6
POPULATION HEALTH: PREVENTIVE HEALTH, WELLNESS AND AT-RISK ENROLLEE SUPPORT

Covered California and Contractor recognize that access to care, timely preventive care, coordination of care, and early identification of high risk enrollees are central to the improvement of Enrollee health. Contractor and Covered California shall identify ways to increase access and coordination of care and work collaboratively to achieve these objectives.

6.01 Health and Wellness Services

Contractor shall ensure Enrollees have access to preventive health and wellness services. For the services described below, Contractor must identify Enrollees who are eligible, notify Enrollees of their availability, and report utilization.

1) Necessary preventive services appropriate for each Enrollee. Contractor must report utilization to Covered California on the number and percent of Enrollees who take advantage of their wellness benefit.

2) Tobacco cessation intervention, inclusive of evidenced-based counseling and appropriate pharmacotherapy, if applicable. Contractor must report to Covered California the number and percent of Enrollees who take advantage of the tobacco cessation benefit.

3) Obesity management, if applicable. Contractor must report to Covered California the number and percent of its Enrollees who take advantage of the obesity benefit.

4) To ensure the Enrollee health and wellness process is supported, Contractor must report on its:

   (a) Health and wellness communication processes delivered to its Enrollees and applicable Participating Providers, that take into account cultural and linguistic diversity; and

   (b) Processes to incorporate Enrollee's health and wellness information into Contractor's data and information specific to each individual Enrollee. This Enrollee's data is Contractor's most complete information on each Enrollee and is distinct from the Enrollee's medical record maintained by the Providers.

Contractor will be required to report on each of these four service categories in its annual application for certification. Additionally, Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for exchange-only business and any required data will be submitted as part of Contractor's annual application for certification.

For each of the four service categories described above, Covered California will establish targets for 2018 and annual milestones thereafter for the percent of the population that uses annual preventive visits based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders

6.02 Community Health and Wellness Promotion

Covered California and Contractor recognize that promoting better health for Enrollees also requires engagement and promotion of community-wide initiatives that foster better health, healthier environments and the promotion of healthy behaviors across the community. Contractor is encouraged to support community health initiatives that have undergone or are being piloted through systematic review to determine effectiveness in promoting health and preventing disease, injury, or disability and have been recommended by the Community Preventive Services Task Force.

Contractor will be required to report annually in its application for certification the initiatives, programs and projects that it supports that promote wellness and better community health for Enrollees, and is encouraged to report on such initiatives for Contractor's overall population. Such reports must include available results of evaluations of these community programs for Enrollees, including clinical or other health impacts and efficacy and will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

Such programs may include:

1) Partnerships with local, state or federal public health departments such as Let's Get Healthy California;

2) CMS Accountable Health Communities;

3) Voluntary health organizations which operate preventive and other health programs such as CalFresh; and

4) Hospital activities undertaken under the Community Health Needs Assessment required every three years under the Affordable Care Act.

6.03 Determining Enrollee Health Status and Use of Health Assessments

Contractor shall demonstrate the capacity and systems to collect, maintain, use, and protect from disclosure individual information about Enrollees' health status and behaviors in order to promote better health and to better manage Enrollees' health conditions.

To the extent the Contractor uses or relies upon Health Assessments to determine health status, Contractor shall offer, upon initial enrollment and on a regular basis thereafter, a Health Assessment in all threshold languages to all Enrollees over the age of 18, including those Enrollees that have previously completed such an assessment. If a Health Assessment tool is used, Contractor should select a tool that adequately evaluates Enrollees current health status and provides a mechanism to conduct ongoing monitoring for future intervention(s).In addition, Health Assessments should advise policyholders at the outset on how the information collected may be used, and explain that the member is opting in to receive information from the plan, and that participating in the assessment is optional.

6.04 Reporting to and Collaborating with Covered California Regarding Health Status

Contractor shall provide to Covered California, in a format that shall be mutually agreed upon, information on how it collects and reports, at both individual and aggregate levels, changes in Enrollees' health status. Reporting may include a comparative analysis of health status improvements across geographic regions and demographics.

Contractor shall report to Covered California its process to monitor and track Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such Enrollees to Contractor care management and chronic condition program(s) as defined in Section 6.05, for the necessary intervention. Contractor shall annually report to Covered California the number of Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

6.05 Supporting At-Risk Enrollees Requiring Transition

Contractor shall have an evaluation and transition plan in place for the Enrollees transitioning into or from employer-sponsored insurance, Medi-Cal, Medicare, or other insurance coverage who require therapeutic Provider and formulary transitions. Contractor shall also support transitions in the reverse direction. The plan must include the following:

1) Identification of in-network Providers with appropriate clinical expertise or any alternative therapies including specific drugs when transitioning care;

2) Clear processes to communicate Enrollee's continued treatment using a specific therapy, specific drug or a specific Provider when no equivalent is available in-network;

3) Where possible, advance notification and understanding of out-of-network Provider status for treating and prescribing physicians; and

4) A process to allow incoming Enrollees access to Contractor's formulary information prior to enrollment.

6.06 Identification and Services for At-Risk Enrollees

Contractor agrees to identify and proactively manage Enrollees with existing and newly diagnosed chronic conditions, including, diabetes, asthma, heart disease, or hypertension, and who are most likely to benefit from well-coordinated care ("At-Risk Enrollees"). Contractor agrees to support disease management activities at the plan or health care Provider level that meet standards of accrediting programs such as NCQA. Contractor shall provide Covered California with a documented process, care management plan and strategy for targeting and managing At-Risk Enrollees. Such documentation may include the following:

1) Methods to identify and target At-Risk Enrollees;

2) Description of Contractor's predictive analytic capabilities to assist in identifying At-Risk Enrollees who would benefit from early, proactive intervention;

3) Communication plan for known At-Risk Enrollees to receive information prior to Provider visit, including the provision of culturally and linguistically appropriate communication;

4) Process to update At-Risk Enrollee medical history in Contractor's maintained Enrollee health profile;

5) Process for sharing registries of Enrollees with their identified risk, as permitted by state and federal law, with appropriate accountable Providers, especially the enrollee's PCP.

6) Mechanisms to evaluate access within the Provider network on an ongoing basis, to ensure that an adequate network is in place to support a proactive intervention and care management program for At-Risk Enrollees;

7) Care and network strategies that focus on supporting a proactive approach to At-Risk Enrollee intervention and care management. Contractor agrees to provide Covered California with a documented plan and include "tools" and strategies to supplement or expand care management and Provider network capabilities, including an expansion or reconfiguration of specialties or health care professionals to meet clinical needs of At-Risk Enrollees;

8) Data on number of Enrollees identified and types of services provided.

ARTICLE 7

PATIENT-CENTERED INFORMATION AND SUPPORT

Empowering consumers with knowledge to support healthcare decision-making is a crucial part of Covered California's mission and naturally promotes the Triple Aim by supporting decisions consistent with the Enrollee's values and preferences and fostering consumer access to care.

Covered California and Contractor agree that valid, reliable, and actionable information relating to the cost and quality of healthcare services is important to Enrollees, Covered California, and Providers.

Thus, Covered California expects that Contractor will participate in activities necessary to provide this information to consumers. The specifics of this phased approach are described in Section 7.01 below.

7.01 Enrollee Healthcare Services Price and Quality Transparency Plan

1) In the application for certification for 2017, Contractor will have reported for negotiation and certification purposes, its planned approach to providing healthcare shopping cost and quality information available to all Enrollees. Covered California does not require using a specific form or format and recognizes that the timeline and expectations will differ, based on variables such as Contractor's membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Contractor planned approach must include:

   (a) Cost information:

      i. That enables Enrollees to understand their exposure to out-of-pocket costs based on their benefit design, including real time information on member accumulation toward deductibles, when applicable, and out of pocket maximums. Health Savings Account (HSA) user information shall include account deposit and withdrawal/payment amounts.

      ii. That enables Enrollees to understand Provider-specific consumer cost shares for prescription drugs and for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings. Such information must include the facility name, address, and other contact information and be based on the contracting rates to give the Enrollee estimates of out of pocket costs that are as accurate as possible.

      iii. Commonly used service information should be organized in ways that are useful and meaningful for consumers to understand.

   (b) Quality information:

      i. That enables Enrollees to compare Providers based on quality performance in selecting a Primary Care clinician or common elective specialty and hospital Providers.

      ii. That is based on quality measurement consistent with nationally-endorsed quality information in accordance with the principles of the

Patient Charter for Physician Performance Measurement.

iii. That, as an interim step prior to integrating quality measurement into Provider chooser tools, can be provided by linking to:

a. The California Office of the Patient Advocate (www.opa.ca.gov/)

b. The Department of Insurance Healthcare Compare (www.consumerreports.org/cro/health/california-health-cost-and-quality---consumer-reports/index.htm)

c. CMS Hospital Compare Program (https://www.medicare.gov/hospitalcompare/search.html)

d. CMS Physician Quality Reporting System (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqri/)

iv. In addition, Contractor must recognize California hospitals that have achieved target rates for HACs and NTSV C-Section utilization as defined in Article 5, Sections 5.02 and 5.03.

(c) Health Insurance Benefit Information. Contractor shall make available personalized benefit-specific information to all enrollees that includes accumulations of expenses applicable to deductible and out-of-pocket maximums.

(d) Contractor agrees to monitor care provided out of network to ensure that consumers understand that their cost share will be higher and are choosing care out of network intentionally.

(e) If Contractor enrollment exceeds 100,000 for Covered California business, the cost and quality information shall be provided through an online tool easily accessible across a variety of platforms and made available by 2018. If Contractor enrollment is under 100,000 for Covered California business, the information may be provided by alternative means such as a call center.

2) Contractor will be required in its annual application for certification to:

(a) Report the number and percent of unique Enrollees for each of the consumer tools offered for the reporting period of the plan year.

(b) Report user experience with the tool (or equivalent service such as a call center) from a representative sample of users who respond to a survey which includes a user overall satisfaction with rating.

(c) Provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for exchange-only business and any required data will be submitted as part of Contractor's annual application for certification

7.02 Enrollee Personalized Health Record Information

1) In its Application for Certification for 2017, Contractor will have reported for negotiation and certification purposes, the extent to which Enrollees can easily access personal health information or have reported its plan to provide such access through such tools as a Personal Health Record (PHR) or other "patient portal".

2) The content of such PHRs includes: medical records, billing and payment records, insurance information, clinical laboratory test results, medical images such as X-rays, wellness and disease management program files, clinical case notes, and other information used to make decisions about individuals.

3) Covered California will establish targets for 2019 and annual milestones thereafter for Enrollee use of personal health information based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

4) Contractor will provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

7.03. Enrollee Shared Decision-Making

Covered California requires deployment of decision-making tools to support Enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their Provider. Educating Enrollees on their diagnosis and alternative treatment options is a powerful evidence-based approach to reducing overuse or misuse of clinical interventions.

Contractor agrees to promote and encourage patient engagement in shared decision-making with contracted Providers.

1) Contractor will be required to report in its annual application for certification specific information regarding the number of Enrollees who have accessed consumer information or have participated in a shared decision-making process prior to reaching an agreement on a treatment plan. For example, Contractor may adopt shared-decision-making practices for preference-sensitive conditions, including breast cancer, prostate cancer, and knee and hip replacements, that feature patient-decision-making aids in addition to physician opinions and present trade-offs regarding quality or length of life.

2) Contractor will be required to report in its annual application for certification the percentage of Enrollees with identified health conditions above who received information

that allowed the Enrollee to share in the decision-making process prior to agreeing to a treatment plan.

3) Contractor will be required to report in its annual application for certification participation in these programs and their results, including clinical, patient experience and costs impacts.

4) These reports will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

7.04 Reducing Overuse through Choosing Wisely

Contractor shall participate in the statewide workgroup on Overuse sponsored by Covered California, DHCS and CalPERS. This multi-stakeholder work group facilitated by IHA, will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of:

1) C- Sections for low risk (NTSV) deliveries;
2) Opioid overuse and misuse; and
3) Imaging for low back pain.

The mechanism for reduction of NTSV C-Sections will be participation in the California State Initiative Model (CalSIM) Maternity Care Initiative, with the target of ensuring all network hospitals achieve rates of 23.9 percent or less by 2020. (See section 5.03)

Improvement strategies and targets for 2019 as well as for annual intermediate milestones in reductions of overuse of opioids and imaging for low back pain will be established by Covered California in collaboration with other stakeholders participating in the workgroup based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

ARTICLE 8
PAYMENT INCENTIVES TO PROMOTE HIGHER VALUE CARE

8.01 Reward-based Consumer Incentive Programs

Contractor may, to the extent permitted by law, maintain or develop a Reward-based Consumer Incentive Program to promote evidence-based, optimal care for Enrollees with identified chronic conditions. To the extent Contractor implements such a program and to the extent such information is known, Contractor shall report participation rates and outcomes results, including clinical, patient experience and cost impacts, to Covered California annually.

8.02 Value-Based Reimbursement Inventory and Performance

Contractor agrees to implement value-based reimbursement methodologies to Providers within networks contracted to serve Covered California. Value-based reimbursement methodologies must include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and value measures and must include the Contractor's entire book of business with the Provider.

1) Among the strategies for which Covered California has established requirements for payment strategies to support delivery system reforms are:

   (a) Advanced Primary Care or Patient-Centered Medical Homes (4.02)

   (b) Integrated Healthcare Models (4.03)

   (c) Appropriate use of C-sections (5.03)

   (d) Hospital Patient Safety (5.02)

2) In addition to the required payment strategies above, Contractor will be required to report in its annual application for certification an inventory and evaluation of the impact of other value-based payment models it is implementing including, but not limited to:

   (a) Direct participation or alignment with CMMI innovative payment models such as the Oncology or Joint Replacement model; and

   (b) Adoption of new Alternative Payment Models associated with the implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

8.03 Value-Pricing Programs

Contractor agrees to provide Covered California with the details of any value-pricing programs for procedures or in service areas that have the potential to improve care and generate savings for Enrollees. Contractor agrees to share with Covered California, the results of programs that may focus on high cost regions or those with the greatest cost variation(s). These programs may include payment bundling pilots for specific procedures where wide cost variations exist.

8.04 Payment Reform and Data Submission

1) Contractor agrees to provide information to Covered California pursuant to this Article 8, understanding that Covered California will provide such information to the Catalyst for Payment Reform's (CPR) National Scorecard on Payment Reform and National Compendium on Payment Reform.

2) The CPR National Scorecard will provide a view of progress on payment reform at the national level and then at the market level as the methodology and data collection mechanisms allow.

3) The CPR National Compendium will be an up-to-date resource regarding payment reforms being tested in the marketplace and their available results. The Compendium will be publicly available for use by all health care stakeholders working to increase value in the system.

4) Contractor must annually report on the progress and impact of value-oriented payment initiatives imputed to the Purchaser's annual spend for the preceding calendar year, using both the format and calculation methodology in the Covered California eValue8 RFI and CPR's Payment Reform Evaluation Framework.

ARTICLE 9
ACCREDITATION

1) Contractor agrees to maintain a current accreditation throughout the term of the Agreement from one of the following accrediting bodies: (i) Utilization Review Accreditation Commission (URAC); (ii) National Committee on Quality Assurance (NCQA); (iii) Accreditation Association for Ambulatory Health Care (AAAHC). Contractor shall authorize the accrediting agency to provide information and data to Covered California relating to Contractor's accreditation, including, the most recent accreditation survey and other data and information maintained by the accrediting agency as required under 45 C.F.R. § 156.275.

2) Contractor shall be currently accredited and maintain its NCQA, URAC or AAAHC accreditation throughout the term of the Agreement. Contractor shall notify Covered California of the date of any accreditation review scheduled during the term of this Agreement and the results of such review. Upon completion of any health plan accreditation review conducted during the term of this Agreement, Contractor shall provide Covered California with a copy of the Assessment Report within forty-five (45) days of report receipt.

3) If Contractor receives a rating of less than "accredited" in any category, loses an accreditation or fails to maintain a current and up to date accreditation, Contractor shall notify Covered California within ten (10) business days of such rating change and must provide Covered California with all corrective action(s). Contractor will implement strategies to raise Contractor's rating to a level of at least "accredited" or to reinstate accreditation. Contractor will submit a written corrective action plan (CAP) to Covered California within forty-five 45 days of receiving its initial notification of the change in category ratings.

4) Following the initial submission of the CAPs, Contractor shall provide a written report to Covered California on at least a quarterly basis regarding the status and progress of the submitted CAP. Contractor shall request a follow-up review by the accreditation entity at the end of twelve (12) months and submit a copy of the follow-up Assessment Report to Covered California within thirty (30) days of receipt, if applicable.

5) In the event Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, Covered California reserves the right to terminate this Agreement , suspend enrollment in Contractor's QHPs or avail itself of any other remedies in this Agreement, to ensure Covered California is in compliance with the federal requirement that all participating issuers maintain a current approved accreditation.

6) Upon request by Covered California, Contractor will identify all health plan certification or accreditation programs undertaken, including any failed accreditation or certifications, and will also provide the full written report of such certification or accreditation undertakings to Covered California.

Quality, Network Management and Delivery System Standards

Glossary of Key Terms

Accountable Care Organization (ACO) - A healthcare organization characterized by a payment and care delivery model that seeks to tie Provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. An ACO is intended to provide incentives for participating Providers (i.e. clinics, hospitals and physicians) to collectively share financial risk, working towards common goals to 1) reduce medical costs, 2) reduce waste and redundancy, 3) adhere to best care practices (i.e. evidence-based care guidelines, and 4) improve care quality. Care Management and Population Health Management are critical program components that are intended to enable ACOs to achieve favorable financial outcomes as the result of improved care outcomes.

Bundled Payments (also known as Global Payment Bundles, episode-of-care payment, or global case rates) - An alternative payment method to reimburse healthcare Providers for services that provides a single payment for all physician, hospital and ancillary services that a patient uses in the course of an overall treatment for a specific, defined condition, or care episode. These services may span multiple Providers in multiple settings over a period of time, and are reimbursed individually under typical fee-for-service models. The Payment Bundle may cover all inpatient/outpatient costs related to the care episode, including physician services, hospital services, ancillary services, procedures, lab tests, and medical devices/implants. Using Payment Bundles, Providers assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications, but not the insurance risk (that is, the risk that a patient will acquire that condition, as is the case under capitation).

Care Management - Healthcare services, programs and technologies designed to help individuals with certain long-term conditions better manage their overall care and treatment. Care management typically encompasses Utilization Management (UM), Disease Management (DM) and Case Management (CM). Care Management's primary goal is to prevent the sick from getting sicker, and avoiding acute care events. Care Management is usually considered a subset of Population Health Management.

Complex Conditions - Clinical conditions that are of a complex nature that typically involve ongoing case management support from appropriately trained clinical staff. Frequently, individuals have multiple chronic clinical conditions that complicate management ("polychronic") or may have a complex, infrequent specialty condition that requires specialized expertise for optimal management.

Delivery System Transformation - A set of initiatives taken by purchasers, employers, health plans or Providers, together or individually, to drive the creation and preferred use of care delivery models that are designed to deliver higher value aligned with the "triple aim" goals of patient care experience including quality and satisfaction, improve the health of the populations, and reduce the per capita cost of Covered Services. Generally these models require improved care coordination, Provider and payor information sharing and programs that identify and manage populations of individuals through care delivery and payment models.

Enrollees – Those individuals with coverage through the Issuer received through Covered California.

Patient Centered Medical Home - A health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information Covered California and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The medical home is best described as a model or philosophy of primary care that

is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Health Disparities - Healthy People 2020 defines a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”9 Racial and ethnic disparities populations include persons with Limited English Proficiency. (LEP).

Health Equity - Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

Primary Care - The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community. (IOM, 1978) Contractors may allow enrollees to select Nurse Practitioners and Physician Assistants to serve as their Primary Care clinician. Covered California does not require that Primary Care clinicians serve as a “gatekeeper” or the source of referral and access to specialty care. Covered California recognizes Internal Medicine, Pediatrics and Family Medicine as primary care specialties.

Population Health Management - A management process that strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the population. The goal of a Population Health Management program is to maintain and/or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions.

Preventive Health and Wellness Services - The provision of specified preventive and wellness services and chronic disease management services, including preventive care, screening and immunizations, set forth under Section 1302 of the Affordable Care Act (42 U.S.C. Section 18022) under the Section 2713 of the Affordable Care Act (42 U.S.C. Section 300gg-13), to the extent that such services are required under the California Affordable Care Act.

Reference Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care based on transparent display of comparative costs for identical services or procedures, typically after each Provider has passed a quality assessment screen. In some cases, value pricing will identify the individual enrollee’s out-of-pocket costs accounting for plan design and deductible status. While quality is incorporated in the process, typically there is no differentiation based on comparative quality once a threshold performance level is achieved.

Remote Patient Monitoring - A technology or set of technologies to enable monitoring of patients outside of conventional clinical settings (e.g. in the home), which may increase access to care and decrease healthcare delivery costs.

Reward Based Consumer Incentive Program - (aka: Value-Based Insurance Design) individualizes the benefits and claims adjudication to the specific clinical conditions of each high risk member and to reward participation in appropriate disease management & wellness programs. Positive Consumer Incentive

programs help align employee incentives with the use of high-value services and medications, offering an opportunity for quality improvement, cost savings and reduction in unnecessary and ineffective care.

Shared Decision Making - The process of making decisions regarding health care diagnosis and treatment that are shared by doctors and patients, informed by the best evidence available and weighted according to the specific characteristics and values of the patient. Shared decision making combines the measurement of patient preferences with evidence-based practice.

Team Care - A plan for patient care that is based on philosophy in which groups of professional and non-professional personnel work together and share the work to identify, plan, implement and evaluate comprehensive client-centered care. The key concept is a group that works together toward a common goal, providing qualitative comprehensive care. The team care concept has its roots in team nursing concepts developed in the 1950's.

Telemedicine - Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site. Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Value Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care that provide better value through the identification and transparent display of comparative total cost, out-of-pocket cost for enrollees and standardized quality performance to allow for informed consumer choice and Provider referrals for individual services and bundles of services.

Value-Based Reimbursement - Payment models that rewards physicians and Providers for taking a broader, more active role in the management of patient health, and provides for a reimbursement rate that reflects results and quality instead of solely for specific visits or procedures.

Appendix 1 to Attachment 7

Standard Layout								
Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
1	Subscriber SSN	1	9	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated		Not required at this time. Blank Fill.
2	CC_SubscriberID	10	29	20	Character	Unique code assigned by CC to the		
3	Enrollee SSN	30	38	9	Character	Member's Social Security Number		Not required at this time. Blank Fill.
4	CC_MemberID	39	58	20	Character	Unique code assigned by CC to the		
5	Plan_MemberID	59	78	20	Character	Unique code assigned by health plan to identify a member		Not required at this time. Blank Fill.
6	Policy ID	79	98	20	Character	Policy ID assigned by health plan		Not required at this time. Blank Fill.
7	Capitation Amount	99	108	10	Numeric	The pre-paid amount paid to plans or providers under risk-based managed		Format 9(7)v99 (2 - digit, implied decimal)
8	Capitation Type Code	109	109	1	Character	This field identifies the type of capitation payment record: • 1 – Professional • 2 – Facility • 3 – Mental Health • 4 – Drug • 5 – Dental • 6 – Vision • 7 – Hearing • 8 – Blended		
9	Date Paid	110	119	10	Date	The date the transaction was paid.		MM/DD/CCYY Format
10	Date of Service	120	129	10	Date	The date/period of service for the transaction. If the period of service is a month, this can be populated with the		MM/DD/CCYY Format
11	Gender Code	130	130	1	Character	The member's gender code.		"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
12	Date of Birth	131	140	10	Date	The birth date of the person.		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
13	Adjustment Type Code	141	141	1	Character	Client-specific code for the claim adjustment type.	Yes	Adjustment Type values will be identified in the **Data Dictionary**.
14	Provider Type Code	142	144	3	Character	This field contains the provider specialty code.	Yes	
15	Provider ID TIN	145	157	13	Character	The unique identifier for the provider. Providers include facilities, physicians, PCPs, pharmacies, and professionals.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
16	Provider NPI	158	167	10	Character	The National Provider Identifier for the provider.		
17	Withhold Amount	168	177	10	Numeric	Withheld Capitation Payment		

Standard Layout								
Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
18	Filler	178	699	522	Character	Reserved for future use		Fill with blanks
19	Record Type	700	700	1	Character	Record type identifier		Hard Code to "D"
End of Layout - Do not remove this row - All field additions to be inserted above the Filler Row								

Standard Layout								
Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	Data Supplier Comments
Standard Truven Health Analytics Fields								
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.	
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.	
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.	
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file	
5	Filler	45	699	655	Character	Reserved for future use	Fill with Blanks	
6	Record Type	700	700	1	Character	Record Type Identifier	Hard Code 'T'	
End of Layout - Do not remove this row - All field additions to be inserted above the Filler row								

TRUVEN HEALTH ANALYTICS

Covered California EAS
Enrollment Functional Specification
03/15/2016

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
3/15/2016	Dan Lopez	Field lenghts of race code increased to 3 bytes, added new field, Cost Share Reduction Amount
6/12/2015	Dan Lopez	Update after all data summits
5/26/2015	Katie Andrada-Bacorn	Update after initial data summit
5/19/2015	Dan Lopez	Updated after meeting with Covered CA and Cal HEERS
5/11/2015	Dan Lopez	initial document

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a monthly enrollment file for plan participants.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

Data will be provided in a monthly file that reflects the status as of the end of the month, i.e. a "snapshot" as of a point in time. For example, the project requires historical data from January 1, 2014 -current. Truven Health Analytics will expect to receive one file for every month from January 1, 2014 to current. Each file will contain one record per member, per month. Ongoing file submissions would include one record for each member for the latest month only.

DATA SUBMISSION

The data will be submitted to Truven Health Analytics via SFTP on a monthly basis. Monthly files should be submitted on or before the agreed upon date of the month.

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled • Truven Health Analytics prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-1234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal)
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (under score) , (comma)

POPULATION OF DATA ONTO DEPENDENT RECORDS

For certain fields, e.g. Policy Holder ID we would like to have information copied down from the policy holder to the enrollee record. For others, e.g. Gender or Date of Birth, we would like the data to be specific to the person.

For each field, Truven Health Analytics has noted one of the three values below in the right-most column.

ENROLLEE-SPECIFIC (MEMBER SPECIFIC)	Information relevant to the enrollee (e.g. Date of Birth, Truven Health Analytics would like each enrollee's date of birth). Please populate on each record with the information specific to that enrollee.
POLICY-HOLDER-ONLY (SUBSCRIBER ONLY)	Information relevant to the policy holder that Truven Health Analytics would like on the contract holder, i.e. not copied onto the enrollee's records.
POLICY-HOLDER-SPECIFIC (SUBSCRIBER SPECIFIC)	Information relevant to the policy holder, but needs to be copied down to the enrollee. Please populate on each record with the information that has been copied from the policy holder.

***Note: Selections of Rows or Columns for each action must be made **after** pressing the de

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
1	Enrollment Snapshot Month	1	10	10	Date	MM/DD/CCYY Format		X		Enrollee-Specific
2	Date of Birth	11	20	10	Date	MM/DD/CCYY format				Enrollee-Specific
3	Date of Death	21	30	10	Date	Blank Fill this field at this time		X		Enrollee-Specific
4	Subscriber SSN	31	39	9	Character	Blank Fill this field at this time		X		Policy Holder-Specific
5	CC Subscriber ID	40	59	20	Character					Policy Holder-Specific
6	Enrollee/member SSN	60	68	9	Character	Blank Fill this field at this time		X		Enrollee-Specific
7	CC Member ID	69	88	20	Character			X		Enrollee-Specific
8	Plan Member ID	89	108	20	Character	Blank Fill this field at this time		X		Enrollee-Specific
9	Policy ID	109	128	20	Character	Blank Fill this field at this time				Policy -holder specific
10	Enrollee First Name	129	188	60	Character	Blank Fill this field at this time		X		Enrollee-Specific
11	Enrollee Last Name	189	248	60	Character	Blank Fill this field at this time		X		Enrollee-Specific
12	Enrollee Middle Initial	249	249	1	Character	Blank Fill this field at this time				Enrollee-Specific
13	Enrollment End Reason Code	250	253	4	Character	Reason codes will be identified in the Data Dictionary.			Yes	Enrollee-specific
14	Address 1	254	303	50	Character	Blank Fill this field at this time		X		Enrollee-Specific
15	Address 2	304	333	30	Character	Blank Fill this field at this time		X		Enrollee-Specific
16	City	334	363	30	Character			X		Enrollee-Specific
17	State Code	364	365	2	Character			X		Enrollee-Specific
18	Zip Code (5 digit)	366	370	5	Character			X		Enrollee-Specific
19	Zip Code plus 4 (last 4)	371	374	4	Character	Blank Fill this field at this time				Enrollee-Specific
20	County Code	375	379	5	Character					Enrollee-Specific
21	Gender Code	380	380	1	Character	M or F		X		Enrollee-Specific
22	Relationship Code	381	385	5	Character	Relationship code values will be identified in the **Data Dictionary**.		X	Yes	Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
23	Race 1 Code	386	388	3	Character	Race code values will be identified in the **Data Dictionary.** 3/15/16 -Size of field expanded to 3 bytes		X	Yes	Enrollee-Specific
24	Race 2 Code	389	391	3	Character	Race code values will be identified in the **Data Dictionary.** 3/15/16 -Size of field expanded to 3 bytes		X	Yes	Enrollee-Specific
25	Race 3 Code	392	394	3	Character	Race code values will be identified in the **Data Dictionary.** 3/15/16 -Size of field expanded to 3 bytes		X	Yes	Enrollee-Specific
26	Ethnicity 1 Code	395	400	6	Character	Ethnicity code values will be identified in the **Data Dictionary.**		X	Yes	Enrollee-Specific
27	Ethnicity 2 Code	401	406	6	Character	Ethnicity code values will be identified in the **Data Dictionary.**		X	Yes	Enrollee-Specific
28	Ethnicity 3 Code	407	412	6	Character	Ethnicity code values will be identified in the **Data Dictionary.**		X	Yes	Enrollee-Specific
29	Language Written Code	413	416	4	Character	values will be identified in the **Data Dictionary**.			Yes	Enrollee-Specific
30	Language Spoken Code	417	420	4	Character	values will be identified in the **Data Dictionary**.			Yes	Enrollee-Specific
31	Coverage Start Date	421	430	10	Date	MM/DD/CCYY Format		X		Enrollee-Specific
32	Coverage End Date	431	440	10	Date	MM/DD/CCYY Format		X		Enrollee-Specific
33	Coverage Indicator Dental	441	441	1	Character	Standard values: Y = Have coverage, N = Do not have coverage Children Only Hard code to "N"		X		Enrollee-Specific
34	Coverage Indicator Drug	442	442	1	Character	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"		X		Enrollee-Specific
35	Coverage Indicator Hearing	443	443	1	Character	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"		X		Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
36	Coverage Indicator Medical	444	444	1	Character	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"		X		Enrollee-Specific
37	Coverage Indicator MHSA	445	445	1	Character	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"		X		Enrollee-Specific
38	Coverage Indicator Vision	446	446	1	Character	Standard values: Y = Have coverage, N = Do not have coverage Children Only Hard code to "N"		X		Enrollee-Specific
39	PCP Type Code	447	450	4	Character	PCP Type code values will be identified in the **Data Dictionary**. Field is not available, Truven to impute PCP		X	Yes	Enrollee-Specific
40	PCP Provider ID TIN	451	463	13	Character	For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.		X		Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
41	Gross Premium	464	473	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid by the government for fully-insured plans and not premium equivalents. <It should not be the net amount (minus policy-holder contribution) as this will be calculated within the Truven Health Analytics product. It should be populated only on employee records for those employees enrolled in fully-insured medical plans. On all other records this field should be zero filled.		X		Policy Holder/Contract Holder Only
42	Net Premium	474	483	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy-holder records).		X		Policy Holder/Contract Holder Only
43	Subsidy Amount	484	493	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy holder records).		X		Policy Holder/Contract Holder Only
44	Product Type/Medical Plan Type	494	497	4	Character	Indemnity, HMO, PPO, FFS, POS, HDHP, CDHP, etc.		X	Yes	Enrollee-specific
45	Medical Fully Insured Indicator	498	498	1	Character	Y = Yes N = No hard code to "Y"		X		Enrollee-specific
46	Drug Fully Insured Indicator	499	499	1	Character	Y = Yes N = No hard code to "Y"		X		Enrollee-specific
47	HIOS Plan Code	500	515	16	Character			X		Enrollee-Specific
48	Rating Region Code	516	520	5	Character			X		Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
49	Policy Structure Code/Coverage Tier Code	521	524	4	Character	Customer-specific values will be identified in the **Data Dictionary**.		X	Yes	Policy Holder-Specific
50	Dental Plan Code	525	530	6	Character	This will currently be blank-filled from the data supplier, Truven to populate with the same code from Medical. It's desirable to have a plan code explicitly identifying "Opt-outs".		X	Yes	Enrollee-Specific
51	Dental Policy Structure Code/Coverage Tier Code	531	534	4	Character	values will be identified in the **Data Dictionary**.		X	Yes	Enrollee-Specific
52	Monthly Policy Holder Dental Contribution	535	544	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy-holder records).		X		Policy Holder/Contract Holder Only
53	Monthly Dental Premium	545	554	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid by the government for fully-insured plans and not premium equivalents. <It should not be the net amount (minus policy-holder contrib.) as this will be calculated within the Truven Health Analytics product. It should be populated only on policy-holder records for those enrolled in fully-insured medical plans. On all other records this field should be zero filled.		X		Policy Holder/Contract Holder Only
54	Vision Plan Code	555	560	6	Character	Vision plan code values will be identified in the **Data Dictionary**. It's desirable to have a plan code explicitly identifying "Opt-outs". **This field will be initially set to blanks**		X	Yes	Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
55	Vision Policy Structure Code/Coverage Tier Code	561	564	4	Character	values will be identified in the **Data Dictionary**. **This field will be initially set to blanks**		X	Yes	Enrollee-Specific
56	Monthly Policy Holder Vision Contribution	565	574	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on dependent records). **This field will be initially set to blanks**		X		Policy Holder/Contract Holder Only
57	Monthly Vision Premium	575	584	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid by the government for fully-insured plans and not premium equivalents. <It should not be the net amount (minus policy-holder contrib.) as this will be calculated within the Truven Health Analytics product. It should be populated only on policy-holder records for those enrolled in fully-insured medical plans. On all other records this field should be zero filled. **This field will be initially set to blanks**		X		Policy Holder/Contract Holder Only
58	SHOP Employee Status Code	585	589	5	Character	Employee Status code values will be identified in the **Data Dictionary**. 8/26 - not available in Sharp file.	X	X	Yes	Policy Holder-Specific
59	SHOP Employee Medicare Eligible Indicator	590	590	1	Character	Y = Yes N -No 8/26 - not available in Sharp file.	X			Policy Holder-Specific
60	SHOP Part-Time/Full-time Indicator	591	591	1	Character	P = Part-time F - Full-time 8/26 - not available in Sharp file.	X			Policy Holder-Specific
61	Plan Group Number	592	611	20	Character		X	X	Yes	Enrollee-Specific
62	Plan Group Suffix	612	616	5	Character		X	X	Yes	Enrollee-Specific
63	Industry Classification Code	617	622	6	Character	HPID or SHOP	X	X		Policy Holder-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
64	Cost Sharing Reduction	623	632	10	Numeric	The cost sharing redcution amount. Note: If available, this should be the actual CSR, which may not be the same as the CSR amount on the 834.				Policy Holder-Specific
65	Filler	633	999	367	Character	Fill with blanks				Enrollee-Specific
66	Record Type	1000	1000	1	Character	Hard Code to "D"				Enrollee-Specific
End of Layout - Do not remove this row - All field additions to be inserted above the Filler row										

Eligibility Functional Specifications for File Layout
--- Trailer Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields							
1	Eligibility Start Date	1	10	10	Date	Eligibility Begin Date	MM/DD/CCYY format – i.e. 09/01/2015 This will represent the 1st day of the month for which data is provided.
2	Eligibility End Date	11	20	10	Date	Eligibility End Date	MM/DD/CCYY format – i.e. 09/30/2015 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Filler	31	999	969	Character	Reserved for future use	Fill with Blanks
5	Record Type	1000	1000	1	Character	Record Type Identifier	Hard Code 'T'

TRUVEN HEALTH ANALYTICS

Covered California EAS
Medical Functional Specification
06/15/2015

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
6/12/2015	Dan Lopez	Finalized version after all data summits
6/8/2015	Katie Andrada-Bacorn	Revised after initial data summit
5/21/2015	Dan Lopez	initial document

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a medical claims file for plan participants administered through the data supplier.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

DATA SUBMISSION

The data will be submitted to Truven Health Analytics via SFTP on a monthly basis. Monthly files should be submitted on or before the agreed upon date of the month following the close of each month.

DENIED CLAIMS

Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Truven Health defines denied claims as follows:

- **Fully denied claim** : The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- **Partially denied claim :** The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled • Truven Health Analytics prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-1234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal)
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (under score) , (comma)

DEFINITIONS

- **Fee-for-service claims:** Claims records for services that result in direct payment to providers on a service-specific basis.
- **Encounter records:** Utilization records for services provided under capitation arrangements (i.e., plans in which a provider is paid based on the number of enrollees rather than the services rendered.) These records enable documentation of all services provided regardless of whether or not direct payment was made to the provider.
- **Facility Data:** Facility data includes all services rendered by an inpatient or outpatient facility. The basis for the requirements of facility data is the information found on the standard UB-04 claim form.
- **Professional Data:** Professional data includes all services rendered by a physician or other professional provider, including dental, vision and hearing. The basis for the requirements of professional data is the information found on the standard CMS-1500 claim form.
- **Fee-for-Service Equivalents:** Financial amounts for services rendered under a capitated arrangement found within encounter records.

DISCUSSION ITEMS

- If both fee-for-service claims and encounter records are included on the data file, Truven Health will rely on the data supplier to explain how to differentiate them, preferably using the field Capitated Service Indicator.
- If encounter records contain fee-for-service equivalents, it is essential for Truven Health to understand which fields contain these amounts.
- Financial fields should be populated at the service line level, not at the claim level.
- Truven Health will need to understand the circumstances under which claims are not paid on a line item basis. For example, situations where claims are paid on a per diem basis or paid based on a DRG. It is our preference if the supplier can apply a factor so that the financials are spread across the lines based on the service rendered.

Claim is paid based on the DRG and Net Payment for the entire claim is $3,632.00; financials are applied across lines

CLAIM LEVEL INFORMATION				SERVICE LEVEL DETAIL				
Claim Id	Provider Id	DRG	Provider Type	Line Number	Revenue Code	Service Count	Allowed Amount	Net Payment
11111	121212121	177	25	1	120	2	$ 2,500.00	$ 2,000.00
11111	121212121	177	25	2	250	1	$ 115.00	$ 100.00
11111	121212121	177	25	3	720	10	$ 1,800.00	$ 1,532.00

- If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

DISCUSSION ITEMS - PROVIDER

- Truven Health requires unique provider identifiers and associated names. Truven Health would like both the identifier and the name to be specific to each provider, rather than group level information. TAXID is preferred for the identifier.
- If providers within group practices use a single TAXID, Truven Health would prefer an additional qualifier that would make each identifier and name unique.
- If only the group name is available with the associated TIN, and a qualifier is not available, Truven Health prefers another identifier for professional claims and the TAXID for the facility claims. NPI is preferred for the alternate identifier. In this case the TAXID is still requested in addition to the NPI or alternate identifier.

Provider Example 1

When providers in group practices use the same TAXID, a qualifier is needed to insure unique provider names.

Claim ID	TAXID	Qualifier	Provider Name	Prov Type	Service Count	Net Payment
11111	121212121	2222	Dr. Brown	25	2	$ 2,000.00
22222	121212121	3333	Dr. Smith	35	1	$ 100.00

Provider Example 2

The following is an example of what is not desired.

Claim ID	TAXID	Provider Name	Prov Type	Svc Count	Net Payment
11111	121212121	Dr. Brown	25	2	$ 2,000.00
22222	121212121	Dr. Smith	35	1	$ 100.00
33333	232323232	XYZ	25	1	$ 125.00
22222	232323232	XYZ	35	1	$ 110.00

Provider Example 3

When only the groups name is available with TAXID, NPI is requested in addition to TAXID.

Professional

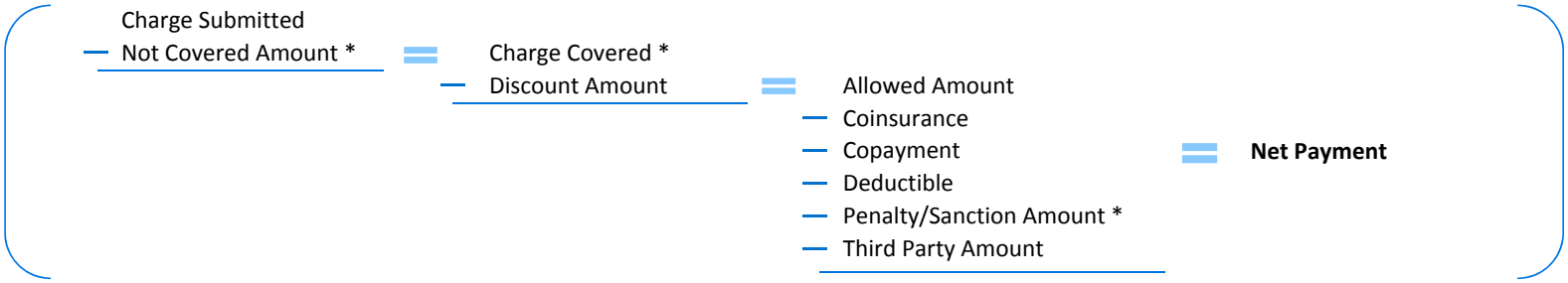
Claim ID	TAXID	Group Name	NPI	Prov Name	Prov Type	Svc Count	Net Payment
11111	121212121	XYZ Pediatrics	2222222222	Dr Brown	25	2	$ 2,000.00
22222	121212121	XYZ Pediatrics	3333333333	Dr Smith	35	1	$ 100.00

Facility

Claim ID	TAXID	NPI	Provider Name	Prov Type	Rev Code	Net Payment
11111	343434343	22222222222	University Hospital	1	110	$ 2,000.00
22222	454545454	33333333333	University Children's Hospital	1	120	$ 100.00

FINANCIAL RELATIONSHIP

Truven Health defines the relationship among financial fields as follows. Those marked with an asterisk are desirable, but not required for the data extract.



CORRECTIONS TO PAID CLAIMS

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Truven Health defines these as follows:

VOID/REPLACEMENT

A **void** is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it. The original, void and replacement need not appear in the same file.

After adjudication, a paid claim with a $25 Copay and $50 Net Pay, a correction was necessary. The correction contains a $10 Copay and $65 Net Pay.

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Void	-1	$ (75.00)	$ (25.00)	$ -	$ (50.00)
Replacement	1	$ 75.00	$ 10.00	$ -	$ 65.00

ADJUSTMENT

A financial **adjustment** is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well. The original and adjustment need not appear in the same file.

After a claim was adjudicated with a $25 Copay and $50 Net Pay, it was discovered that there should have been a $10 Copay and $65 Net Pay.

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Adjustment	0	$ -	$ (15.00)	$ -	$ 15.00

FACILITY RECORD CONTENT

- The standard UB-04 claim form contains both information that pertains to the entire claim and single service/procedure within the claim.
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

One facility claim with three service lines

CLAIM LEVEL INFORMATION			SERVICE LEVEL DETAIL			
Claim Id	**Provider Id**	**Provider Type**	**Line Number**	**Revenue Code**	**Service Count**	**Net Payment**
11111	121212121	25	1	120	2	$ 2,000.00
11111	121212121	25	2	250	1	$ 100.00
11111	121212121	25	3	720	10	$ 1,532.00

PROFESSIONAL RECORD CONTENT

Truven Health does not store separate header/claim-level and detail/service-level information for professional claims. Truven Health requires the following:

- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

One professional claim with two service lines

CLAIM LEVEL INFORMATION			SERVICE LEVEL DETAIL			
Claim Id	**Provider Id**	**Provider Type**	**Line Number**	**Procedure**	**Service Count**	**Net Payment**
13331	621262121	51	1	99201	1	$ 100.00
13331	621262121	51	2	99175	1	$ 150.00

Medical Functional Specifications for File Layout

--- Detail Layout ---

***Note: Selections of Rows or Columns for each action must be made **after** pressing the desired button.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
1	Subscriber SSN	1	9	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		Blank Fill this field at this time
2	CC Subscriber ID	10	29	20	Character	The subscriber ID as assigned by Covered California		
3	Enrollee/member SSN	30	38	9	Character	Member's Social Security Number		Blank Fill this field at this time
4	CC Member ID	39	58	20	Character	The member ID as assigned by Covered California		
5	Plan Member ID	59	78	20	Character	The member ID as assigned by the plan		Blank Fill this field at this time
6	Policy ID	79	98	20	Character	The policy number of the policy-holder		Blank Fill this field at this time
7	Rendering Provider ID	99	111	13	Character	The unique identifier for the provider of service.		This is the unique provider ID of the health plan
8	Rendering Provider TIN	112	120	9	Character	The federal tax ID of the provider of service. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For doctors and other healthcare providers where a SSN is provided within the TIN Field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
9	Rendering Provider NPI	121	130	10	Character	The National Provider ID number for the provider of service..		
10	Rendering Provider First Name	131	160	30	Character	The description or name corresponding to the servicing Provider ID.		The Provider Name should be specific to the provider and not a group name.
11	Rendering Provider Last Name	161	190	30	Character	The last name corresponding to the servicing Provider ID.		The Provider Name should be specific to the provider and not a group name.
12	Rendering Provider Middle Initial	191	191	1	Character	The middle initial corresponding to the servicing Provider ID.		
13	Rendering Provider Address 1	192	241	50	Character	The current street address1 of the provider of service.		If the provider has multiple addresses, the primary address is preferred.
14	Rendering Provider Address 2	242	271	30	Character	The current street address2 of the provider of service.		If the provider has multiple addresses, the primary address is preferred.
15	Rendering Provider City	272	301	30	Character	The current city of the provider of service.		
16	Rendering Provider State	302	303	2	Character	The current state of the provider of service.		
17	Rendering Provider County Code	304	308	5	Character	FIPS State/County code of the servicing provider		
18	Rendering Provider Zip Code	309	313	5	Character	The 5-digit zip code corresponding to the servicing Provider ID		Provider Location zip code
19	Rendering Provider Zip Plus 4 Code	314	317	4	Character	The 4 digit zip code extension code of the servicing provider		
20	Rendering Provider Type Code Claim	318	321	4	Character	Client-specific code for the provider type on the claim record	Yes	Provider Type codes are further defined in the **Data Dictionary**
21	Referring Provider ID	322	334	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.		This is the unique provider ID of the health plan
22	Referring Provider TIN	335	343	9	Character	The federal tax ID of the Referring provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
23	Referring Provider NPI	344	353	10	Character	The National Provider ID number for the Referring provider.		
24	Referring Provider First Name	354	383	30	Character	The description or name corresponding to the Refering Provider ID.		
25	Referring Provider Last Name	384	413	30	Character	The last name corresponding to the Provider ID.		
26	Referring Provider Middle Initial	414	414	1	Character	The middle initial corresponding to the Refering Provider ID.		
27	Referring Provider Zip Code	415	419	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.		
28	Referring Provider Zip Plus 4 Code	420	423	4	Character	The 4 digit zip code extension code of the referring provider		
29	Billing Provider ID	424	436	13	Character	The unique ID number of the Billing provider.		This is the unique provider ID of the health plan
30	Billing Provider TIN	437	445	9	Character	The federal tax ID of the billing provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
31	Billing Provider NPI	446	455	10	Character	The National Provider ID number for the billing provider.		
32	Attending Provider ID	456	468	13	Character	The unique ID number of the attending provider.		This is the unique provider ID of the health plan
33	Attending Provider TIN	469	477	9	Character	The federal tax ID of the attending provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
34	Attending Provider NPI	478	487	10	Character	The National Provider ID number for the attending provider.		
35	PCP Provider ID	488	500	13	Character	The unique ID number of the PCP provider.		For doctors and other healthcare providers where a SSN is provided within the TIN Field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
36	PCP Provider TIN	501	509	9	Character	The federal tax ID of the PCP provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For doctors and other healthcare providers where a SSN is provided within the TIN Field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
37	PCP Provider NPI	510	519	10	Character	The National Provider ID number for the PCP provider.		
38	PCP Responsibility Indicator	520	520	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.		"Y" or "N"
39	Adjustment Type Code	521	521	1	Character	Client-specific code for the claim adjustment type	Yes	Adjustment Type values will be identified in the **Data Dictionary**.
40	Allowed Amount	522	531	10	Numeric	The maximum amount allowed by the plan for payment.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
41	Bill Type Code UB	532	535	4	Character	The UB-04 standard code for the billing type, indicating type of facility, bill classification, and frequency of bill.	See Notes	Bill Type values will be identified in the Data Dictionary only if standard codes are not used.
42	Capitated Service Indicator	536	536	1	Character	An indicator that this service (encounter record) was capitated		Applicable field values are "Y" for Capitated services and "N" for non-cap services.
43	Charge Submitted	537	546	10	Numeric	The submitted or billed charge amount		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
44	Claim ID	547	596	50	Character	The client-specific identifier of the claim.		
45	Claim Type Code	597	599	3	Character	Client-specific code for the type of claim	Yes	Claim Type Codes will be identified in the **Data Dictionary**.
46	Coinsurance	600	609	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
47	Copayment	610	619	10	Numeric	The copayment paid by the subscriber as specified by the plan provision.		
48	Date of Birth	620	629	10	Date	Birth date of the person		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
49	Date of First Service	630	639	10	Date	The date of the first service reported on the claim or authorization record.		MM/DD/CCYY Format
50	Date of Last Service	640	649	10	Date	The date of the last service reported on the claim or authorization record.		MM/DD/CCYY Format
51	Date of Service Facility Detail	650	659	10	Date	The date of service for the facility detail record.		MM/DD/CCYY Format
52	Date Paid	660	669	10	Date	The date the claim or data record was paid.		MM/DD/CCYY format This is the check date.
53	Days Stay	670	675	6	Numeric	The number of inpatient days for the facility claim.		
54	Deductible	676	685	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
55	Diagnosis Code Principal	686	693	8	Character	The first or principal diagnosis code for a service, claim or lab result. Length expanded from 5 to 8 for future use.		No decimal point.
56	Diagnosis Code 2	694	701	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
57	Diagnosis Code 3	702	709	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
58	Diagnosis Code 4	710	717	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
59	Diagnosis Code 5	718	725	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
60	Diagnosis Code 6	726	733	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
61	Diagnosis Code 7	734	741	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
62	Diagnosis Code 8	742	749	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
63	Diagnosis Code 9	750	757	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
64	Diagnosis Code 10	758	765	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
65	Diagnosis Code 11	766	773	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
66	Diagnosis Code 12	774	781	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
67	Diagnosis Code 13	782	789	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
68	Diagnosis Code 14	790	797	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
69	Diagnosis Code 15	798	805	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
70	Diagnosis Code 16	806	813	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
71	Diagnosis Code 17	814	821	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
72	Diagnosis Code 18	822	829	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
73	Diagnosis Code 19	830	837	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
74	Diagnosis Code 20	838	845	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
75	Diagnosis Code 21	846	853	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
76	Diagnosis Code 22	854	861	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
77	Diagnosis Code 23	862	869	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
78	Diagnosis Code 24	870	877	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
79	Diagnosis Code 25	878	885	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
80	Discharge Status Code UB	886	887	2	Numeric	The UB-04 standard patient status code, indicating disposition at the time of billing.		
81	Discount Amount	888	897	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
82	Gender Code	898	898	1	Character	Gender of the person.		M or F The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility
83	Line Number	899	900	2	Numeric	The detail line number for the service on the claim		
84	Net Payment	901	910	10	Numeric	The actual check amount for the record		Format 9(8)v99 (2 - digit, implied decimal)
85	Network Paid Indicator	911	911	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level		On facility records, this field must be at the service/detail level as opposed to the header/claim level.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
86	Network Provider Indicator	912	912	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs		"Y" or "N"
87	Place of Service Code	913	914	2	Character	Client-specific code for the place of service.	See Notes	Truven prefers the CMS place of service values. Place of Service values will be identified in the **Data Dictionary** only if non-standard values are used.
88	Procedure Code	915	921	7	Character	The procedure code for the service record. Length expanded from 5 to 7 for future use.		CPT/HCPCS codes.
89	Procedure Code UB Surg 1	922	928	7	Character	The primary surgical procedure code (1) on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
90	Procedure Code UB Surg 2	929	935	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
91	Procedure Code UB Surg 3	936	942	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
92	Procedure Code UB Surg 4	943	949	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
93	Procedure Code UB Surg 5	950	956	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
94	Procedure Code UB Surg 6	957	963	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
95	Procedure Code UB Surg 7	964	970	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
96	Procedure Code UB Surg 8	971	977	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
97	Procedure Code UB Surg 9	978	984	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
98	Procedure Code UB Surg 10	985	991	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
99	Procedure Code UB Surg 11	992	998	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
100	Procedure Code UB Surg 12	999	1005	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
101	Procedure Code UB Surg 13	1006	1012	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
102	Procedure Code UB Surg 14	1013	1019	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
103	Procedure Code UB Surg 15	1020	1026	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
104	Procedure Code UB Surg 16	1027	1033	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
105	Procedure Code UB Surg 17	1034	1040	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
106	Procedure Code UB Surg 18	1041	1047	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
107	Procedure Code UB Surg 19	1048	1054	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
108	Procedure Code UB Surg 20	1055	1061	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
109	Procedure Code UB Surg 21	1062	1068	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
110	Procedure Code UB Surg 22	1069	1075	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
111	Procedure Code UB Surg 23	1076	1082	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
112	Procedure Code UB Surg 24	1083	1089	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
113	Procedure Code UB Surg 25	1090	1096	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
114	Procedure Modifier Code 1	1097	1098	2	Character	The 2-character code of the first procedure code modifier on the professional claim		
115	Procedure Modifier Code 2	1099	1100	2	Character	The 2-character code of the second procedure code modifier on the professional claim		
116	Procedure Modifier Code 3	1101	1102	2	Character	The 2-character code of the third procedure code modifier on the professional claim		
117	Procedure Modifier Code 4	1103	1104	2	Character	The 2-character code of the fourth procedure code modifier on the professional claim		
118	Revenue Code UB	1105	1108	4	Character	The CMS standard revenue code from the facility claim		This field must be at the service/detail level.
119	Third Party Amount	1109	1118	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
120	Units of Service	1119	1122	4	Numeric	Client-specific quantity of services or units		
121	Funding Type Code	1123	1123	1	Character	Specifies whether the claim was paid under a fully or self-funded arrangement		Blank Fill this field at this time.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
122	Account Structure	1124	1143	20	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Yes	Additional fields may be added to the layout if there is more than one component of the account structure.
123	HRA Amount	1144	1153	10	Numeric	The amount paid from the HRA as a result of this claim.		Not required at this time. Set all values to 000 to accommodate the 2-digit implied decimal.
124	HSA Amount	1154	1163	10	Numeric	The amount paid from the HSA as a result of this claim.		Only send if applicable to the plan type and if available.
125	Present on Admission Principal	1164	1164	1	Character	The principal POA code for the facility claim. Indicates whether the principal diagnosis was present on admission. Standard Values: 1 – Unreported/Not Used N – No, not present at admission U – Unknown W – Clinically Undetermined Y – Yes, present at admission	See Notes	If standard values are not used, define in the **Data Dictionary.**
126	Present on Admission 02	1165	1165	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
127	Present on Admission 03	1166	1166	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
128	Present on Admission 04	1167	1167	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
129	Present on Admission 05	1168	1168	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
130	Present on Admission 06	1169	1169	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
131	Present on Admission 07	1170	1170	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
132	Present on Admission 08	1171	1171	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
133	Present on Admission 09	1172	1172	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
134	Present on Admission 10	1173	1173	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
135	Present on Admission 11	1174	1174	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
136	Present on Admission 12	1175	1175	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
137	Present on Admission 13	1176	1176	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
138	Present on Admission 14	1177	1177	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
139	Present on Admission 15	1178	1178	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
140	Present on Admission 16	1179	1179	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
141	Present on Admission 17	1180	1180	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
142	Present on Admission 18	1181	1181	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
143	Present on Admission 19	1182	1182	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
144	Present on Admission 20	1183	1183	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
145	Present on Admission 21	1184	1184	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
146	Present on Admission 22	1185	1185	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
147	Present on Admission 23	1186	1186	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
148	Present on Admission 24	1187	1187	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
149	Present on Admission 25	1188	1188	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
150	DRG MS Payment Code	1189	1191	3	Character	The Diagnosis Related Group (MS-DRG) code under which the claim was paid.		
151	ICD Version	1192	1192	1	Character	The ICD version or qualifier code that identifies either ICD-9 (9) or ICD-10 (0) diagnosis and procedure codes on the facility claim.	See Notes	If 0 and 9 not used, values defined in the **Data Dictionary.**
152	Tax Amount	1193	1202	10	Numeric	The amount charged by some states per medical claim.		Not required at this time. Set all values to 000 to accommodate the 2-digit implied decimal.
153	Tax Type Code	1203	1203	1	Character	Data Supplier specific code identifying the state and/or type of tax.	Yes	Blank Fill this field at this time
154	NDC Number Code	1204	1214	11	Character	The FDA (Food and Drug Administration) registered number for the drug. Please include for any drugs dispensed in the medical setting if available.		Please leave out the dashes.
155	Penalty Amount	1215	1224	10	Numeric	Penalty amount on the claim		
156	Referral Indicator	1225	1225	1	Character	Indicates if patient was referred		
157	Non-Medicare Paid Amount	1226	1235	10	Numeric	Third party amount, non-Medicare		
158	Withhold Amount	1236	1245	10	Numeric	Amount withheld		
159	Filler	1246	1699	454	Character	Reserved for future use		Fill with blanks
160	Record Type	1700	1700	1	Character	Record type identifier		Hard Code to "D"
End of Layout - Do not remove this row - All field additions to be inserted above the Filler Row								

Medical Functional Specifications for File Layout

--- Trailer Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	1699	1655	Character	Reserved for future use	Fill with Blanks
6	Record Type	1700	1700	1	Character	Record Type Identifier	Hard Code 'T'

TRUVEN HEALTH ANALYTICS

Covered California EAS
Drug Claims Functional Specification
3/15/2016

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
3/16/2016	Dan Lopez	Added new field for Pharamcy Name due to data quality reviews
6/12/2015	Dan Lopez	Updated following all data summits
6/9/2015	Katie Andrada-Bacorn	Updated following initial data summit
5/20/2015	Katie Andrada-Bacorn	Added fields to the Detail Layout

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a prescription drug claims file for plan participants administered through the data supplier.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

DATA SUBMISSION

The data will be submitted to Truven Health Analytics via SFTP on a monthly basis. Monthly files should be submitted on or before the agreed upon date of the month following the close of each month.

DEFINITIONS AND DENIED CLAIMS

Prescription drug data are claim records for services that result in direct payment to a pharmacy on a service-specific (for example, prescription-specific) basis.

If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

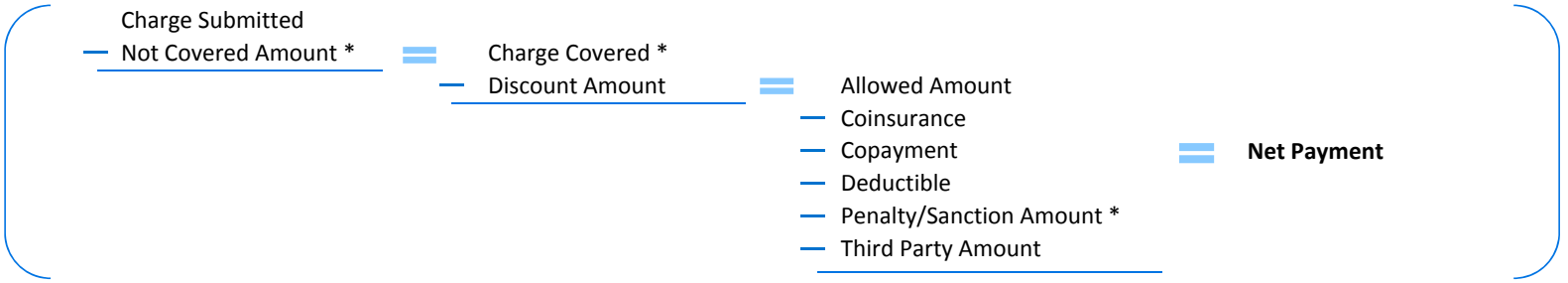
Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Truven Health defines denied claims as follows:

- **Fully denied claim** : The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- **Partially denied claim :** The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled • Truven Health Analytics prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-1234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal)
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (under score) , (comma)

FINANCIAL RELATIONSHIP

Truven Health defines the relationship among financial fields as follows. Those marked with an asterisk are desirable, but not required for the data extract.



CORRECTIONS TO PAID CLAIMS

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Truven Health defines these as follows:

VOID/REPLACEMENT

A **void** is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it. The original, void and replacement need not appear in the same file.

After adjudication, a paid claim with a $25 Copay and $50 Net Pay, a correction was necessary. The correction contains a $10 Copay and $65 Net Pay.

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Void	-1	$ (75.00)	$ (25.00)	$ -	$ (50.00)
Replacement	1	$ 75.00	$ 10.00	$ -	$ 65.00

ADJUSTMENT

A financial **adjustment** is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well. The original and adjustment need not appear in the same file.

After a claim was adjudicated with a $25 Copay and $50 Net Pay, it was discovered that there should have been a $10 Copay and $65 Net Pay.

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Adjustment	0	$ -	$ (15.00)	$ -	$ 15.00

Drug Claims Functional Specifications for File Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
1	Subscriber SSN	1	9	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		Blank Fill this field at this time.
2	CC Subscriber ID	10	29	20	Character	Unique code assigned by CC to the subscriber		
3	Enrollee/member SSN	30	38	9	Character	Member's Social Security Number		Blank Fill this field at this time.
4	CC_MemberID	39	58	20	Character	The member ID as assigned by Covered California		
5	Plan_MemberID	59	78	20	Character	Unique code assigned by health plan to identify a member		Blank Fill this field at this time.
6	Policy ID	79	98	20	Character	Policy ID assigned by health plan		Blank Fill this field at this time.
7	Claim ID	99	148	50	Character	The client-specific identifier of the claim.		
8	Date of Birth	149	158	10	Date	The birth date of the person.		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
9	Gender Code	159	159	1	Character	The member's gender code.		"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
10	Adjustment Type Code	160	160	1	Character	Client-specific code for the claim adjustment type	Yes	Adjustment Type values will be identified in the **Data Dictionary.**
11	Allowed Amount	161	170	10	Numeric	The maximum amount allowed by the plan for payment.		Format 9(8)v99 (2 - digit, implied decimal)
12	Charge Submitted	171	180	10	Numeric	The submitted or billed charge amount		Format 9(8)v99 (2 - digit, implied decimal)
13	Claim Type Code	181	183	3	Character	Client-specific code for the type of claim	Yes	Claim Type Codes will be identified in the **Data Dictionary.**
14	Coinsurance	184	193	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 - digit, implied decimal)
15	Copayment	194	203	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 - digit, implied decimal)
16	Date of Service	204	213	10	Date	The date of service for the drug claim.		MM/DD/CCYY format
17	Date Paid	214	223	10	Date	The date the claim or data record was paid.		MM/DD/CCYY format This is the check date.
18	Days Supply	224	227	4	Numeric	The number of days of drug therapy covered by the prescription.		
19	Deductible	228	237	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.		Format 9(8)v99 (2 - digit, implied decimal)
20	Dispensing Fee	238	247	10	Numeric	An administrative fee charged by the pharmacy for dispensing the prescription.		Format 9(8)v99 (2 - digit, implied decimal)
21	Formulary Indicator	248	248	1	Character	An indicator that the prescription drug is included in the formulary.		"Y" or "N"
22	Ingredient Cost	249	258	10	Numeric	The charge or cost associated with the pharmaceutical product.		Format 9(8)v99 (2 - digit, implied decimal)
23	Metric Quantity Dispensed	259	269	11	Numeric	The number of units dispensed for the prescription drug claim, as defined by the NCPDPD (National Council for Prescription Drug Programs) standard format.		Format 9(8)v99 (3 - digit, implied decimal)

Drug Claims Functional Specifications for File Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
24	NDC Number Code	270	280	11	Character	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.		Please leave out the dashes.
25	Net Payment	281	290	10	Numeric	The actual check amount for the record		Format 9(8)v99 (2 - digit, implied decimal)
26	Network Paid Indicator	291	291	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level.		"Y" or "N"
27	Network Provider Indicator	292	292	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs.		"Y" or "N"
28	PCP Responsibility Indicator	293	293	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.		"Y" or "N"
29	Pharmacy NPI Number	294	303	10	Character	The National Provider Identifier for the pharmacy.		
30	Pharmacy Provider ID	304	316	13	Character	The identifier for the provider of service.		This should be the NCPDP (National Council for Prescription Drug Programs) number. (Note: The pharmacy NPI is collected in field #28 in this layout.)
31	Pharmacy Name	317	356	40	Character	The name of the pharmacy where the prescription was filled.		3/15/16 - Added this field to the layout
32	Pharmacy Address 1	357	406	50	Character	The first line of the address for the pharmacy.		
33	Pharmacy Address 2	407	436	30	Character	The second line of the address for the pharmacy.		
34	Pharmacy County	437	441	5	Character	The FIPS state/county code for the pharmacy.		
35	Pharmacy City	442	471	30	Character	The city for which the pharmacy resides.		
36	Pharmacy State	472	473	2	Character	The state in which the pharmacy resides.		
37	Pharmacy Zip	474	478	5	Character	The zip code of the pharmacy		
38	Pharmacy Zip Plus 4 Code	479	482	4	Character	The zip plus 4 code of the pharmacy		
39	Referring Provider ID	483	495	13	Character	The ID number of the provider who prescribed the drug.		
40	Referring Provider First name	496	525	30	Character	The First Name of the provider who referred the patient or ordered the test or procedure.		
41	Referring Provider Last Name	526	555	30	Character	The Last Name of the provider who referred the patient or ordered the test or procedure.		
42	Referring Provider Middle Initial	556	556	1	Character	The Middle Initial of the provider who referred the patient or ordered the test or procedure.		
43	Referring Provider Address 1	557	606	50	Character	The first line of the Referring provider's address		
44	Referring Provider Address 2	607	636	30	Character	The second line of the Referring provider's address		
45	Referring Provider City	637	666	30	Character	The Referring provider's city		
46	Referring Provider State	667	668	2	Character	The Referring provider's state		

Drug Claims Functional Specifications for File Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
47	Referring Provider Zip Code	669	673	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.		
48	Referring Provider Zip Plus 4 Code	674	677	4	Character	The zip plus 4 code of the Referring Provider		
49	Referring Provider NPI	678	687	10	Character	Referring Provider Submitted National Provider Identifier Type 1		
50	Referring Provider DEA number	688	699	12	Character	The DEA Number of the referring provider		
51	Referring Provider TIN	700	708	9	Character	The Tax ID of the referring provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for Medical Groups and Facilities are necessary.		For doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is poplulated on that record. However, TINs on facility claims must be provided.
52	Rx Dispensed as Written Code	709	709	1	Character	The NCPDP (National Council for Prescription Drug Programs) industry standard code that indicates how the product was dispensed.		
53	Rx Mail or Retail Code	710	710	1	Character	The Truven Health standard code indicating the purchase place of the prescription.		"M" for Mail, "R" for Retail
54	Rx Payment Tier	711	711	1	Character	Client-specific description for the payment tier of the drug claim.		Data Supplier will help Truven Health understand which fields to use in order to set this field for the customer. Examples of Rx Payment Tier are as follows: 1. Generic 2. Brand Formulary 3. Brand Non Formulary 4. Specialty Drug
55	Rx Refill Number	712	715	4	Numeric	A number indicating the original prescription or the refill number.		This is the refill number, not the number of refills remaining.
56	Tax Amount	716	725	10	Numeric	The amount of sales tax applied to the cost of the prescription.		Not required at this time. Set all values to 000 to accommodate the 2-digit implied decimal.
57	Third Party Amount	726	735	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Format 9(8)v99 (2 - digit, implied decimal)
58	Discount Amount	736	745	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.		Format 9(8)v99 (2 - digit, implied decimal)
59	Funding Type Code	746	746	1	Character	Specifies whether the claim was paid under a fully or self-funded arrangement		Blank Fill this field at this time.
60	Account Structure	747	766	20	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Yes	Additional fields may be added to the layout if there is more than one component of the account structure.
61	HRA Amount	767	776	10	Numeric	The amount paid from the HRA to pay the provider.		Not required at this time. Set all values to 000 to accommodate the 2-digit implied decimal.
62	HSA Amount	777	786	10	Numeric	The financial amount of the healthcare savings account for consumer-driven health plans		Provide only if applicable to the play type and if available

Drug Claims Functional Specifications for File Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
63	Compound Code	787	787	1	Character	Client-specific code for the compound of the drug.	Yes	Compound Codes will be identified in the **Data Dictionary.** Note that the NCPDP values include: '0' – Not Specified '1' – Not a Compound '2' – Compound
64	Excess Copayment Amount	788	797	10	Numeric	The amount paid by the patient outside of the flat copayment amount. Examples include when the patient chooses brand name instead of the generic alternative or non-formulary drug instead of the formulary option.		Format 9(8)v99 (2 - digit, implied decimal)
65	Capitation Indicator	798	798	1	Character	Service is/is not capitated (Y/N)		Blank Fill this field at this time.
66	NABP Number	799	808	10	Character	National Association of Boards of Pharmacy Number		
67	MAC Price	809	818	10	Numeric	The maximum acquisition cost price		Not required at this time. Set all values to 000 to accommodate the 2-digit implied decimal.
68	Penalty Amount	819	828	10	Numeric	The penalty amount on the claim		
69	Withhold Amount	829	838	10	Numeric	The amount withheld		
70	Filler	839	1199	361	Character	Reserved for future use		Fill with blanks
71	Record Type	1200	1200	1	Character	Record type identifier		Hard Code to "D"

Drug Claims Functional Specifications for File Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	1199	1155	Character	Reserved for future use	Fill with Blanks
6	Record Type	1200	1200	1	Character	Record Type Identifier	Hard Code 'T'

Appendix 2 to Attachment 7

Appendix 2 to Attachment 7: Measurement Specifications

QHP Issuers shall use the following metrics to establish baseline measurements for Attachment 7 requirements and demonstrate improvement on each of these measurements over time. These metrics were reported in the 2017 Application for Certification or in subsequent data requests and must be reported according to the table below. Additionally, QHP Issuers must report these metrics as necessary upon Covered California's request. Covered California and QHP Issuers shall work collaboratively during the term of this Agreement to enhance these specifications to further define the requirements. Hospitalization metrics for disparities measurement are to be reported as both separately-reported standard Prevention Quality Indicator (PQI) (ambulatory sensitive admissions) measures and the composite metric of combined PQI, which is not a national standard. Covered California will assess these two approaches during the baseline measurement years (2015 and 2016) and anticipates a smaller set of measures for measurement year 2017.

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
1	3.01	Self-Reported Racial or Ethnic Identity	Report members self-identifying racial and ethnic group through the enrollment application, web site registration, health assessment, reported at provider site, etc.	Covered California members enrolled during the applicable Plan Year who self-identified a racial or ethnic group.	Total Covered California membership for the applicable Plan Year. Exclude members actively selecting an option to decline self-report (e.g. "decline to state" or "prefer not to say").	Administrative Data (enrollment)	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Applications for Certification - QIS	• California SB 853: The Health Care Language Assistance Act
2	3.01	Racial or Ethnic Identity	Report racial and ethnic identity based on self-report or proxy methodology (i.e. zip code or surname analysis, or both)	Covered California members enrolled during the applicable Plan Year with racial and ethnic group identified	Total Covered California membership for the applicable Plan Year	Administrative Data (enrollment)	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI	• California SB 853: The Health Care Language Assistance Act
3	3.01	Diabetes Care: HbA1c Control < 8.0% (NQF 0575)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino	HEDIS numerator administrative specifications for HbA1c Control <8.0%	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative and clinical data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• NCQA • Medi-Cal External Accountability Set • IHA P4P • Quality Rating System

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
			▪ Native Hawaiian or Other Pacific Islander ▪ White, not Hispanic or Latino							
4	3.01	CBP – Controlling High Blood Pressure (NQF 0018)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or Other Pacific Islander ▪ White, not Hispanic or Latino	HEDIS numerator specifications for Controlling High Blood Pressure	HEDIS eligible population specifications for Controlling High Blood Pressure	Clinical data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• NCQA • Medi-Cal External Accountability Set • IHA P4P • Quality Rating System
5	3.01	Asthma Medication Ratio Ages 5-85 (NQF 1800)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or Other Pacific Islander ▪ White, not Hispanic or Latino	HEDIS numerator specifications for Asthma Medication Ratio	HEDIS eligible population specifications for Asthma Medication Ratio	Administrative data	Annually	January 1 – December 31 of applicable measurement year and prior measurement year	2017, 2018, and 2019 Application for Certification - QIS	• NCQA • IHA P4P
6	3.01	Antidepressant Medication Management (NQF 0105)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or Other Pacific Islander ▪ White, not Hispanic or Latino	HEDIS numerator specifications for Antidepressant Medication Management	HEDIS eligible population specifications for Antidepressant Medication Management	Pharmacy data	Annually	May 1 of prior measurement year – April 30 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• NCQA • IHA P4P
7	3.01	Depression Response at Twelve Months-Progress Towards Remission (NQF 1885)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or Other Pacific Islander	MN Community Measurement specifications for numerator	MN Community Measurement specifications for denominator	Clinical data	Annually	January 1 – December 31 of applicable measurement year	Deferred until further notice	• CMS Consensus Core Set: ACO and PCMH Primary Care Measures

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
			▪ White, not Hispanic or Latino							
8	3.01	Diabetes Hospitalization Measure	Combine the following AHRQ PQI measures for the Diabetes Hospitalization Measure: • PQI #1 – Diabetes Short-Term Complications Admissions Rate • PQI #3 – Diabetes Long-Term Complications Admissions Rate • PQI #14 - Uncontrolled Diabetes Admission Rate • PQI #16 – Lower-Extremity Amputation among Patients with Diabetes Rate Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	Combine AHRQ measure numerator specifications for PQI #1, 3, 14, 16	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	
9	3.01	Admissions for diabetes short-term complications, based on PQI #1 – Diabetes Short-Term Complications Admissions Rate (NQF 0272)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #1 numerator specifications	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• Medicaid 2016 Adult Core Set • NQF Population Health Measures
10	3.01	Admissions for diabetes long-term complications, based on PQI #3 – Diabetes Long-Term Complications	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American	AHRQ PQI #3 numerator specifications	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• NQF Population Health Measures

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
		Admissions Rate (NQF 0274)	▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino							
11	3.01	Admissions for uncontrolled diabetes, based on PQI #14 – Uncontrolled Diabetes Admission Rate (NQF 0638)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #14 numerator specifications	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	• NQF Population Health Measures
12	3.01	Admissions for lower-extremity amputation, based on PQI #16 - Lower-Extremity Amputation among Patients with Diabetes Rate (NQF 0285)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #16 numerator specifications	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	• NQF Population Health Measures
13	3.01	Hypertension Hospitalization Measure	Combine the following AHRQ PQI measures for the Hypertension Hospitalization Measure: • PQI #7 – Hypertension Admission Rate • PQI #8 – Heart Failure Admission Rate • PQI #13 – Angina Without Procedure Admission Rate Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	Combine AHRQ measure numerator specifications for PQI #7, 8, 13	HEDIS eligible population specifications for Controlling High Blood Pressure	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
14	3.01	Admissions for hypertension, based on PQI #7 - Hypertension Admission Rate	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #7 numerator specifications	HEDIS eligible population specifications for Controlling High Blood Pressure	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	
15	3.01	Admissions for heart failure, based on PQI #8 – Heart Failure Admission Rate (NQF 0277)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #8 numerator specifications	HEDIS eligible population specifications for Controlling High Blood Pressure	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	• Medicaid 2016 Adult Core Set • Accountable Care Organization Quality Measures (Shared Savings Program)
16	3.01	Admissions for angina, based on PQI #13 – Angina Without Procedure Admission Rate	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #13 numerator specifications	HEDIS eligible population specifications for Controlling High Blood Pressure	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	
17	3.01	Asthma Hospitalization Measure	Combine the following AHRQ PQI measures for the Asthma Hospitalization Measure: • PQI #5 COPD or Asthma in Older Adults Admission Rate • PQI #11: Bacterial Pneumonia Admission Rate • PQI #15: Asthma in Younger Adults Admission Rate Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories:	Combine AHRQ measure numerator specifications for PQI #5, 11, 15. Exclude COPD codes from PQI #5.	HEDIS eligible population specifications for Asthma Medication Ratio. Use age range of 18 years and older.	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
			• Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino							
18	3.01	Admissions for asthma in older adults, based on PQI #5 - COPD or Asthma in Older Adults Admission Rate (NQF 0275)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #5 numerator specifications. Exclude COPD codes.	HEDIS eligible population specifications for Asthma Medication Ratio. Use age range of 18 years and older.	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• Medicaid 2016 Adult Core Set
19	3.01	Admissions for bacterial pneumonia, based on PQI #11 - Bacterial Pneumonia Admission Rate (NQF 0279)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #11 numerator specifications	HEDIS eligible population specifications for Asthma Medication Ratio. Use age range of 18 years and older.	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	
20	3.01	Admissions for asthma in younger adults, based on PQI #15 - Asthma in Younger Adults Admission Rate	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #15 numerator specifications	HEDIS eligible population specifications for Asthma Medication Ratio. Use age range of 18 years and older.	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• Medicaid 2016 Adult Core Set
21	4.01	Primary Care Physician Selection	Report members by product in the health plan's Covered California business with a personal care physician (PCP)	Number of Covered California members	Total Covered California membership enrolled during	Administrative data	Quarterly	January 1 – December 31 (quarterly reporting	2017, 2018, and 2019 Application for Certification -	

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
				enrolled during the applicable Plan Year who have selected or were assigned to a PCP	the applicable Plan Year			periods to be defined upon request by Covered California)	QIS / quarterly reports as requested	
22	4.02	Primary Care Payment Strategies	Report the number and percentage of California members attributed to providers for whom a payment strategy is deployed to adopt accessible, data-driven, team-based care with accountability for improving triple aim metrics	Number of California members enrolled during the applicable Plan Year attributed to a provider with a payment reform strategy	Total California membership enrolled during the applicable Plan Year	Administrative / financial data	Annually	January 1 – December 31 of applicable measurement year	2018 and 2019 Application for Certification - QIS	
23	4.02	Primary Care Payment Strategies	Report the number and percentage of Covered California members attributed to providers for whom a payment strategy is deployed to adopt accessible, data-driven, team-based care with accountability for improving triple aim metrics	Number of Covered California members enrolled during the applicable Plan Year attributed to a provider with a payment reform strategy	Total Covered California membership enrolled during the applicable Plan Year	Administrative / financial data	Annually	January 1 – December 31 of applicable measurement year	2018 and 2019 Application for Certification - QIS	
24	4.03	Membership Attributed to IHMs	Report the number and percentage of California members in each product who are managed under an IHM	Number of California members enrolled during the applicable Plan Year managed under an IHM	Total California membership enrolled during the applicable Plan Year	Administrative / financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	
25	4.03	Membership Attributed to IHMs	Report the number and percentage of Covered California members in each product who are managed under an IHM	Number of Covered California members enrolled during the applicable Plan Year managed under an IHM	Total Covered California membership enrolled during the applicable Plan Year	Administrative / financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
26	5.03	Hospitals reporting to CMQCC	Report hospital participation in CMQCC	Number of network hospitals reporting to CMQCC	Total number of hospitals providing maternity services in network	Network data/CMQCC participant list	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• CalSIM
27	5.03	Hospitals meeting CalSIM goal for C-sections	Report hospital network performance for meeting CalSIM NTSV C-Section goal	Number of hospitals meeting CalSIM goal of NTSV C-Section rate at or below 23.9 percent	Total number of hospitals providing maternity services in network	Network data/clinical data submitted to CMQCC	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CalSIM • Healthy People 2020 NTSV target of 23.9%
28	5.03	NTSV C-Section rate for each network hospital	For the plan's network of hospitals providing maternity services, report each hospital name, location, product network (HMO, PPO, EPO), and NTSV C-Section rate	Total number of NTSV C-Section deliveries	Total number of NTSV deliveries	Network data/clinical data submitted to CMQCC	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CalSIM • Healthy People 2020 NTSV target of 23.9%
29	5.01	Payment strategies for maternity services	Report number of hospitals paid under each type of payment strategy for maternity services and the denominator (total number of network hospitals)	Number of hospitals paid under payment strategy or each payment strategy	Total number of network hospitals providing maternity services	Network data/financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	
30	5.02	Opioid Adverse Events (Patients	Report rate for each network hospital:	Number of inpatients treated with an	Number of inpatients who received an	Clinical data (medical record review,	Annually	January 1 – December 31 of applicable	2018 and 2019 Application for	• CMS Hospital Improvement

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
		Treated with Naloxone)	Opioid-related ADE caused by medical error and/or adverse drug reactions Rate Calculation: (Numerator / Denominator) x 100 Target-setting approach: six months historical data for baseline; 25th percentile figure from PfP Campaign (e.g., based on AHA/HRET Hospital Engagement Network data)	opioid who received naloxone	opioid (top 5-10 prescribed)	incident reporting systems, pharmacy reporting system) reported to CMS; HQI proposed		measurement year	Certification - QIS	Innovation Networks (HIINs)
31	5.02	CAUTI SIR for all hospitals	Report SIR for each network hospital excluding small-denominator hospitals:: CAUTI Standardized Infection Ration (SIR) – All Tracked Units – Relative performance Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline	Number of observed inpatient healthcare-associated CAUTIs for all tracked units	Number of predicted inpatient healthcare-associated CAUTIs for all tracked units (determined by NHSN)	CMS Hospital Quality Compare[1]	Annually	January 1 – December 31 of applicable measurement year. For hospitals with predicted infections of less than 0.2, report the combined, 2-year SIR for the measurement year and the previous year.	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS)
32	5.02	Urinary Catheter Utilization Ratio	Report rate for each network hospital: Urinary Catheter Utilization Ratio – All Tracked Units Rate Calculation: (Numerator / Denominator) x 100 Lower ratios are generally associated with better performance and may also impact the CAUTI rate	Number of inpatient indwelling urinary catheter days for all tracked units	Number of inpatient bed days for all tracked units	Numerator may be obtained from NHSN or Partnership for Patients data reported to CMS. Denominator may be obtained from OSHPD, CDPH, or other public source.	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS)

[1] Datasets containing the CAUTI SIR for all California hospitals from 2005 through 2015 are available here: https://data.medicare.gov/data/archives/hospital-compare

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
33	5.02	CLABSI SIR	Report SIR for each network hospital: CLABSI SIR – All Tracked Units Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed inpatient CLABSIs for all tracked units	Number of expected inpatient CLABSIs for all tracked units (determined by NHSN)	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year. For hospitals with predicted infections of less than 0.2, report the combined, 2-year SIR for the measurement year and the previous year.	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS) • CDPH – HAI Annual Report
34	5.02	Central Line Utilization Ratio	Report rate for each network hospital: Central Line Utilization Ratio – All Tracked Units Rate Calculation: (Numerator / Denominator) × 100 Lower ratios are generally associated with better performance and may also impact the CLABSI rate	Number of inpatient central line days for all tracked units	Number of inpatient bed days for all tracked units	Numerator may be obtained from NHSN, CDPH, or Partnership for Patients data reported to CMS. Denominator may be obtained from OSHPD, CDPH, or other public source.	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS)
35	5.02	*Clostridium difficile* SIR	Report SIR for each network hospital: Lab-Identified C. Difficile SIR Rate Calculation: Numerator / Denominator Target Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed inpatient hospital-onset C. difficile lab identified events for all tracked units	Number of expected inpatient hospital-onset cases of C. difficile for all tracked units	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year. For hospitals with predicted infections of less than 0.2, report the combined, 2-year SIR for the measurement	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network	• CMS Hospital Engagement Networks (HENS) • CDPH – HAI Annual Report

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
								year and the previous year.	contracting data.	
36	5.02	SSI-Colon SIR	Report SIR for each network hospital:: Colon Surgery SSI SIR Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed SSIs for colon surgeries (based on NHSN definition)	Number of predicted SSIs for colon surgeries (determined by NHSN definition)	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year. For hospitals with predicted infections of less than 0.2, report the combined, 2-year SIR for the measurement year and the previous year.	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS) • CDPH – HAI Annual Report
37	5.02	MRSA BSI SIR	Report SIR for each network hospital: MRSA BSI SIR Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed MRSA BSI cases	Number of predicted MRSA BSI cases	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year. For hospitals with predicted infections of less than 0.2, report the combined, 2-year SIR for the measurement year and the previous year.	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS) • CDPH – HAI Annual Report
38	5.01	Hospital Reimbursement at Risk for Quality Performance	Report the percentage of hospital performance at risk for quality performance (metrics may include but are not limited to HACs, readmissions, patient satisfaction, etc.)	Hospital payment dollars tied to quality performance	Total hospital payment dollars	Financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	
39	5.01	Hospitals with Reimbursement at Risk for Quality Performance	Report the number and percentage of hospitals with reimbursement at risk for quality performance (metrics may include but are not limited to HACs, readmission, patient satisfaction, etc.)	Hospitals with payment tied to quality performance	Total number of network hospitals	Network data/financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
40	6.01	Members Using Wellness Benefit	Report the number and percentage of members who have a preventive care visit ($0 member cost share)	Members incurring at least one preventive care visit/service	Total membership across all lines of membership excluding Medicare	Claim/ encounter data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification	
41	6.01	Members identified as obese who are participating in a weight management program	Report the number of obese members who are participating in weight management programs	Number of California members identified as obese who are participating in weight management program	California members identified as obese	Claims/ encounter data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI	
42	6.01	Members identified as tobacco dependent who are participating in a smoking cessation program	Report the number of tobacco-dependent members who are participating in smoking cessation programs	California members identified as tobacco dependent participating in smoking cessation program	California members identified as tobacco dependent	Claims/ encounter data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI	

Attachment 8 – 2017 Rates – Individual Market

Attachment 9 – Rate Updates – Individual Exchange

Attachment 10 – Reserved for future use

Attachment 11 – Reserved for future use

Attachment 12 – Overview of the Model QHP Addendum for Indian Health Care Providers

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

Overview of the Model QHP Addendum for Indian Health Care Providers

I. Purpose

CMS has developed the attached Model QHP Addendum for Indian health care providers to facilitate the inclusion of Indian Health Service (IHS), tribes and tribal organizations, and urban Indian organization (I/T/U) providers in qualified health plan (QHP) provider networks and help health insurance issuers comply with the QHP certification standards set forth in 45 C.F.R. Part 156. Similar to the standardized contract addendum used in the Medicare Part D program, this Model QHP Addendum has been developed for QHP issuers to use when contracting with I/T/U providers. This Model QHP Addendum is not required, but the U.S. Department of Health and Human Services (HHS) received several comments supporting the development and issuance of a model addendum for this purpose to assist QHP issuers in including I/T/U providers in their networks.

The federal government has a historic and unique government-to-government relationship with Indian tribes. In adhering to QHP certification standards, QHP issuers should reach out to I/T/U providers. A significant portion of American Indians and Alaska Natives (AI/ANs) access care through longstanding relationships with providers in the Indian health system. An important consideration in evaluating network adequacy and essential community provider accessibility will be the extent to which a QHP includes I/T/U providers and whether it can assure that services to AI/ANs will be accessible without unreasonable delay.

It is anticipated that the Model QHP Addendum will assist issuers to meet the QHP certification standards and facilitate acceptance of network contracts by I/T/U providers. We anticipate that offering contracts that include the Model QHP Addendum will provide QHP issuers with an efficient way to establish contract relationships with I/T/U providers, and also ensure that AI/ANs can continue to be served by their Indian provider of choice.

Indian tribes are entitled to special protections and provisions under federal law, which are described further in Section II. The Addendum identifies several specific provisions that have been established in federal law that apply when contracting with I/T/U providers. The use of this Model QHP Addendum benefits both QHP issuers and the I/T/U providers by lowering the perceived barriers to contracting, assuring QHP issuers comply with key federal laws that apply when contracting with I/T/U providers, and minimizing potential disputes. AI/ANs enrolled in QHPs will be better served when I/T/U providers can coordinate their care through the QHP issuer provider network.

II. Background on Indian Health Care

Indian tribes are afforded specific protections and provisions under federal laws, including the Indian Health Care Improvement Act (IHCIA), the Indian Self-Determination and Education Assistance Act (ISDEAA), and the Patient Protection and Affordable Care Act (ACA). In order

to carry out its obligation to provide health care to American Indians and Alaska Natives (AI/ANs), the federal government has established a unique health care delivery system through the Indian Health Service (IHS). As part of the Indian health care system, health care services to AI/ANs are provided either directly by the IHS, by tribes or tribal organizations, or by urban Indian programs.

Today the Indian health care system includes 44 Indian hospitals (16 of which are tribally-operated and all of which are accredited) and nearly 570 Indian health centers, clinics, and health stations (of which 83 percent are tribally-operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded Contract Health Services (CHS) program. Additionally, 33 urban programs offer services ranging from community health to comprehensive primary care.

III. Key Provisions in the Addendum

The following is a synopsis of key provisions outlined in the Addendum.

Persons Eligible for Items and Services from an Indian Health Care Provider: This section acknowledges that Indian health programs are generally not available to the public; they are established to serve AI/ANs, as provided in the IHCIA. The applicable eligibility rules are generally set out in the IHS regulations at 42 C.F.R. Part 136. The IHCIA § 813 (25 U.S.C. §1680c) sets out the circumstances under which certain non-AI/ANs connected with an AI/AN (such as minor children or a spouse) can receive services as beneficiaries. Also, the IHCIA § 813 authorizes services to certain other non-AI/ANs if defined requirements are satisfied. Pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed as subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from an Indian health program.

Providers should note that 45 C.F.R. 80.3(d) is not an exemption from civil rights obligations generally. It simply clarifies that certain types of exclusions are not considered discrimination under Title VI of the Civil Rights Act of 1964. Providers may be subject to applicable federal nondiscrimination statutes.

Applicability of Other Federal Law: This section describes several federal laws that apply variously when contracting with I/T/U providers.

- *Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 et seq.* This law directs HHS at the request of an Indian tribe, to enter into a contract or compact with a tribe, a tribal organization, or an inter-tribal consortium to operate federal health programs for AI/ANs with the funds the IHS would have otherwise used to carry out the program directly. Through this law, many Indian tribes and tribal organizations have taken over direct operation of health programs from the IHS.

- *Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 2671-2680.* Congress generally extended the FTCA to cover Indian tribes and tribal organizations operating federal programs pursuant to contracts or compacts under the ISDEAA, 25 U.S.C. § 450f. Urban Indian organization health providers who acquire Federally Qualified Health Center status under Section 224 of the Public Health Service Act can acquire FTCA coverage. Since a claim under the FTCA is

the exclusive remedy for actions against Indian health care providers that are covered by the FTCA, those entities are not required to obtain separate professional liability insurance.

- *Federal Medical Care Recovery Act (FMCRA), 42 U.S.C. §§ 2651-2653.* This law authorizes federal agencies, including the IHS, to recover from a tortfeasor (or an insurer of a tortfeasor) the reasonable value of health services furnished to a tortfeasor's victim. The right of recovery under the FMCRA extends to Indian tribes and tribal organizations operating ISDEAA contracts and compacts. 25 U.S.C. § 1621.

- *Federal Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b.* This law and its regulations apply to the IHS, and may apply Indian tribes, tribal organizations, and urban Indian organizations that operate federally-funded health care programs. The Privacy Act governs the use and disclosure of personally identifiable information about individuals that is maintained in a federal system of records. While the Privacy Act generally applies to federal records maintained by a government contractor, patient records of a Tribal health program are not considered federal records for the purposes of chapter 5 of title 5 of the United States Code (including the Privacy Act and the Freedom of Information Act - see 25 U.S.C. § 450l).

- *Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.* These regulations restrict disclosure and use of drug abuse patient records that are maintained in connection with the performance of any federally assisted alcohol or drug abuse program. The restrictions would apply to any such records maintained by the IHS, an Indian tribe, tribal organization, or urban Indian organization.

- *Health Insurance Portability and Accountability Act (HIPAA), (45 C.F.R. Parts 160 and 164).* These regulations restrict access to and disclosure of protected health information maintained by covered entities, including covered health care providers operated by the IHS, Indian tribes, tribal organizations, and urban Indian organizations.

- *Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 et seq.* This law provides the comprehensive statutory framework for delivery of health care services to AI/ANs. It applies to all Indian health providers operating ISDEAA contracts and compacts from the Secretary of the HHS; and urban Indian organizations that receive grants from IHS under Title V of the IHCIA. Specific provisions of the IHCIA that would impact contracts between Indian health care providers and QHPs issuers are cited in various provisions of the Addendum.

Insurance and Indemnification: IHS, tribes and tribal organization providers are generally covered by the FTCA. Some urban Indian organizations are also covered under FTCA. Since a claim under the FTCA is the exclusive remedy for actions against FTCA covered I/T/U providers, those entities are not required to obtain professional liability insurance.

Licensure of Health Care Professionals: Section 221 of the IHCIA, 25 U.S.C. § 1621t, permits an Indian tribe or tribal organization to employ a health care professional who is subject to licensure if that individual is licensed in any state. Employees of the IHS obtain their "licensed in any state" status through other federal law.

Medical Quality Assurance Requirements: Section 805 of the IHCIA, 25 U.S.C. § 1675, facilitates internal medical program quality reviews; shields participants in those reviews; and restricts disclosure of medical quality assurance records, subject to the exceptions in 25 U.S.C. 1675(d), which provides that medical quality assurance records created by or for I/T/U providers may not be disclosed to any person or entity. These disclosure limitations are also applicable to anyone to whom the I/T/U provider discloses such medical quality assurance records under the authority of 25 U.S.C. 1675(d). Although restrictive, we expect these limitations will have limited applicability to QHPs because there will be few, if any circumstances, where such records may be disclosed to a QHP under the law.

Claims Format: Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h) is applicable to issuers when processing claims from an I/T/U provider. Section 206(h) of IHCIA states than a health insurance issuer may not deny a claim submitted by the IHS, an Indian tribe or tribal organization based on the format on which the claim is submitted if the format complies with the Medicare claims format requirements.

Payment of Claims: Federal laws, including Section 206(a) and (i) of the IHCIA, 25 U.S.C. § 1621e(a) and (i) and Title 45 Code of Federal Regulation, Part 156, Subpart E[1], are applicable to health insurance issuers when paying claims from I/T/U providers. Section 206(a) and (i) of IHCIA provide that the IHS, an Indian tribe, tribal organization, and urban Indian organization have a right to recover the reasonable charges billed, or, if higher, the highest amount an insurance carrier would pay to other providers. However, this paragraph also notes if the issuer and I/T/U Provider mutually agree to rates or amounts specified in the QHP agreement as payment in full, the QHP issuer is deemed to be compliant with Section 206 of IHCIA.

Contract Health Service Referral Requirements: In some instances, I/T/U providers may be subject to referral requirements under the contract health services program. For example, IHS may have existing contractual arrangements that require IHS to refer to specific providers and suppliers; or IHS may be prohibited from referring to a provider that has been excluded from Federal Health Care Programs, as defined in § 1128 of the Social Security Act. We believe these circumstances will be rare, but to the extent that they occur, the I/T/U provider may not be able to adhere to QHP issuer referral requirements to use in-network providers. This section acknowledges the potential for conflicting requirements, and that I/T/U providers may be prevented from following QHP issuer referral requirements in such instances. This section affirms that the I/T/U provider will otherwise comply with in network coordination of care and referral requirements.

IV. Database of Indian Providers

To assist issuers in identifying I/T/U providers in their service areas, please use the attached link to obtain a database of I/T/U provider locations, developed with the assistance of the Indian Health Service: http://cciio.cms.gov/programs/exchanges/qhp.html.

[1] Title 45 Code of Federal Regulation, Part 156, Subpart E describes rules for the elimination of cost sharing for EHB, for Indians at or below 300% of the Federal Poverty Level, and for no cost sharing for Indians receiving an item or service that is an EHB furnished by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or through referral under contract health services. 78 Fed. Reg. 15410, 15535-39 (Mar. 11, 2013).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

Model QHP Addendum for Indian Health Care Providers

1. Purpose of Addendum; Supersession.

The purpose of this Addendum for Indian health care providers is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____ (herein "Qualified Health Plan issuer" and/or "QHP issuer") and _____ (herein " Provider"). To the extent that any provision of the Qualified Health Plan issuer's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. Definitions.

For purposes of the Qualified Health Plan issuer's agreement, any other addendum thereto, and this Addendum, the following terms and definitions shall apply:

(a) "Contract health services" has the meaning given in the Indian Health Care Improvement Act (IHCIA) Section 4(5), 25 U.S.C. § 1603(5).
(b) "Indian" has the meaning given in 45 C.F.R. 155.300.
(c) "Provider" means a health program administered by the Indian Health Service, a tribal health program, an Indian tribe or a tribal organization to which funding is provided pursuant to 25 U.S.C. § 47(commonly known as the "Buy Indian Act"), or an urban Indian organization that receives funding from the IHS pursuant to Title V of the IHCIA (Pub. L. 94-437), as amended, and is identified by name in Section 1 of this Addendum.
(d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.
(e) "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).
(f) "Qualified Health Plan" (QHP) has the meaning given in Section 1301 of the Affordable Care Act, 42 U.S.C. § 18021.
(g) "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).
(h) "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).
(i) "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of Provider.

The Provider identified in Section 1 of this Addendum is (check the appropriate box):

/_/ The IHS.

/_/ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

/_/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

/_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Persons Eligible for Items and Services from Provider.

(a) The parties acknowledge that eligibility for services at the Provider's facilities is determined by federal law, including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the Provider's programs.

(b) No term or condition of the QHP issuer's agreement or any addendum thereto shall be construed to require the Provider to serve individuals who are ineligible under federal law for services from the Provider. The QHP issuer acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the Provider. Provider acknowledges that the nondiscrimination provisions of federal law may apply.

5. Applicability of Other Federal Laws.

Federal laws and regulations affecting the Provider, include but are not limited to the following:

(a) The IHS as a Provider:

(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.*;*
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
(7) Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164; and
(8) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

(1) ISDEAA, 25 U.S.C. § 450 et seq.*;*
(2) IHCIA, 25 U.S.C. § 1601 et seq.*;*
(3) FTCA, 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

(1) IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors)*;*
(2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(3) HIPAA, 45 C.F.R. Parts 160 and 164.

6. Non-Taxable Entity.

To the extent the Provider is a non-taxable entity, the Provider shall not be required by a QHP issuer to collect or remit any federal, state, or local tax.

7. Insurance and Indemnification.

(a) *Indian Health Service*. The IHS is covered by the FTCA which obviates the requirement that IHS carry private malpractice insurance as the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. 28 U.S.C. §§ 2671-2680. Nothing in the QHP network provider agreement shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment. The IHS shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP will be held harmless from liability.

(b) *Indian Tribes and Tribal Organizations*. A Provider which is an Indian tribe, a tribal organization, or employee of a tribe or tribal organization shall not be required to obtain or maintain professional liability insurance to the extent such Provider is covered by the FTCA pursuant to federal law (Public Law 101-512, Title III, § 314, as amended by Public Law 103-138, Title III, § 308 (codified at 25 U.S.C. § 450f note); and 25 C.F.R. Part 900, Subpart M; 25 U.S.C. §458aaa-15(a); and 42 C.F.R. § 137.220). Nothing in the QHP issuer network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP issuer will be held harmless from liability.

(c) *Urban Indian Organizations*. To the extent a Provider that is an urban Indian organization is covered by the FTCA pursuant to Section 224(g)-(n) of the Public Health Service Act, as amended by the Federally Supported Health Centers Assistance Act, Public Law 104-73, (codified at 42 U.S.C. § 233(g)-(n)), 42 C.F.R. Part 6, such Provider shall not be required to obtain or maintain professional liability insurance. Nothing in the QHP issuer network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such Provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP issuer will be held harmless from liability.

8. Licensure of Health Care Professionals.

(a) *Indian Health Service.* States may not regulate the activities of IHS-operated health care programs nor require that IHS health care professionals be licensed in the state where they are providing services, whether the IHS employee is working at an IHS-operated facility or has been assigned to a health care program of a tribe, tribal organization, or urban Indian organization. The parties agree that during the term of the QHP issuer's agreement, IHS health care professionals shall hold state licenses in accordance with applicable federal law, and that IHS facilities shall be accredited in accordance with federal statutes and regulations.

(b) *Indian tribes and tribal organizations.* Section 221 of the IHCIA, 25 U.S.C. § 1621t, exempts a health care professional employed by an Indian tribe or tribal organization from the licensing requirements of the state in which such tribe or organization performs services, provided the health care professional is licensed in any state. The parties agree that these federal laws apply to the QHP issuer's agreement and any addenda thereto.

(c) *Urban Indian organizations.* To the extent that any health care professional of an urban Indian provider is exempt from state regulation, such professional shall be deemed qualified to perform services under the QHP Sponsor's agreement and all addenda thereto, provided such employee is licensed to practice in any state. The parties agree that this federal law applies to the QHP issuer's agreement and any addenda thereto.

9. Licensure of Provider; Eligibility for Payments.

To the extent that the Provider is exempt from state licensing requirements, such Provider shall not be required to hold a state license to receive any payments under the QHP issuer's network provider agreement and any addendum thereto.

10. Dispute Resolution.

In the event of any dispute arising under the QHP issuer's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes prior to resolution of any disputes through any process identified in the network provider agreement. If the Provider is an IHS provider, the laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith. Notwithstanding any provision in the provider network agreement, IHS shall not be required to submit any disputes between the parties to binding arbitration.

11. Governing Law.

The QHP issuer's network provider agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the QHP issuer's network provider agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

12. Medical Quality Assurance Requirements.

To the extent the QHP issuer imposes any medical quality assurance requirements on its network providers, any such requirements applicable to the Provider shall be subject to Section 805 of the IHCIA, 25 U.S.C. § 1675.

13. Claims Format.

The QHP issuer shall process claims from the Provider in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a Provider based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

14. Payment of Claims.

The QHP issuer shall pay claims from the Provider in accordance with federal law, including Section 206 of the IHCIA (25 U.S.C. §1621e), and 45 C.F.R., Part 156, Subpart E. The QHP issuer shall be deemed compliant with Section 206 to the extent the QHP issuer and Provider mutually agree to the rates or amounts specified in the QHP issuer agreement as payment in full.

15. Hours and Days of Service.

The hours and days of service of the Provider shall be established by the Provider. Though not required prior to the establishment of such service hours, the QHP issuer and the Provider may negotiate and agree on specific hours and days of service. At the request of the QHP issuer, such Provider shall provide written notification of its hours and days of service.

16. Contract Health Service Referral Requirements

The Provider shall comply with coordination of care and referral obligations of the QHP issuer except only in specific circumstances in which such referrals would conflict with federal law or that referral requirements applicable to Contract Health Services would not be met. The Provider will notify the QHP issuer when such circumstances occur.

17. Sovereign Immunity.

Nothing in the QHP issuer's network provider agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

18. Endorsement.

An endorsement of a non-federal entity, event, product, service, or enterprise may be neither stated nor implied by the IHS Provider or IHS employees in their official capacities and titles. Such agency names and positions may not be used to suggest official endorsement or preferential treatment of any non-federal entity under this agreement.

APPROVALS

For the Qualified Health Plan Issuer:

_____

Date _____

For the Provider:

_____

Date _____

Attachment 13 – List of Required Reports

Attachment 13 - List of Required Reports

Contractor Reports to be provided to Covered CA

Below is a list of reports to be provided by the Contractor to Covered California on a monthly, quarterly or annual basis.

Report Name	Contract Section	Frequency	Due Date	Submit to:
Fraud, waste and abuse detection and prevention programs and report total moneys recovered by Contractor in the most recent 12-month period in relation to Services provided to Enrollees	1.16	Annually	February 28, 2018 – Report for prior calendar year 2017.	QHP@covered.ca.gov
Enrollment Reconciliation Comparison extract	2.1.2	Monthly	As required in 2.1.2	SFTP
Description on Contractor's standard agent compensation program and policies	2.2.6	Annually	60 days prior to open enrollment	QHP@covered.ca.gov
Marketing Plan	2.3	Annually	30 days prior to open enrollment	QHPMarketingMaterials@covered.ca.gov
Marketing Plans of Retention and Renewal	2.3	Annually	30 days after open enrollment begins	QHPMarketingMaterials@covered.ca.gov
Marketing Actualized Spend Amounts	2.3	Annually	For open enrollment – 30 days after open enrollment closes; for the special enrollment period – 30 days after calendar year ends; and for retention and renewal, 30 days after open enrollment begins	QHPMarketingMaterials@covered.ca.gov

Reporting Requirements in Attachment 7				
Reducing Health Disparities and Assuring Health Equity – HEDIS Reporting	Attachment 7, 3.01, 3.02	Annually	Separate Report	Submit through the Extranet
Hospital Acquired Conditions (HACs) Report – Rates of five specified HACS by hospital	Attachment 7, 5.02	Annually	Separate Report	Submit through the Extranet
The following Reporting Requirements in Attachment 14				
Customer Service Performance Standards	Attachment 14 Groups 1 & 2 Standards 2.1 - 2.4	Monthly	The 10th of the following month	QHP@covered.ca.gov
Provider Directory and Attachment 7 EAS Data	Attachment 14 2.5 & Attachment 7 EAS Data	Monthly	As requested	Monthly Provider Data (Contract Section 3.4.4) submitted to Covered California, EAS Data submitted to EAS Vendor.
Agent of Record Exception Reports	Attachment 14 Group 2 Standard 2.6	Monthly	Last business day of each month	outreachandsales@covered.ca.gov
Quality, Network Management & Delivery System Standards	Attachment 14 Group 3 Standards 3.1 - 3.2	Annually	For calendar year 2017, due date to be determined by CMS	Data submitted to CMS for review.
Quality, Network Management & Delivery System Standards	Attachment 14 Group 3 Standard 3.3	Monthly	As requested	Monthly Provider Data submitted to Covered California. (Same report as Contract Section 3.4.4 above)
Quality, Network Management and Delivery System Standards	Attachment 14 Group 3, 3.4-3.9	Quarterly	Quarterly as request	Application for certification and the Extranet
Dental Quality Alliance (DQA) Pediatric Measure Set – for embedded pediatric dental	Attachment 14 Group 5	Annually	For calendar year 2017 due on April 30, 2018	QHP@covered.ca.gov

Financial Management Division – Required Reports				
Payment Reconciliation – Schedule of Notifications Contractors participating in the individual market shall report delinquent full or partial payments of premiums to the Exchange. The schedule shall include a record of all notifications, including phone calls and letters, to participants of delinquent accounts.		Monthly	Report due in the month following the payment due date.	Accounting SCRtickets@covered.ca.gov
Billing Detail – Discrepancy Report Contractors participating in the individual market shall use the PM/PM (per member, per month) member level billing detail template to communicate billing discrepancies to the Exchange. Contractor shall use the PM/PM member level billing detail, as provided by the Exchange, to compare against the Contractor's confirmed enrollment to identify discrepancies. Contractor shall use the "comments" column, on the far right of the PM/PM member level billing detail template to identify billing discrepancies such as member duplication, cancellation, termination, missing Covered CA, missing Carrier, effective date, or plan difference. Contractor shall submit the completed template in both a format and secure manner approved by the Exchange. Furthermore, Contractor understands submittal of the completed billing discrepancy template does not extend or revise the invoice due date.		Monthly	Report due in the month following the payment due date. Use FMD Issuer Billing Discrepancy Report Template.	Accounting SCRtickets@covered.ca.gov Please include "PMPM Billing Detail Discrepancy Report - for <billing month-year>" in the subject line of the email.

Attachment 14 – Performance Measurement Standards

Attachment 14. Performance Standards

During the term of this Agreement, Contractor shall meet or exceed the Performance Standards identified in this Attachment. Contractor shall be responsible for payment of penalties that may be assessed by the Exchange with respect to Contractor's failure to meet or exceed the Performance Standards in accordance with the terms set forth at Section 6.1 of the Agreement and in this Attachment.

The assessment of penalties by the Exchange shall be determined on an annual basis in accordance with the computation methodology set forth in this Attachment. In no event shall the total amount at risk with respect to Contractor's failure to comply with the Performance Standards exceed ten percent (10%) of the total Participation Fee that is payable to the Exchange in accordance with the terms set forth in Section 5.1.3 of the Agreement for the Individual Market. Additionally, the amount of Contractor's penalty shall be offset by any credit that is provided in the event that Contractor exceeds a Performance Standard in a separate category or if the Exchange fails to meet its Performance Standards as described below. Credits from one category may be used to offset penalties in that category, or applied to offset penalties assessed in another category.

The Exchange must also comply with the Performance Standards as described in Group 4. In the event that the Exchange does not satisfy a Performance Standard, based on the final calendar year-end data, the Exchange shall provide credits to Contractor which will be applied to any penalties accrued to Contractor. Such credits may reduce up to 15% of Contractor's performance penalties that may be assessed. In no event shall the total credits to Contractor exceed the total amount of the performance penalty owed to the Exchange by Contractor

The Exchange will calculate penalties and credits at the end of each calendar year, based on Contractor's final year-end data for each performance standard beginning with Group 1 and 2 and the Exchange's final year-end data for Group 4. The Exchange's calculations will be provided to Contractor through the Initial Contractor Performance Standard Evaluation Report, covering Groups 1, 2, and 4, which the Exchange will send to Contractor for review no later than February 28th of the following calendar year.

Contractor shall submit the data required by the Performance Standards for Group 3, by the date specified by the Exchange. Some of the data required applies to a window of time, which is defined as measurement year 2015 and 2016.Some of the data represents a point in time. This measurement timing is described in more detail in the table below.

Group 3 Performance Standards	Reporting Period for Baseline (against which 2017 performance is assessed):
3.4a, 3.5-3.7	Point in time of current state, at the time of the 2017 and 2018 Applications for Certification
3.4b, 3.8, 3.9	Measurement Year 2015 / 2016

Contractor will report the same information in Applications for 2018 and 2019, which will allow the Exchange to assess the trajectory and assign penalties or credits. Any data not available by the due date for the 2017 Certification Application shall be reported by the end of the third quarter of 2016.

When the results of Group 3 are received by the Exchange, Contractor's final results will be calculated. The Exchange will then provide Contractor with a Final Contractor Performance Standard Evaluation Report, along with an invoice, within 60 calendar days of receipt of the Group 3 data requirements.

Contractor shall remit payment to the Exchange within 30 calendar days of receiving the Final Contractor Performance Measurement Evaluation Report and invoice.

If Contractor does not agree with either the Initial or Final Performance Standard Evaluation Report, Contractor may dispute the Report in writing within thirty (30) calendar days of receipt of that Report. The written notification of dispute shall provide a detailed explanation of the basis for the dispute. The Exchange shall review and provide a written response to Contractor's dispute within thirty (30) calendar days of receipt of Contractor's notification of dispute. If the Contractor still disputes the findings of the Exchange, Contractor may pursue additional remedies in accordance with Section 12.1 of the Agreement.

An overview of each Performance Standard and each penalty and credit percentage is attached hereto as Appendix 1.

Any amounts collected as performance penalties under this Attachment must be used to support Exchange operations.

Contractor shall annually submit the required data for Group 5. Group 5 is a reporting requirement only. No penalties or credits will be assessed for Group 5 in 2017.

Call Center Operations Performance Standards Reporting - Group 1 - Customer Service and Group 2 – Operational, Performance Standards 1.1 – 1.10 and 2.1 – 2. 6.

Monthly Performance Report: Contractor shall monitor and track its performance each month against the Performance Standards set forth herein. Contractor shall provide detailed supporting information (as mutually agreed by the parties) for each Monthly Performance Report to the Exchange in electronic format. Contractor shall report on Exchange business only and shall report Contractor's Enrollees in the Individual Exchange separate from Contractor's Enrollees in Covered California for Small Business.

Measurement Rules:

Except as otherwise specified below in the Performance Standards Table, the reporting period for each Performance Standard shall be one calendar month. All references to days shall be calendar days and references to time of day shall be to Pacific Standard Time.

Performance Standards:

1) General - The Performance Standards Table sets forth the categories of Performance Standards and their associated measurements. In performing its services under this Agreement, Contractor shall use commercially reasonable efforts to meet or exceed the Performance Standards.

2) Root Cause Analysis/Corrective Action - If Contractor fails to meet any Performance Standard in any calendar month (whether or not the failure is excused), Contractor shall promptly (a) investigate and report on the root cause of the problem; (b) develop a corrective action plan (where applicable); (c) to the extent within Contractor's control, remedy the cause of the performance failure and resume meeting the affected Performance Standards; (d)

implement and notify the Exchange of measures taken by Contractor to prevent recurrences, if the performance failure is otherwise likely to recur; and (e) make written recommendations to the Exchange for improvements in Contractor's procedures.

3) Performance Standard Exceptions - Contractor shall not be responsible for any failure to meet a Performance Standard if and to the extent that the failure is excused pursuant to Section 12.7 of the Agreement (Force Majeure) or the parties agree that the lack of compliance is due to the Exchange's failure to properly or timely perform (or cause to be properly or timely performed) any responsibility, duty, or other obligation under this Agreement, provided that Contractor timely notifies the Exchange of the problem and uses commercially reasonable efforts to perform and meet the Performance Standards notwithstanding the Exchange's failure to perform or delay in performing.

If Contractor wishes to avail itself of one of these exceptions, Contractor shall indicate in the applicable performance report delivered in the first report following the failure to meet such Performance Standard: (a) the identity of the Performance Standard that is subject to the exception, and (b) the circumstances that gave rise to the exception in sufficient detail to permit the Exchange to evaluate whether Contractor's claim of exception is valid. Notwithstanding anything to the contrary herein, in no event shall any failure to meet a Customer Satisfaction Performance Standard fall within an exception.

The Exchange must also comply with the Performance Standards to the extent that such standards are applicable to the Exchange's operations.

4) Agreed Adjustments/Service Level Relief - In addition, the Parties may agree on Performance Standard relief or adjustments to Performance Standards from time to time, including, the inclusion of new or temporary Performance Standards.

5) Performance Defaults - Failure of the Contractor to meet the performance standards shall grant the Exchange the authority to assess penalties where applicable, or require that the Contractor provide and implement a corrective action plan.

6) Credits - For certain measures of the performance standards set forth in the Performance Standards Table, Contractor will have the opportunity to earn credit for performance that exceeds the Performance Standards. The Credits shall be used to offset (i.e., reduce) any penalties that are imposed during any Contract Year.

7) Performance Tables - The Performance Standards are set forth in the tables below, titled Covered California Performance Standards for Contractor.

Performance Standards Reporting-Group 3 - Quality, Network Management and Delivery System Reform, Performance Standards 3.1 - 3.9

QHP Issuers are required by CMS in 2018 to collect and submit third-party validated QRS measure data, for measurement year 2017 that will be used by CMS to calculate QHP scores and ratings. These measures will be determined by CMS. The Exchange will publicly report the QRS scores and ratings that are produced by CMS, and reserves the right to produce additional QRS scores from the CMS data for public release. QRS scores are based on surveys of both individual market and Covered California for Small Business Enrollees for those products offered in both marketplaces. Performance penalties will be calculated using the PMPM for individual market only.

Many of the performance measures described in 3.4-3.9 will be based on targets set from baseline data that will be reported in 2017. Most will be reported in 2017, through the 2018 Application for Certification, however some information will be reported later due to availability of data (for example HEDIS scores). The corresponding reports on 2017 performance will be reported in 2018, either through the 2019 Application for Certification or later in 2018. This Agreement may be amended to modify Performance Standards Contractor must meet during plan years 2018 and 2019, which will be mutually agreed upon during the 2018 and 2019 Applications for Certification.

Performance Standards Reporting – Group 5 - Dental Quality Alliance (DQA) Pediatric Measure Set

Contractor shall annually report on the Performance Standards for dental in Group 5. Reporting will be on embedded pediatric dental for each Plan Year. Contractor must submit this report at the end of the first quarter of the following calendar year.

Covered California Performance Standards for Contractor

Group 1: Customer Service Performance Standards 15% of Total Performance Penalty At Risk or Credit		
Performance Standard		**Performance Requirements**
1.1	**Inbound Call Volume – Covered California Calls Only**	Reporting Required Only. No penalty or credit. Total number of calls received by the IVR.
1.2	**Number of Covered California Calls offered to Phone Representatives**	Reporting Required Only. No penalty or credit. Do not include any calls terminated in the IVR or self-serviced in the IVR.
1.3	**Number of Covered California Calls Abandoned**	Reporting Required Only. No penalty or credit. Do not include calls abandoned in 10 seconds or less.
1.4	**Abandonment Rate (%)** 3% of total performance penalty for this Group.	Divide number of abandoned calls by the number of calls offered to a phone representative. Expectation: No more than 3% of incoming calls abandoned in a calendar month. Performance Level: >3% abandoned: 3% performance penalty. 2-3% abandoned: no penalty. <2% abandoned: 3% performance credit.
1.5	**Average Speed of Answer** 3% of total performance penalty for this Group.	Expectation: 80% of calls answered in 30 seconds or less. Performance Level: <80%: 3% performance penalty. 80%-90%: no penalty. >90%: 3% performance credit.
1.6	**Average Handle Time**	Reporting Required only. No penalty or credit. This includes talk time, hold time, and after call wrap up time.
1.7	**Initial Call Resolution** 3% of total performance penalty for this Group.	Expectation: 85% of Covered California enrollee issues will be resolved within one (1) business day of receipt of the issue. Performance Level: <85%: 3% performance penalty. 85-95%: no penalty. >95%: 3% performance credit.

Covered California Performance Standards for Contractor

Group 1: Customer Service Performance Standards 15% of Total Performance Penalty At Risk or Credit		
Performance Standard		**Performance Requirements**
1.8	**Grievance Resolution** 3% of total performance penalty for this Group.	Expectation: 95% of Covered California enrollee grievances resolved within 30 calendar days of initial receipt. Performance Level: <95% resolved within 30 calendar days of initial receipt: 3% performance penalty. 95% or greater resolved within 30 calendar days of initial receipt: no penalty. 95% or greater resolved within 15 calendar days of initial receipt: 3% performance credit.
1.9	**Covered California member Email or Written Inquiries.**	Reporting Required Only. No penalty or credit. Volume will be used in calculation of performance standard 1.10 Total number of Covered California member email or written inquiries received.
1.10	**Covered California member Email or Written Inquiries Answered and Completed.** 3% of total performance penalty for this Group.	Expectation: 90% of Covered California member email or written inquiries answered and completed within 15 business days of the inquiry. Does not include appeals or grievances. Performance Level: <90%: 3% performance penalty. 90-95%: no penalty. >95% in 15 days: 3% performance credit.

Group 2: Operational Performance Standards 40% of Total Performance Penalty at Risk		
Performance Standard		**Performance Requirements**
2.1	**ID Card Processing Time** 5% of total performance penalty for this Group.	Expectation: 99% of ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer(s) Performance Level: <99%: 5% performance penalty.
2.2	**834 Processing** 5% of total performance penalty for this Group. **Pilot Period:** January 1, 2017 – March 31, 2017	Expectation: The Exchange will receive a TA1 or 999 file, or both as appropriate within two to three business days of receipt of the 834 file 95% of the time. Performance Level: <95%: 5% performance penalty.
2.3	**834 Generation** 5% of total performance penalty for this Group. **Pilot Period:** January 1, 2017 – March 31, 2017	Expectation: The Exchange will successfully receive and process effectuation, cancellation and termination 834 files within 60 days from either the coverage effective date or transaction timestamp, whichever is later 95% of the time. Performance Level: <95%: 5% performance penalty
2.4	**Reconciliation Process** 10% of total performance penalty for this Group.	Expectation: The Exchange shall receive a comparison reconciliation extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the reconciliation process guide 90% of the time. Performance Level: <90%: 10% performance penalty
2.5	**Data Submission specific to contract Section 3.4.4 Provider Directory and Attachment 7, Section 2.02 Data Submission.** 10% of total performance penalty for this Group.	Expectation: Full and regular submission of data according to the standards outlined. 10% of total performance penalty at risk. Performance Level: Incomplete, irregular, late or non-useable data submission: 10% penalty of total performance requirement. Full and regular submission according to the formats specified and useable by Covered California within 5 business days of each monthly reporting cycle: no penalty.

Group 2: Operational Performance Standards 40% of Total Performance Penalty at Risk		
Performance Standard		**Performance Requirements**
2.6	**Agent of Record Exception Reports** 5% of total performance penalty for this Group. **Pilot Period:** October 1, 2016 – December 31, 2016.	Expectation: The Exchange shall receive the required Agent of Record exception reports referenced in Section 2.2.6 (f) and (g) within 7 business days of the due date. Performance Level: Incomplete, irregular, late or non-useable data submission: 5% performance penalty. Complete monthly submissions within 7 business days of each monthly reporting cycle for at least 10 of 12 submissions: no penalty.

Group 3: Covered California Performance Standards Quality, Network Management and Delivery System Standards 45% of Total Performance Penalty or Credit for Measurement Year 2017 and Thereafter Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.		
Performance Standard		**Performance Requirements**
3.1	**Quality Rating System (QRS) - Clinical Effectiveness Rating; related to Attachment 7, Section 2.01.** 3.5% of total performance penalty for this Group.	Expectation: Rating Clinical Effectiveness Rating (product type reporting): Performance Level: The percentile score will be based on a blended all-product types, national marketplace benchmark. 1-2 Stars: 3.5% performance penalty. 3 Stars: no penalty. 4-5 Stars: 3.5% performance credit.
3.2	**Quality Rating System (QRS) QHP Enrollee Survey Summary Rating; related to Attachment 7, Section 2.01.** 3.5% of total performance penalty for this Group.	Expectation: - QHP Enrollee Survey Summary Rating - (product type reporting) Performance Level: The percentile score will be based on a blended all-product types, national marketplace benchmark. 1-2 Stars: 3.5% performance penalty. 3 Stars: no penalty. 4-5 Stars: 3.5% performance credit.

Group 3: Covered California Performance Standards

Quality, Network Management and Delivery System Standards

45% of Total Performance Penalty or Credit for Measurement Year 2017 and Thereafter

Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.

Performance Standard		Performance Requirements
3.3	**Essential Community Providers – Article 3, Section 3.3.3** 10% of total performance penalty for this Group.	Expectation: Contractor shall maintain a network that includes a sufficient geographic distribution of care, including essential community providers, and other providers, to provide reasonable and timely access to Covered Services for low income, vulnerable, or medically underserved populations in regions served by Contractor. Contractor to demonstrate provider agreements with at least 15% of 340B non-hospital providers in each applicable rating region. Contractor to demonstrate provider agreements that reflect a mix of essential community providers (hospital and non-hospital) reasonably distributed to serve the low-income, vulnerable, or medically underserved populations. Performance Level: 1. Sufficient ECP participation: 10% performance credit. 2. Developing ECP participation: no penalty or credit. 3. Insufficient ECP participation: 10% performance penalty. Alternate Standard Contractor Expectation: Contractor to produce access map to demonstrate low income, medically underserved enrollee access to health care services. Low income, vulnerable, or medically underserved individuals shall be defined as those Covered California enrollees who fall below 200 percent of the Federal Poverty Level (FPL). Maps shall demonstrate the extent to which provider sites are accessible to and have services that meet the needs of specific underserved populations, including: • Individuals with HIV/AIDS • American Indians and Alaska Natives • Low income and underserved individuals seeking women's health and reproductive health services

Group 3: Covered California Performance Standards Quality, Network Management and Delivery System Standards 45% of Total Performance Penalty or Credit for Measurement Year 2017 and Thereafter Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.		
Performance Standard		**Performance Requirements**
	Essential Community Providers – Article 3, Section 3.3.3 (continued)	• Other specific populations served by Essential Community Providers in the service area such as STD Clinics, Tuberculosis Clinics, Hemophilia Treatment Centers, Black Lung Clinics and other entities that serve predominantly low income, medically underserved individuals. Performance Level: Alternate Standard Contractors shall not be eligible for performance credits, nor shall they be subject to performance penalties. Submission of the above required mapping is a contract compliance requirement.
3.4	**Reducing Health Disparities – Article 3, Sections 3.01 and 3.02** 5% of total performance penalty for this Group.	a. Expectation: Contractor reports the percent of Exchange enrollees who have self-reported racial or ethnic identity in the Application for Certification for 2017. This information will be used as baseline to set incremental targets for percent of membership who have self-identified by end of 2017, which will be reported in 2018 through the Application for Certification for 2019. In 2020, the Contractor will report the percent of membership who have self-identified and will be measured against the 2019 target for 80% self-reported identity, to be reported in the Application for Certification for 2021. Data will be submitted in a run chart demonstrating improvement in the percentage of self-reported identity compared to baseline reported. Performance Levels: Contractor achieves no improvement in self-reported identity: 2% penalty Contractor shows improvement in self-reported identity but does not meet target: no penalty Contractor achieves target improvement in self-reported identity: 2% credit b. Expectation: The Exchange will set targets for reduction in disparities for end of year 2019 and for annual intermediate milestones after baseline was reported. Contractor reports required metrics across all lines of business excluding Medicare for diabetes, asthma,

Group 3: Covered California Performance Standards Quality, Network Management and Delivery System Standards 45% of Total Performance Penalty or Credit for Measurement Year 2017 and Thereafter Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.		
Performance Standard		**Performance Requirements**
	Reducing Health Disparities – Article 3, Sections 3.01 and 3.02 (continued)	Hypertension, and depression by race/ethnicity and gender once the scores for 2017 performance become available, in July 2018. The scores will be reported in run charts demonstrating comparison with baseline 2016 performance, which will be reported in July 2017. The Exchange and Contractor will set an intermediate milestone for each measure against which performance in 2017 will assessed. Performance Levels: Contractor achieves intermediate milestones for less than half of all measures: 3% penalty Contractor achieves intermediate milestones for at least half of all measures: No penalty. Contractor achieves intermediate milestones for all measures: 3% credit
3.5	**Network Design Based on Quality – Article 1, Section 1.02** 4% of total performance penalty for this Group.	Expectation: Contractor shall include quality criteria into its Exchange network development, with a phased approach starting in plan year 2017. Contractor will report on progress after 2017 plan year is complete, in 2018, through the Application for Certification for 2019. Performance Levels: Contractor is unable to describe valid inclusion of quality criteria into Exchange network development by end of year 2017: 4% penalty Contractor reports strategy for inclusion of quality criteria in all networks offered to Exchange enrollees, and demonstrates implementation of criteria by end of year 2017: No penalty Contractor fulfills the requirement for “no penalty” above, plus submits documentation that contracted hospitals have been notified in 2017 of expectation to meet targets for appropriate use of C-Section and reduction in Hospital Acquired Conditions by 2019: 4% credit

Group 3: Covered California Performance Standards Quality, Network Management and Delivery System Standards 45% of Total Performance Penalty or Credit for Measurement Year 2017 and Thereafter Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.		
Performance Standard		**Performance Requirements**
3.6	**Primary Care – Article 4, Section 4.01 and 4.02** 5% of total performance penalty for this Group.	a. Expectation: All members (defined as 95%) in Exchange products will select or be assigned to a primary care clinician beginning with enrollment effective January 2017. Contractor will submit quarterly reports describing the percent of members assigned to a primary care clinician by product and will submit this percent through the Applications for Certification in 2018 and 2019. Performance Levels: Contractor reports less than 95% of Exchange members have selected or been provisionally assigned a personal care physician: 2% penalty Contractor reports 95% or more of Exchange members have selected or been provisionally assigned a personal care physician: 2% credit b. Expectation: Contractor describes and begins re-contracting, for Exchange enrollees, with a payment strategy that creates a business case for PCPs to adopt accessible, data-driven, team-based care in Application for Certification for 2019. Performance Levels: Contractor reports no PCPs contracted based on new payment strategy: 3% penalty Contractor reports less than 5% of PCPs contracted under new payment strategy: no penalty Contractor reports 10% or more of PCPs contracted under new payment strategy: 3% credit
3.7	**Integrated Healthcare Models – Article 4, Section 4.03** 5% of total performance penalty for this Group.	Expectation: Contractor reports Exchange enrollment in integrated healthcare models, based on definition in Attachment 7, Article 4, Section 4.03 in Application for Certification for 2019. Target percentage of Exchange members who select or are attributed to IHMs will be established by the Exchange for 2019 with annual intermediate milestones after baselines are reported in the Application for Certification for 2017. Performance Levels: Contractor does not meet intermediate milestone for percent of Exchange membership attributed to integrated healthcare models: 5% penalty

Group 3: Covered California Performance Standards Quality, Network Management and Delivery System Standards 45% of Total Performance Penalty or Credit for Measurement Year 2017 and Thereafter Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.		
Performance Standard		**Performance Requirements**
	Integrated Healthcare Models – Article 4, Section 4.03 (continued)	Contractor achieves intermediate milestone for percent of Exchange membership attributed to integrated care models: No penalty Contractor exceeds intermediate milestone for percent of Exchange members attributed to integrated care models: 5% credit
3.8	**Appropriate Use of C-Sections – Article 5, Section 5.03** 4.5% total performance penalty for this Group.	a. Expectation: Contractor shall report percent of low risk, Nulliparous Term Singleton Vertex (NTSV) C-Section rates and overall C-Section rates for all Exchange network maternity hospitals where data is available in its annual Application for Certification starting in application for 2017. Performance Levels: Contractor does not report network low risk maternity hospital C-Section rates and overall C-Section rates: 2% penalty Contractor reports low risk C-Section rates for network maternity hospitals and overall C-Section rates: No penalty Contractor engages hospitals not tracking C-Section rates to initiate and submit information to the Maternity Data Center: 2% credit b. Expectation: Contractor shall adopt new payment strategies for physicians and hospitals such that by 2019 payment for Exchange enrollees is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Contractor will report progress in Application for Certification for 2019. Performance Levels: Contractor reports no physicians or maternity hospitals in Exchange network(s), reported separately, contracted based on new payment strategy: 2.5% penalty Contractor reports less than 20% of physicians or maternity hospitals in Exchange network(s), reported separately, contracted under new payment strategy: no penalty Contractor reports 20% or more of physicians or maternity hospitals in Exchange network(s), reported separately, contracted under new payment strategy: 2.5% credit

Group 3: Covered California Performance Standards

Quality, Network Management and Delivery System Standards

45% of Total Performance Penalty or Credit for Measurement Year 2017 and Thereafter

Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.

Performance Standard		Performance Requirements
3.9	**Hospital Safety - Article 5, Section 5.02** 4.5% total performance penalty for this Group.	a. Expectation: Contractor shall report rates of the five selected Hospital Acquired Conditions (HACs) for each Exchange network hospital, as defined in Attachment 7, Article 5, Section 5.02, (based on clinical data), in its annual Application for Certification starting with baseline in Application for Certification for 2017. Performance Levels: Contractor does not report rates on HACs: 2% penalty Contractor reports rates on specified HACs: No penalty Contractor reports rates on specific HACs, and engages non-reporting hospitals to begin tracking specific HAC rates: 2% credit b. Expectation: Contractor shall adopt a payment strategy that by January 1, 2019 places at least two percent of payment to hospitals for Exchange enrollees at-risk for quality performance and increases incrementally to at least six percent by January 1, 2023. Contractor may structure this strategy according to its own priorities, with the exception that if the Contractor uses a readmissions measure, it shall not be the only measure. Contractor shall report its strategy for promoting and rewarding better quality care at hospitals and its progress on adoption of the payment strategy in its annual Application for Certification. Performance Levels: Contractor reports no hospitals in Exchange network(s) contracted based on new payment strategy: 2.5% penalty Contractor reports less than 20% of hospitals in Exchange network(s) contracted under new payment strategy: no penalty Contractor reports 20% or more of hospitals in Exchange network(s) contracted under new payment strategy: 2.5% credit

Group 4: Covered California Performance Standards for Covered California Potential 15% Credit		
Customer Service Measures		**Covered California Performance Requirements**
4.1	**Average Speed of Answer**	Expectation: 80% of calls answered in 30 seconds or less. Performance Level: <80%: 3.75% performance credit. 80%-90%: no credit. >90%: 3.75% reduction in performance credit.
4.2	**Abandonment Rate (%)**	Divide number of calls abandoned by the number of calls offered to a phone representative. Expectation: No more than 3% of incoming calls are abandoned in a calendar month. Performance Level: >3% abandoned: 3.75% performance credit. 2-3% abandoned: no credit. <2% abandoned: 3.75% reduction in performance credit.
4.3	**Initial Call Resolution for Covered California**	Expectation: 85% of Enrollee issues will be resolved within one (1) business day of receipt of the issue Performance Level: <85%: 3.75% performance credit. 85-95%: no credit. >95%: 3.75% reduction in performance credit.
4.4	**Complaint Resolution for Covered California**	Expectation: 95% of Enrollee complaints resolved within 30 calendar days. Performance Level: <95% resolved within 30 calendar days: 3.75% performance credit. 95% or greater resolved within 30 calendar days: no credit. 95% or greater resolved within 15 calendar days: 3.75% reduction in performance credit

Group 5: Dental Quality Alliance (DQA) Pediatric Measure Set					
Measure	**Description**	**Numerator**	**Denominator**	**QDP Performance Rate**	**Expectation**
Utilization of Services	Percentage of all enrolled children under age 19 who received at least one dental service within the reporting year.	Unduplicated number of children who received at least one dental service.	Unduplicated number of all enrolled children under age19.	NUM/DEN	75%
Oral Evaluation	Percentage of enrolled children under age 19 who received a comprehensive or periodic oral evaluation within the reporting year.	Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service.	Unduplicated number of enrolled children under age19.	NUM/DEN	75%
Sealants in 6 to 9 years	Percentage of enrolled children in the age category of 6-9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth within the reporting year.	Unduplicated number of all enrolled children age 6-9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth as a dental service.	Unduplicated number of enrolled children age 6-9 years at “elevated” risk (i.e., “moderate” or “high”).	NUM/DEN	75%

Group 5: Dental Quality Alliance (DQA) Pediatric Measure Set					
Measure	**Description**	**Numerator**	**Denominator**	**QDP Performance Rate**	**Expectation**
Sealants in 10 to 14 years	Percentage of enrolled children in the age category of 10-14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent second molar tooth within the reporting year.	Unduplicated number of enrolled children age 10-14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent second molar tooth as a dental service.	Unduplicated number of enrolled children age 10-14 years at "elevated" risk (i.e., "moderate" or "high").	NUM/DEN	75%
Topical Fluoride for Children at Elevated Caries Risk	Percentage of enrolled children aged 1-18 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year.	Unduplicated number of children at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications as a dental service.	Unduplicated number of enrolled children aged 1-18 years at "elevated" risk (i.e. "moderate" or "high").	NUM/DEN	75%
Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	Number of emergency department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children.	Number of ED visits with caries-related diagnosis code among all enrolled children.	All member months for enrollees 0 through 18 years during the reporting year.	(NUM/DEN) x 100,000	< 15%

Group 5: Dental Quality Alliance (DQA) Pediatric Measure Set					
Measure	**Description**	**Numerator**	**Denominator**	**QDP Performance Rate**	**Expectation**
Follow-Up After ED Visit by Children for Dental Caries	The percentage of caries-related emergency department visits among children 0 through 18 years in the reporting year for which the member visited a dentist within 7 days of the ED visit.	Number of caries-related ED visits in the reporting year for which the member visited a dentist within 7 days (NUM) of the ED visit.	Number of caries-related ED visits in the reporting year.	NUM/DEN	75%
Follow-Up After ED Visit by Children for Dental Caries	The percentage of caries-related emergency department visits among children 0 through 18 years in the reporting year for which the member visited a dentist within 30 days of the ED visit.	Number of caries-related ED visits in the reporting year for which the member visited a dentist within 30 days (NUM) of the ED visit.	Number of caries-related ED visits in the reporting year.	NUM/DEN	90%

Appendix 1 to Attachment 14

Individual Group 1: Customer Service Performance Standards - 15% of Total Performance Penalty or Credit						
		Total Participation Fee Penalty or Credit in Percentages		**Expectation**		
#	**Performance Measure**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**No Penalty**	**Credit**
1.1	Inbound Call Volume	Reporting Measures Only				
1.2	Number of Calls offered to Phone Representatives					
1.3	Number of Abandoned Calls					
1.4	Abandonment Rate (%)	-3.0%	3.0%	>3%	2%-3%	<2%
1.5	Average Speed of Answer	-3.0%	3.0%	<80%	80%-90%	>90%
1.6	Average Handle Time					
1.7	Initial Call Resolution	-3.0%	3.0%	<85%	85%-95%	>95%
1.8	Grievance Resolution	-3.0%	3.0%	<95%	>95%	>95%[1]
1.9	Member Email or Written Inquiries	Reporting Measure Only				
1.10	Member E-Mail or Written Inquiries Answered & Completed	-3.0%	3.0%	<90%	90%-95%	>95%[1]
Total Group 1 Customer Service Performance		**-15.0%**	**15.0%**			

Note 1. Credit is based on 95% or greater resolved with 15 calendar days of receipt

Individual Group 2: Operational Performance Standards - 40% of Total Performance Penalty						
		Total Participation Fee Penalty in Percentages		**Expectation**		
#	**Performance Measure**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**No Penalty**	**Credit**
2.1	ID Card Processing Time	-5.0%	N/A	<99%	99% or greater	N/A
2.2	834 Processing	-5.0%	N/A	<95%	95% or greater	N/A
2.3	834 Generation	-5.0%	N/A	<95%	95% or greater	N/A
2.4	Reconciliation Process	-10.0%	N/A	<90%	90% or greater	N/A
2.5	Data Submission specific to contract Section 3..4.4 and Attach 7, Section 3.03	-10.0%	N/A	>5 days	5 days or less	N/A
2.6	Agent of Record Exception Report	-5.0%	N/A	> 7 days	7 days or less	N/A
Total Group 2 Operational Performance Standards		**-40.0%**	**N/A**			

Individual Group 3: Quality, Network Management and Delivery Standards 45% of Total Performance Penalty or Credit						
		Total Participation Fee Penalty or Credit in Percentages		**Expectation**		
#	**Area of Performance**	**Maximum Penalty**	**Maximum Credit**	**Maximum Penalty**	**No Penalty**	**Credit**
3.1	Quality Rating System (QRS)-Global Rating - Clinical Measures and Enrollee Experience	-3.5%	3.5%	1-2 Stars	3 Stars	4-5 Stars
3.2	Quality Rating System (QRS) - Enrollee Experience	-3.5%	3.5%	1-2 Stars	3 Stars	4-5 Stars
3.3	Essential Community Partners	-10.0%	10.0%	Insufficient	Developing	Sufficient
3.4a	Reducing Health Disparities	-2.0%	2.0%	No improvement	Improvement but does not meet targets	Achieves target
3.4b	Reducing Health Disparities	-3.0%	3.0%	Achieves intermediate milestones for less than half of all measures	Achieves intermediate milestones for at least half of all measures	Achieves intermediate milestones for all measures
3.5	Network Design Based on Quality	-4.0%	4.0%	Contractor unable to describe inclusion of quality criteria into network development	Contractor reports strategy and demonstrates implementation	Contractor fulfills "no penalty requirement", plus submits documentation that hospitals have been notified of expectation to meet hospital safety and C-Section targets.
3.6a	Primary Care	-2.0%	2.0%	Reports less than 95% of members attributed to personal care physician	NA	Reports 95% or more members attributed to personal care physician
3.6b	Primary Care	-3.0%	3.0%	No PCPs contracted based on new payment strategy	Less than 5% of PCP contracted under new payment strategy	Reports 10% or more of PCPs contracted under new payment strategy
3.7	Integrated Health Models	-5.0%	5.0%	Does not meet intermediate milestone for percent of Exchange membership attributed to IHMs	Meets intermediate milestone for percent of Exchange membership attributed to IHMs	Exceeds intermediate milestone for percent of Exchange membership attributed to IHMs

3.8a	Appropriate Use of C-Sections	-2.0%	2.0%	Does not report low risk maternity hospital C- Sections	Contractor reports low risk C-Section rates for network maternity hospitals	Contractor engages hospitals not tracking C-Section rates to initiate and submit information to the Maternity Data Center
3.8b	Appropriate Use of C-Sections	-2.5%	2.5%	Reports no physicians or maternity hospitals contracted on new payment strategy	Reports less than 20% physicians or hospitals contracted under new payment strategy	20% or more physicians or maternity hospitals, reported separately, contracted under new payment strategy
3.9a	Hospital Safety	-2.0%	2.0%	Contractor does not report rates on HACs	Contractor Reports rates on specified HACs	Contractor reports rates on specific HACs and engages non-reporting hospitals to begin tracking specific HAC rates.
3.9b	Hospital Safety	-2.5%	2.5%	Contractor reports no hospitals contracted based on new payment strategy	Less than 20% of hospitals contracted under new payment strategy	Contractor reports 20% or more hospitals contracted under new payment strategy
Total Group 3 Operational Performance Standards		**-45.0%**	**45.0%**			
Total Groups 1-3 Performance Standards [2]		**-100.0%**	**60.0%**			

Note 2. Performance Measurement Standards at risk is 10% of Participation Fee which is 4% of the PMPM in 2017-2019.

Group 4: Covered California Performance Standards - Individual						
		Total Participation Fee Credit or Credit Reduction in Percentages		**Expectation**		
#	**Performance Measure**	**Maximum Credit**	**Maximum Credit Reduction**	**Maximum Credit**	**No Credit**	**Reduction in Performance Credit**
4.1	Call Answer Timeliness	-3.75%	3.75%	<80%	80%-90%	>90%
4.2	Telephone Abandonment Rate	-3.75%	3.75%	>3%	2%-3%	<2%
4.3	Initial Call Resolution	-3.75%	3.75%	<85%	85%-95%	>95%
4.4	Complaint Resolution	-3.75%	3.75%	<95%	>95%	>95%[1]
Total Group 4 Customer Service Performance		**-15.0%**	**15.0%**			

Note 1. Reduction in Performance Credit is based on 95% or greater resolved in 15 calendar days of receipt